Colorado Department of Public Health and Environment
Health Facilities and Emergency Medical Services Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION BUILDING:	DATE SURVEY COMPLETED
	064024		10/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS BEHAVIORAL HEALTH SYSTEM	**8565 S POPLAR WAY LITTLETON 80130**

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S 000	Initial Comments An unannounced on-site complaint investigation was conducted on 09/16/13 through 10/7/13. The survey was generated by CO # 14978 and CO # 14979. Nine Deficiencies were cited. A plan of correction is required.	S 000		
S 002	~ Survey Details This REGULATION is not met as evidenced by: 6 CCR 1011-1 STANDARDS FOR HOSPITALS AND HEALTH FACILITIES (PROMULGATED BY THE STATE BOARD OF HEALTH) Chapter II - General Licensure Standards Last amended 06/19/13, effective 08/14/13 PART 3. QUALITY MANAGEMENT 3.1 QUALITY MANAGEMENT PROGRAM. Every licensed or certified facility, except personal care boarding homes of nineteen beds or fewer and except, community residential homes for persons with developmental disabilities shall establish a quality management program appropriate to the size and type of facility that evaluates the quality of patient or resident care and safety, and that complies with this part 3. 3.1.1 Within 90 days of the effective date of this regulation for facilities licensed on the effective date of this regulation and within 90 days of the issuance of a license to a new facility, every facility defined in section 3.1 shall submit to the Department for its approval a plan for a quality management system that includes the following elements: (4) a description of the method for investigating and analyzing the frequency and causes of individual problems and patterns of problems; (5) a description of the methods for taking corrective action to address the problems, including prevention and minimizing problems or	S 002	1. The facility conducted quality management activities related to nursing care provided. Among other actions taken, Patient Patient Observation Rounds Process: The CEO, Director of Nursing, Director of Risk Management, and Director of Education and Process Improvement revised the Hospital's procedures regarding patient observation rounds. The revisions included adding the responsibilities of the nurse manager, charge nurse, nursing supervisor, and Hospital administration to oversee that appropriate and compliant patient observation rounds (including Quiet Room rounds) are being conducted. The CEO also revised the patient observation rounds policy and procedure by adding a "zero-tolerance" expectation of compliance to reinforce the importance of patient observation rounds and to put patient care staff on notice that noncompliance will subject staff members to additional training and possibly appropriate corrective action, up to and including termination. Administrator on Call (AOC) Process: The CEO reviewed and revised the Administrator on Call (AOC) process to	11/29/2013

I attest that the plan of correction will be implemented and monitored for compliance

AUTHORIZED PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | DATE

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S 002	Continued From page 1 risks; (6) a description of the method for the follow-up of corrective action to determine the effectiveness of such action; (7) a description of the method for coordinating all pertinent case, problem, or risk review information with other applicable quality assurance and/or risk management activities, such as procedures for granting staff or clinical privileges; review of patient or resident care; review of staff or employee conduct; the patient grievance system; and education and training programs; (8) documentation of required quality management activities, including cases, problems, or risks identified for review; findings of investigations; and any actions taken to address problems or risks; and (9) a schedule for plan implementation 3.1.5 The Department may audit the quality management program to determine its compliance with the approved plan. (1) If the Department determines that an investigation of any incident or patient or resident outcome is necessary, it may, unless otherwise prohibited by law, investigate and review relevant documents to determine actions taken by the facility. (2) This section shall be effective June 1, 1988. The Requirement is NOT MET as evidenced by: Based on staff interviews and review of facility documents, the facility failed to conduct quality management activities related to nursing care provided, such as patient observation rounding, medication administration and patient assessment and documentation. The facility failed to assess the quality of the discharge planning process and to incorporate adverse patient outcomes after discharge into the evaluation of the discharge planning process and the the facility-wide quality program. The	S 002	have the AOC provide non-clinical support to the evening and overnight shifts to reinforce the importance of the patient observation rounds process. Hospital executives required to fulfill AOC duties include the CEO, CFO, Director of Risk Management, Director of Education and Process Improvement, Director of Plant Operations, Director of Business Development, Director of Intake, and Director of Clinical Services. The revised process provides for the AOCs to conduct a physical walk-through of Intake, Unit 1, Unit 2, and the Adolescent Unit to observe Unit Staff conducting patient observation rounds on each Unit. The AOCs also communicate with staff about the importance of quality patient care and potential employee concerns/issues. Ambassador Rounding: The CEO reviewed and revised the patient observation rounds process by adding a designated training ambassador to assist nursing staff with observing, reinforcing, and educating staff performing patient observation rounds. The Director of Nursing selected the training ambassador from among Behavioral Health Associates (BHAs) that have consistently demonstrated excellent rounding skills, communication skills, and role modeling skills. The ambassador conducts random visits on the different units and shifts seven days per week. The ambassador directly observes employees conducting rounds and reviews video camera tapes. In addition to giving the employee direct verbal feedback, written feedback when appropriate, and providing verbal feedback to the charge nurse and nurse supervisor as appropriate, the ambassador also monitors usage of the Quiet Room and observation rounds done	

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S 002	Continued From page 2 facility failed to conduct quality management activities related to adverse events in the care and death of Sample Patient #1. Findings: 1. The facility failed to ensure that nursing services conducted effective quality management activities to evaluate the nursing care provided related to patient observation rounds, medication administration and patient assessment and documentation. Reference S 0009 for findings regarding staff failure to conduct patient observation rounds. Reference S 0007 for findings regarding staff failure to adequately identify assess/reassess a patient with a change of condition and to document findings and initiate appropriate interventions and monitoring. Reference S 0008 for findings regarding nursing staff failure to administer medications according to physician orders and to adequately monitor the response to medications. 2. The facility failed to ensure that the quality of the discharge planning process was assessed and to incorporate adverse patient outcomes after discharge into the evaluation of the discharge planning process and the facility-wide quality program to improve patient care and outcomes. Reference S 0006 for findings regarding discharge planning/facility failure to develop and maintain a process for evaluating the effectiveness of the hospital-wide discharge planning process and to review adverse patient events, including deaths/suicides, after discharge, from a quality improvement point-of-view.	S 002	on patients in the Quiet Room, and then submits a written report to the Director of Nursing after each visit. The Director of Nursing reviews the ambassador's reports each weekday. Monitoring/Tracking: For a period of 30 days, the CEO directed the Director of Nursing to monitor the training ambassador process through review of the ambassador's reports each weekday and submission of reports to the CEO each weekday and weekly. Monitoring results will also be reviewed by the Performance Improvement Committee at its monthly meeting. After 30 days, if it is determined that there is 100% compliance with rounding, the frequency of reporting to the CEO may be reduced, but will not be discontinued until it has been determined that the compliant rounding process and culture of safety are thoroughly ingrained. Staff Training: The CEO directed 100% of nursing staff (RNs and BHAs) to undergo training and complete a Return Demonstration on patient observation rounds. Return Demonstrations were validated by the nurse manager, nurse supervisor, or BHA training ambassador. In addition, the training emphasized the limited use of the Quiet Room and the continued use of patient observation rounds when it is deemed appropriate to place a patient in the Quiet Room for a limited period of time. 100% of patient care staff performed a Return Demonstration competency on patient observation rounds. The Return Demonstration outlined key components concerning patient safety and the patient observation rounding processes, including: 1. Proper use of the flashlight when	

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S 002	Continued From page 3 3. The facility failed to conduct quality management activities related to adverse events in the care and death of Sample Patient #1. Reference S 0008 for findings related to the facility failure to adequately identify and investigate medication variances related to the care and death of Sample Patient #1.	S 002	rounding on sleeping patients at night and the process for confirming three respirations and any change in a patient's position. 2. Informing the RN of any change in condition such as abnormal breathing (including snoring), and patient repositioning so the RN will assess/reassess the patient's condition. 3. Nurses were also re-trained by the Director of Education and Process Improvement to assess/reassess patient breathing, to take vital signs as appropriate including taking pulse oximeter reading, to attempt to rouse a patient when necessary, to notify the physician of changes in condition, and to document findings and actions. Monitoring/Tracking: Training was provided to 100% of all nursing staff with evidence of this retraining placed in the master training file. The Director of Nursing was responsible for confirming that all staff received the training. New Employee Orientation: The CEO directed the Director of Education and Process Improvement to revise the New Employee Orientation process as follows: 1. To include a suicide prevention video that orients 100% of new employees on the importance of patient observation rounds. 2. To provide training on the revised patient observation rounds policy describing the Hospital's "zero tolerance" expectation and promoting the importance of patient observation rounds as one of the most critical functions performed by nursing staff. 3. To emphasize the limited use of the Quiet Room and the continued use of patient observation rounds when the use of the Quiet Room is deemed appropriate.	

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S 002	Continued From page 4	S 002	4. To include a patient observation rounds practice for all new hires of clinical staff. 5. To have a Return Demonstration competency on patient observation rounding incorporated into the training and overseen by a Registered Nurse. Annual Competencies Process: The CEO directed the Director of Education and Process Improvement to include patient observation rounds training in the Hospital's Annual Competencies process with nursing staff showing competency through Return Demonstration. The Director of Nursing is responsible for confirming the competency of all nurse managers and nurse supervisors in patient observation rounding and in overseeing patient observation rounding by other nursing staff members. Annual Competencies Training was provided to 100% of all patient care and nursing staff with evidence of this retraining placed in the master training files. Video Camera Review Process: The CEO directed the Director of Plant Operations to make video camera review capability accessible to the entire Hospital leadership team to enable them to conduct periodic reviews of patient observation rounds. The CEO and Director of Plant Operations reviewed the physical location of all Hospital camera monitoring stations to confirm functionality of each camera reviewing station. The Director of Plant Operations added camera monitors to all Units and to the CEO's office to provide review accessibility to the CEO, Director of Nursing, and all Nursing Supervisors. Monitoring/Tracking: One randomly selected hour of patient observation	

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S 002	Continued From page 5	S 002	rounds is reviewed daily by Nurse Managers/Supervisors, and weekly by the CEO, Director of Risk Management, and the Director of Education and Process Improvement. Observations are documented on the Video Camera Review of Staff Observation Rounds Form which was specifically developed by the Director of Nursing for this process. The CEO provides a summary report of audit results to the monthly meetings of the Committee of the Whole and the MEC, and quarterly to the Board of Directors. Assessment/Reassessment The CEO directed the Director of Nursing to revise the patient observation rounds policy by adding more precise language about nurses' assessment/reassessment of patients. This clearer language emphasizes that all patients should be reassessed by an RN if they exhibit medical and/or behavioral changes including repositioning, snoring, and unusual breathing patterns of sleeping patients. The CEO directed the Director of Nursing to have 100% of nurses complete a competency check-off on assessment/reassessment of patients. The Director of Nursing/designees provided retraining and competency checks to all nurses on assessment/reassessment of patients. The checklists are in the master training files. This training covered the assessment and reassessment of patients' general physical and mental condition, signs and symptoms of change in condition, expectations for corresponding documentation, and notification of physicians of changes in patients' condition, including but not limited to:	

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S 002	Continued From page 6	S 002	1. Vital signs 2. Oxygen saturation level 3. Emesis (including color, quantity and quality) 4. Any additional change in patient condition 5. Notification of physician and orders received The Director of Nursing also re-educated nurses on issues that can arise when patients are prescribed multiple medications, particularly medications with sedative effects, and on the need to initiate on-going assessments of patients on multiple medications when the patients appear sedated. The Chief Medical Officer presented a revised Clinical Institute Withdrawal (CIWA) Assessment form for assessing patients going through alcohol detox and a new Clinical Opiate Withdrawal Scale (COWS) Assessment form for assessing patients going through opiate detox to the Medical Executive Committee (MEC) for approval. The CIWA and COWS Assessment forms contain criteria for nurses to use in assessing and scoring withdrawal symptoms of patients going through detoxification. The MEC approved the forms and emphasized the importance of: 1. Nurses notifying the physician of any change in patient condition or of high scores on the CIWA or COWS assessment. 2. Nurses documenting their assessment and observations, including their withholding of additional medcations and conducting of close patient monitoring while waiting for additional physician orders. The Director of Nursing trained 100% of the RNs on the use of the revised CIWA and the new COWS assessment forms.	

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S 002	Continued From page 7	S 002	The Director of Nursing is monitoring completion of 100% of CIWA and COWS forms as described further below. The CEO directed the Director of Education and Process Improvement to conduct additional Mock Code Blue Drills to reinforce nurse competency for patient assessment/reassessment. The Mock Code Blue Drills are conducted using various scenarios to provide nursing staff a variety of potential patient circumstances where nurses practice assessment and critical-thinking processes. Ten Mock Code Blue Drills have been completed: two mock drills were conducted in July (7.31.13—Unit 2 and the Adolescent Unit), three mock drills in August (8.26.13—Unit 1, 8.29.13—Unit 1 and Intake), three mock drills in September (9.5.13—Adolescent medical response, 9.16.13—Gymnasium and Unit 2), and two mock drills in October (10.16.13—Adolescent Unit and 10.26.13—Unit 1 and Adolescent Unit). Mock drills are to continue at least twice a month. Findings confirm that nursing staff benefit by practicing critical thinking skills on various patient scenarios. The Director of Education and Process Improvement reports mock drill outcomes monthly at the Committee of the Whole and MEC meetings, and quarterly to the Board of Directors. Each weekday the Director of Nursing is reviewing nurses' assessment/reassessment documentation, including 100% of any CIWA or COWS forms, for patients admitted on and receiving pain medications. The review is to confirm completeness of assessment/reassessment documentation and appropriate actions taken in accordance with policy based on a	

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S 002	Continued From page 8	S 002	patient's response to medications, change in condition, and/or high score on a CIWA or COWS assessment. The Director of Nursing provides a summary report of audit results to the monthly meetings of the Committee of the Whole and the MEC, and the quarterly meetings of the Board of Directors. Medication Administration The Director of Nursing reviewed and confirmed the accuracy and completeness of the Hospital's medication administration policies. The Director of Nursing re-educated nursing staff on the process for reporting a medication variance or potential error, and clarified what is a variance and what should be reported as follows: 1. All medication orders that are not written on the MAR as the physician prescribed are considered to be a variance. 2. Additionally, all medications that are administered incorrectly, or not as the physician prescribed, are considered to be a medication variance. 3. Any staff member identifying a medication variance or potential error should complete an Incident Report and return it to his/her supervisor. 4. The supervisor then forwards the Incident Report to the Director of Nursing. 5. following the Director of Nursing's review, the Director of Risk Management and the Director of Education and Process Improvement also conduct a review. 6. All medication variances are reported to the monthly meetings of the Committee of the Whole and the MEC, and to the quarterly meetings of the Board of Directors. 7. The Director of Nursing works with	

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S 002	Continued From page 9	S 002	the specific nurse involved with the variance(s), and identifies and analyzes what happened and any trends (as applicable) with the pharmacist in order to attempt to prevent reoccurrences. The clarification of what constitutes a reportable medication variance was addressed in the Committee of the Whole meeting. During the MEC meeting on 9/24/2013, all physicians were encouraged to check on their patients' controlled substance prescriptions through review of an online medication verification database. The CEO confirmed that the pharmacist regularly uses this website to check for polypharmacy issues and is responsible for discussing polypharmacy concerns with the prescribing physician. The Director of Nursing developed a new policy on "Medication Patches," which was approved by the MEC. The new policy clearly articulates: 1. That Fentanyl patches are not allowed at this Hospital. Those patients presenting with a Fentanyl patch will have the patch removed, and the treating physician will prescribe an alternate medication if needed. 2. The correct process for administering, monitoring, accounting for, and destroying other medication patches, including conducting daily skin assessments; initialing, timing, and dating the patch; and documenting the skin assessment and presence or absence of a patch. 3. That daily skin assessments may be increased if a patient has a change in condition that warrants an additional assessment. 4. The requirement for nurses to contact a physician if a patient exhibits an unusual or unexpected response to a	

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S 002	Continued From page 10	S 002	medication patch, or if a patient appears to have lost a medication patch, and to obtain new orders about the patch. The Director of Nursing trained 100% of RNs on the new Medication Patches policy, which includes the correct process for administering, monitoring, accounting for, and destroying the patches; conducting skin assessment; validating the location of the patch on the patient, and the time, date and the nurse's initials on the patch; contacting the physician in the event of a problem with a patch; and documenting the assessment, any issues, and any communication with a physician in the medical record. The Director of Nursing also trained 100% of RNs on documenting the date, time and location of the patch and removal of the patch in the MAR. Training also reviewed the process for administering oral medications. Monitoring/Tracking: The pharmacist monitors medication patch administration and communicates with the Director of Nursing to confirm proper administration of medication patches. The Director of Nursing audits 100% of documentation on patients with any medication patches, including reviewing the MAR in addition to other locations in the medical record, to confirm compliance with the new medication patch policy. All medication variances are reported monthly at the Committee of the Whole and MEC meetings, and quarterly to the Board of Directors. All trends are referred to and addressed through the Nursing and Pharmacy Departments and subcommittees formed as indicated depending on the identified issues. The Director of Nursing is monitoring the Nursing assessments/reassessments, including 100% of any CIWA or COWS	

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S 002	Continued From page 11	S 002	forms used for patients undergoing detoxification, for documentation accuracy and completeness, with results/trends/variances reported monthly at the Committee of the Whole and MEC meetings, and quarterly to the Board of Directors. The Director of Nursing is auditing 100% of assessments of patients admitted on pain medication to confirm documentation accuracy and completeness. Results are reported monthly in the Committee of the Whole and the MEC meetings, and quarterly to the Board of Directors. 2. The Director of Education and Process Improvement reviewed and confirmed that, when it is aware of them, the facility reviews and evaluates post-discharge deaths through the QAPI process and Peer Reviews within 30 days after notification of the death. Physicians perform the medical review in the Peer Reviews. Other appropriate clinical personnel, including at least one physician, conduct a multidisciplinary Root Cause Analysis (RCA) of deaths within 72 hours after discharge or a multidisciplinary intensive review of other post-discharge deaths. When an autopsy is involved and the Hospital is provided with a copy, the Chief Medical Officer reviews the autopsy report and determines whether additional analysis by the multidisciplinary group is warranted. During the Medical Executive Committee (MEC) meeting on 10/01/2013, the physicians on the MEC determined that, going forward, one physician must be present during all reviews of post-discharge deaths.	

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S 002	Continued From page 12	S 002	The Director of Education and Process Improvement confirmed that reviews of the reported deaths of patients #1, #11, #12, #13, #14, #16 & #21 were done by a multidisciplinary group. The Director of Education and Process Improvement then revisited the reviews with the Director of Nursing, Director of Risk Management, Director of Clinical Services, Nurse Managers, and Chief Medical Officer. The Utilization Manager reviewed and confirmed the process for evaluating the effectiveness of the facility-wide discharge planning activities and also reviewed recent improvements that were made as a result of previous RCAs or intensive analyses. Recent improvements include (but are not limited to) taking psychosocial factors into consideration as part of discharge planning, increasing documentation on Master Treatment Plans, and calling physicians about all potential patient assessments. The Director of Clinical Services re-educated the therapists to include psychosocial stressors in the Master Treatment Plans (MTPs) on November 30, 2012. The Director of Clinical Services reviewed the MTPs of the cited patients to confirm that therapists had included psychosocial stressors in the MTPs. The Director of Clinical Services also confirmed that therapists regularly schedule post-discharge appointments (as indicated) as part of discharge planning so that appropriate follow-up care is in place before a patient is discharged. Monitoring: The Director of Risk	

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S 002	Continued From page 13	S 002	Management reviews all post-discharge deaths and confirms that peer review and a multidisciplinary analysis is initiated, and that the group conducting the multidisciplinary analysis includes a physician. Outcomes are reported monthly to the Committee of the Whole (COW). The facility reviewed and improved its discharge planning process, with attention to review and evaluation of adverse patient outcomes that occur after discharge and of which the facility is aware. The Director of Nursing, Performance Improvement Manager, and Director of Clinical Services will meet quarterly to review and analyse post-discharge outcomes and death after discharge data for trends to incorporate into the evaluation of the discharge planning process and facility-wide quality program. The Director of Risk Management will meet quarterly with Medical Staff Executive Committee to review the quarters death's after discharge for coroner updates,and analyze additional input from physicians and clinical for loop closure and identification of trends regarding the effectiveness of the discharge planning process. Performance Improvement and Risk Management will implement a Behavior and Symptom Identification Scale "Basis 32" in April 2014. Patient's will have the opportunity to fill out the scale at intake and once again at discharge for additional guidance in the discharge process. The program also provides a 45 day post-discharge follow-up that provides	

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S 002	Continued From page 14	S 002	post-discharge data for analysis. The Director of Nursing, Manager of Performance Improvement, Clinical Services Director and Director of Risk Management will review the post-discharge data and use the data to improve the effectiveness of the discharge planning process.	
S 003	~ Survey Details This REGULATION is not met as evidenced by: 6 CCR 1011-1 STANDARDS FOR HOSPITALS AND HEALTH FACILITIES (PROMULGATED BY THE STATE BOARD OF HEALTH) Chapter II - General Licensure Standards Last amended 06/19/13, effective 08/14/13 PART 6. PATIENT RIGHTS 6.100 PATIENT RIGHTS 6.104 PATIENT RIGHTS POLICY (1) The health care entity shall develop and implement a policy regarding patient rights. The policy shall ensure that each patient or, where appropriate, patient designated representative has the right to: (a) participate in all decisions involving the patient's care or treatment; (c) refuse any drug, test, procedure, or treatment and to be informed of risks and benefits of this action; The Requirement is NOT MET as evidenced by: Based on interview and document review the facility failed to respond to a request by a patient, and the patient's legal guardian, to be discharged from the facility. The patient was a minor, admitted as a voluntary patient, and was not placed on a mental health hold while hospitalized.	S 003	The MEC discussed patient discharges resulting from the request for release either by a patient or the patient's legal guardian and clarified the hospital's process. It was clarified that, if a patient is found to be at risk of harming self or others, a hold will be obtained. If the patient does not meet criteria for a hold, the patient will be released. The Director of Education and Process Improvement re-educated the Nursing Staff and the Therapists on the process for responding to a patient's request for release. The Director of Intake re-educated the Intake staff on the requirements for placing holds and maintaining the hold log, including the requirement to document on the hold log patients that are placed on hold during the hospital stay. The Director of Intake amended the "Conditions of Admission and Services" form to clarify the discharge process for patients on voluntary or involuntary status.	11/29/2013

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S 003	Continued From page 15 This failure resulted in a situation in which the basic right of being able to refuse further treatment was not honored by the facility. Findings: 1. The facility did not respond to the legal guardian's and minor patient's request to be discharged from the facility while the patient was under a voluntary admission. a) On 09/18/13 at 8:45 a.m., review of the medical record for Sample Patient #6 was conducted. The record revealed the patient was a minor, admitted voluntarily on 10/06/12, as a walk-in patient. The patient was accompanied by his/her legal guardian. Diagnoses upon admission were documented as depressive disorder, impulse control disorder, and migraine headaches. The document titled, "Comprehensive Assessment Tool," timed and dated 10/06/12 at 1:30 p.m., stated the patient denied suicidal ideation and homicidal ideation upon admission, with no history of aggression. The document revealed the patient had suicidal ideation "in the last month" but the patient's guardian was not concerned for the patient's safety and the guardian signed the patient in "voluntarily." A physician progress note, dated 10/08/12, at 8:15 a.m., completed by Staff Physician #1, revealed documentation that the patient was "no longer depressed or suicidal" and the physician "suspected" the patient "wants to D/C [discharged]." The physician further documented the patient's guardian called the facility on 10/07/12 concerned that s/he made the "wrong decision" to bring the patient to the facility for inpatient services. No further statement was documented by the physician on this date regarding a plan or timeframe in which	S 003	Monitoring: The Director of Education and Process Improvement monitors 100% of requests for release to confirm compliance with the release process. The Director of Education and Process Improvement reports outcomes monthly to the Committee of the Whole (COW) meeting and quarterly to the Board of Directors (BOD).	

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S 003	Continued From page 16 the patient would be discharged. A document titled, "Clinical Services/ Case Management Note," dated 10/08/12 at 10:30 a.m., stated the parents (legal guardian) of the patient are "now concerned" and want the patient "out." However, there was no evidence to show the facility coordinated or initiated steps to discharge the patient who remained on a voluntary admission. A progress note documented by Staff Counselor #1, revealed Staff Counselor #1 documented s/he called the patient's guardian on 10/08/12 at 2:11p.m., and the patient's family was "upset because the patient was just going to come in for an assessment" and further documented that a family meeting was scheduled for 10/09/12 at 1:00 p.m. Staff Counselor #1 did not document that the patient would be discharged on 10/09/12. A document titled, "Nursing Progress Note," dated 10/08/12 at 3:00 p.m., revealed the patient asked "many times" if this was the day s/he would be discharged. Review of a document titled, "Discharge Summary," documented by Staff Physician #1, stated the patient was brought in by his/her guardian with "thoughts about suicide with no plan." The Discharge Summary also revealed that when Staff Physician #1 saw the patient on 10/08/12, the patient stated s/he "needed to go home" and the patient's guardian had called the facility and stated it was a "mistake" to bring the patient to the facility. Staff Physician #1 documented the patient was discharged the next day, 10/09/12, as there was no reason to hold the patient against his/her will and both the patient and his/her guardian wanted the patient to be discharged.	S 003		

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S 003	Continued From page 17 The document titled, "Conditions of Admission and Services," dated 10/06/12, stated under request for discharge that if a patient wished to "leave the hospital" the patient would need to give verbal or written notice to hospital staff and that the physician would release the patient if deemed no longer a "risk to self or others" unless the physician ordered a face-to-face evaluation to be completed by the physician within 24 hours. The document did not differentiate between patients on a mental health hold on not on a hold. b) On 09/18/13 at 12:38 p.m., the facility policy titled, "Involuntary Admission," revised 07/12, was reviewed. The policy contained guidance for staff regarding the involuntary hospitalization of patients. The policy stated during the admission process, the intake specialist would determine if the patient was a danger to self (suicidal) or others (homicidal) or gravely disabled and if this criteria was met, the facility would initiate a Legal M-1 Hold. The medical record for Sample Patient #6 was reviewed for the presence of a mental health hold, or any documentation that the patient should be held as "involuntary." No such documentation was found in the patient's record. c) On 09/18/13 at 3:46 p.m., an interview was conducted with Staff Intake Specialist #1 and the facility's Director of Nursing (DON). The Staff Intake Specialist stated s/he was responsible for keeping the facility log of patients placed on a mental health hold (M 1 Hold). The Staff Intake Specialist stated Sample Patient #6 was not on the facility's mental health hold log. The DON reviewed the patient's medical record and stated s/he could find no evidence to hold the patient once the patient and the patient's guardian requested to be	S 003		

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S 003	Continued From page 18 discharged. The DON stated the facility's process for this situation should have been for nursing staff, or whoever received the call from the patient's guardian, to inform the guardian of the AMA process and to inform the patient's physician that the patient and guardian wished to discharge. d) On 09/19/13 at 1:45 p.m., an interview was conducted with Staff Adolescent Counselor #1 who described the facility's process when a voluntary patient, not on a mental health hold, requested to be discharged from the facility. The Counselor stated when s/he learned of this request, s/he would inform the patient's physician, who would reassess the patient within 24 hours and request a "second opinion" from another physician if necessary. S/he stated if an adolescent patient or the parent of a patient, not on a mental health hold, wished to be discharged, "Against Medical Advice" paperwork would have to be completed by the patient/parent and the physician would then have 24 hours to respond to the request. There was no documentation to evidence the legal guardian's request for discharge, on 10/07/12, had been responded to and acted upon within 24 hours. e) On 09/19/13 at 2:34 p.m., an interview was conducted with the facility's Corporate Clinical Director who stated the staff person who took the call from the patient's guardian with the request to discharge on 10/07/12, should have contacted the patient's physician immediately and the process to discharge the patient should have been carried out as soon as possible. The Director, who was present when the Staff Counselor was interviewed, stated the Counselor seemed to be unclear how to respond to a discharge request for a patient not on a mental health hold.	S 003		

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S 003	Continued From page 19 The facility document titled, "Conditions of Admission and Services," was reviewed with the Director who confirmed the document did not offer patients clear information regarding voluntary status or being on a mental health hold and a patient's request for discharge. The Director reviewed the medical record for Sample Patient #6 and stated no documentation was found supporting the patient being held in the facility after 10/07/12. The Director confirmed not discharging Sample Patient #6 at the time of the guardian's first request on 10/07/12, was a violation of the patient's rights.	S 003		
S 005	~ Survey Details This REGULATION is not met as evidenced by: 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 18, Psychiatric Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 7. PERSONNEL. The facility shall have a personnel department in conformance with the standards established in Chapter IV, Part 7, Personnel Department. Chapter 4, General Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 7. PERSONNEL 7.100 7.101 ORGANIZATION AND STAFFING (1) Each department or service of the hospital shall be under the direction of a person qualified by training, experience, and ability to direct the department or service. (2) There shall be sufficient personnel qualified by education and experience in each department or service to properly operate the department or service. (3) Facility staff shall be licensed or registered in	S 005	The CEO reviewed and confirmed that the facility had an acting Human Resource Director in place throughout the period of time reviewed by the surveyors. A new permanent Human Resource Director started at the facility on 10/30/13. The facility conducted quality management activities related to nursing care provided. 1. Among other actions taken, Patient Observation Rounding was immediately identified as an issue and actions, including re-education, were initiated on 07/27/13. Please see the detailed response to S 0009 for actions taken regarding patient observation rounds. 2. Please see the detailed response to S 0008 for actions regarding medication administration by nursing staff, documentation of patient responses to medication, and identification of adverse	11/29/2013

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S 005	Continued From page 20 accordance with applicable state laws and regulations and shall provide services within their scope of practice and, as appropriate, in accordance with credentialing. (4) All persons assigned to the direct care of or service to patients shall be prepared through formal education, as applicable, and on-the-job training in the principles, the policies, the procedures, and the techniques involved so that the welfare of patients will be safeguarded. The Requirement is NOT MET as evidenced by: Based on staff interviews and review of medical records and facility documents, the facility/former CEO/former DON failed to ensure that the nursing staff had adequate on-the-job training and demonstrated skills to conduct adequate patient observation rounds, to safely administer and monitor medication responses for patients and to accurately identify patient changes in condition, initiate appropriate action and provide thorough documentation. Findings : 1. Failure to ensure that nursing staff had adequate training and experience to conduct effective patient observation rounds. Reference S 0009 for findings related to nursing staff failure to conduct effective patient observation rounds. 2. Failure to ensure that nursing staff safely administered medications and monitored/documented medication responses. Reference S 0008 for findings related to nursing staff failures to correctly/safely administer medications, document responses and identify adverse medication events/medication errors. 3. Failure to ensure that nursing staff had	S 005	medication events/errors. 3. Please see the detailed response to S 0007 for actions taken regarding nursing assessment/reassessment, identification of changes in patients' condition, documentation, appropriate actions and interventions, and monitoring.	

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S 005	Continued From page 21 adequate training and experience to identify patient changes in condition, initiate appropriate monitoring and other interventions and to document patient care activities/assessments provided. Reference S 0007 for findings relate to nursing staff failure to identify a change in condition for Sample Patient #1 and to take appropriate action and provide complete documentation of patient findings/care activities.	S 005		
S 006	~ Survey Details This REGULATION is not met as evidenced by: 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 18, Psychiatric Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 11. GENERAL PATIENT CARE SERVICES. The facility shall provide patient care services in conformance with the standards established in Chapter IV, Part 11, General Patient Care Services, Sections 11.101 and 11.102. In addition to the aforementioned requirements, the facility shall comply with the following: Chapter 4, General Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 11. GENERAL PATIENT CARE SERVICES 11.100 11.101 ORGANIZATION AND STAFFING (1) The facility shall provide inpatient and outpatient care services. Services shall be provided in accordance with recognized standards of practice, facility policy and procedure, medical orders, and the established plan of care. 11.102 PROGRAMMATIC FUNCTIONS (6) Discharge Planning	S 006	The Director of Education and Process Improvement reviewed and confirmed that, when it is aware of them, the facility reviews and evaluates post-discharge deaths through the QAPI process and Peer Reviews within 30 days after notification of the death. Physicians perform the medical review in the Peer Reviews. Other appropriate clinical personnel, including at least one physician, conduct a multidisciplinary Root Cause Analysis (RCA) of deaths within 72 hours after discharge or a multidisciplinary intensive review of other post-discharge deaths. When an autopsy is involved and the Hospital is provided with a copy, the Chief Medical Officer reviews the autopsy report and determines whether additional analysis by the multidisciplinary group is warranted. During the Medical Executive Committee (MEC) meeting on 10/01/2013, the physicians on the MEC determined that, going forward, one physician must be present during all reviews of	11/29/2013

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S 006	Continued From page 22 (a) The facility shall develop a discharge plan for each inpatient. Discharge planning shall be initiated early in the care, service or treatment process. (b) The facility shall develop and implement policies and procedures regarding discharge planning. At minimum, the policy and procedure shall address: (i) the discharge planning process. (ii) the qualifications of the staff responsible for implementing discharge planning. (iii) initiation of discharge planning in a timely manner to allow for the arrangement of post-hospital care, as needed. (iv) evaluation of the discharge planning process periodically for effectiveness. The Requirement is NOT MET as evidenced by: Based on staff interviews and review of medical records and other facility documents, the hospital failed to develop a mechanism or process for on-going re-assessment of the effectiveness of its discharge planning activities. The facility also failed to conduct clinically oriented reviews of potential discharge failures, including post-discharge suicides/deaths, as a part of discharge planning process evaluation. Findings: 1. The facility failed to have a process for on-going evaluation of the effectiveness of discharge planning activities. a) On 09/27/13 at 10:10 a.m., the Director of Clinical Services was interviewed about the discharge planning activities of the facility. The director stated that s/he was the supervisor of the social workers and discharge planners for the hospital. When asked if there was a process for evaluating the discharge planning process, s/he acknowledged that they did not have a process in place for that. S/he stated	S 006	post-discharge deaths. The Director of Education and Process Improvement confirmed that reviews of the reported deaths of patients #1, #11, #12, #13, #14, #16 & #21 were done by a multidisciplinary group. The Director of Education and Process Improvement then revisited the reviews with the Director of Nursing, Director of Risk Management, Director of Clinical Services, Nurse Managers, and Chief Medical Officer. The Utilization Manager reviewed and confirmed the process for evaluating the effectiveness of the facility-wide discharge planning activities and also reviewed recent improvements that were made as a result of previous RCAs or intensive analyses. Recent improvements include (but are not limited to) taking psychosocial factors into consideration as part of discharge planning, increasing documentation on Master Treatment Plans, and calling physicians about all potential patient assessments. The Director of Clinical Services had re-educated the therapists to include psychosocial stressors in the Master Treatment Plans (MTPs) on November 30, 2012. The Director of Clinical Services reviewed the MTPs of the cited patients to confirm that therapists had included psychosocial stressors in the MTPs. The Director of Clinical Services also confirmed that therapists regularly schedule post-discharge appointments (as indicated) as part of discharge planning so that appropriate follow-up care is in place before a patient is discharged.	

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S 006	Continued From page 23 that the evaluation was during the hospitalization for each individual patient, not the discharge process for all patients. S/he stated s/he was unaware that there was a requirement for on-going evaluation of discharge planning activities for the hospital. 2. The facility failed to conduct clinical case reviews of potential discharge failures, including post-discharge suicides/deaths, as a part of discharge planning process evaluation, to address gaps in discharge planning. a) On 09/17/13, a list of incidents/occurrences for the facility for the past 12 months was reviewed. The list contained 7 deaths after discharge. 5 were listed as "After Discharge Death, Suicide," and 1 was listed as "After Discharge Death, Medical," and 1 was listed as "After Discharge Death Other." 6 of those former patients were added to the sample list for review. Sample Patients #11, #13, #14, and #21 were listed as "After Discharge Death, Suicide." Sample #12 was listed as "After Discharge Death, Medical," and Sample #16 was listed as "After Discharge Death, Other." b) Review on 09/23/13 of the medical record of Sample Patient #11("After Discharge Death, Suicide") revealed that the patient was admitted on 09/12/12 with a diagnosis of Bipolar Disorder with paranoia and history of mania, depression and psychotic symptoms. The patient was discharged on 09/28/12 on day 17 of hospitalization. The hospital was later notified by a county coroner that the patient had committed suicide on 10/22/12, 24 days after discharge. The patient had a history of not following through with medication, significant paranoia and impaired judgment and no established relationship for outpatient therapy support. Review of the case review report, dated	S 006	The Director of Nursing, Performance Improvement Manager, and Director of Clinical Services will meet quarterly to review and analyse post-discharge outcomes and death after discharge data for trends to incorporate into the evaluation of the discharge planning process and facility-wide quality program. The Director of Risk Management will meet quarterly with Medical Staff Executive Committee to review the quarters death's after discharge for coroner updates,and analyze additional input from physicians and clinical for loop closure and identification of trends regarding the effectiveness of the discharge planning process. Performance Improvement and Risk Management will implement a Behavior and Symptom Identification Scale "Basis 32" in April 2014. Patient's will have the opportunity to fill out the scale at intake and once again at discharge for additional guidance in the discharge process. The program also provides a 45 day post-discharge follow-up that provides post-discharge data for analysis. The Director of Nursing, Manager of Performance Improvement, Clinical Services Director and Director of Risk Management will review the post-discharge data and use the data to improve the effectiveness of the discharge planning process. Monitoring: The Director of Risk Management reviews all post-discharge deaths and confirms that peer review and a multidisciplinary analysis is initiated, and that the group conducting the	

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S 006	Continued From page 24 11/07/12, revealed that a psychiatrist was present for the case review. The only significant clinical findings identified during the review were that the treatment plan did not address life changing stressors, such as the patient's difficult financial situation and recent job loss. There was no evidence of a subsequent review or receipt of a coroner's report/autopsy. On 10/07/13, the facility provide a copy of a death certificate that was signed by the coroner on 10/29/12, which stated the cause of death was a suicide due to asphyxia by ligature hanging. c) Review on 09/23/13 of the medical record of Sample Patient #12 ("After Discharge Death, Medical") revealed that the patient was admitted on 01/22/13 with a diagnosis of Mood Disorder. The patient was discharged on 01/30/13, day 9 of hospitalization. The hospital was later notified by a county coroner that the patient had been found dead on 01/31/13, 1 day after discharge. Since the facility review of the death was conducted before the autopsy/coroner's report were available, the facility was not sure of the cause and manner of death. Review of the subsequent case review report, dated 02/05/13, revealed that no physician was present during the review. The only significant clinical factors identified were that the patient's treatment plan was not completed and the 7-day update was not done to review whether the patient had met his/her goals. The review was conducted 5 days after the death. At the time of the review on 02/05/13, the facility did not have the cause of death until the autopsy/coroner's report was received by the facility on 07/11/13. Review on 10/07/13 of the Autopsy/Coroner's Report provided to the survey that day revealed that the patient died of natural causes. The final Cause of Death was Heart Failure due to Hypertension and Arteriosclerotic Cardiovascular Disease, which appeared	S 006	multidisciplinary analysis includes a physician. Outcomes are reported monthly to the Committee of the Whole (COW).	

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S 006	Continued From page 25 unrelated to his/her psychiatric condition and hospitalization. d) Review on 09/23/13 of the medical record of Sample Patient #13 ("After Discharge Death, Suicide") revealed that the patient was admitted on 02/01/13 with a diagnosis of Major Depression, Opiate Abuse and Chronic Pain. The patient was discharged on 02/06/13, day 6 of hospitalization. The hospital was later notified by a county coroner that the patient had committed suicide on 02/13/13, 1 week after discharge. Review of the case review report, dated 03/01/13, revealed that no psychiatrist was present during the review. The only significant clinical factors identified were that pain control and level of depression throughout the hospitalization were not adequately monitored or addressed in the care plan and discharge plan arrangements. The patient contacted a hospital provider 02/12/13, one day before the suicide, stating that the referral plans for pain management appointment had not been successful. The patient was given the name of another pain management program to contact. The case review was conducted approximately 3 weeks after the suicide. A facility document stated that the coroner had requested the medical record of the patient and had provided the information that the patient had died by suicide from a gunshot wound to the head. e) Review on 09/23/13 of the medical record of Sample Patient #14 ("After Discharge Death, Suicide") revealed that the patient was actually only seen on 03/05/13 for less than an hour in the Intake Department. The patient was seen for an evaluation for day program, after having just been released and referred from another acute care hospital psychiatric unit earlier that day after a 14 day inpatient hospitalization. The patient had diagnoses of Anxiety with Xanax	S 006		

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S 006	Continued From page 26 Abuse and Chronic Pain with daily Migraine Headaches. The patient was "referred to pain management specialists," but the record did not contain the name, number or an appointment date for the referral. The assessment stated the patient was extremely anxious and required a pain management specialist as well as Intensive Outpatient Treatment (IOP). It did not appear that the patient was enrolled in the IOP program at the hospital as planned. The hospital was notified that the patient had committed suicide 03/20/12, approximately 2 weeks after being evaluated. On 09/24/13 at 9:23 a.m., the Risk Manager confirmed that no review was conducted on the care provided to the patient, since the patient was not admitted. There was no attempt to obtain a coroner's report/autopsy. f) Review on 09/23/13 of the medical record for Sample Patient #16 "After Discharge Death Other" revealed that the patient was admitted on 07/21/13 with a diagnosis of Mood Disorder and Personality Disorder. The patient was discharged on 07/30/13, day 10. The patient had a very strong family history of Bipolar Disorder with multiple suicides in the extended family and difficult relationships with parents and siblings. The family expressed concerns about the patient's safety and his/her honesty in reporting symptoms and paranoia. The patient was discharged home to family with outpatient therapy arranged. The hospital was later notified by a county coroner that the patient had died on 08/23/13, 23 days after discharge, cause of death still not determined/released by the coroner at the time of the survey. Per interview with the Risk Manager on 09/24/13 at 9:23 a.m., at the time of the survey, no case review had been conducted after approximately a month after the death of the patient.	S 006		

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S 006	Continued From page 27 The Risk Manager stated that the parent corporation for the facility required that a risk-oriented review had to be completed within 30 days after notification of a death and that the coroner reports /autopsies were usually not available for 2-3 months after a death. S/he stated they did the reviews sometimes without knowing the cause of death and whether it was a suicide, from medical causes, or an accident. S/he stated that s/he revisits the review after the coroner's report/autopsy are received and sometimes gets a physician in for a later review. The Risk Manager was unable to provide evidence of a subsequent review or of a physician review. Autopsy/coroner's report received on 10/21/13 after the survey showed that the patient died by hanging/suicide, there were also "cutting" type injuries, the victim left a "suicide-type note at the scene," and there was a "clinical history of depression and suicidal ideation." g) Review on 09/24/13 of the medical record for Sample Patient #21 revealed that the patient was admitted on 04/27/13 with a diagnosis of Bipolar Disorder with history of Alcohol Abuse, Suicidal Ideation, Personality Disorder and Homelessness. During the hospitalization the patient verbalized concern about being discharge too soon and not being able to afford the medication prescribed (Abilify). The provider suggested that the patient speak to the outpatient therapy referral about getting medication samples, but that was not resolved prior to discharge. The patient also had a significant episode of insomnia requiring medication on the night prior to discharge. The patient was discharged on 05/13/13, day 17 of hospitalization. The hospital was later notified by a county coroner that the patient had committed suicide on 05/13/13, the day of discharge. Review of the case review report dated,	S 006		

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S 006	Continued From page 28 05/28/13 revealed that no psychiatrist was present during the review. The only significant clinical factor identified was that the patient refused to participate in a family meeting prior to discharge. A facility document stated that the facility had been contacted by a local county coroner on 5/14/13, the day after the patient 's discharge to requested medical records with information that the patient appeared to have committed suicide by a medication overdose. The case review was conducted approximately 2 weeks after the suicide, and the action plan referred to the Discharge Planning policy/procedure which addressed the provision of community resources, including food and shelter, medical care and psychiatric follow-up to homeless patients as a part of the discharge planning process.. but there was no evidence of a subsequent review or an attempt to obtain/review the coroner's report/autopsy. That was confirmed by the Risk manager on 10/07/13 h) During an interview on 09/24/13 at 9:23 a.m., the Risk Manager stated that the parent corporation for the facility required that a risk-oriented review had to be completed within 30 days after notification of a death and that the coroner reports /autopsies were usually not available for 2-3 months after a death. S/he stated they did the reviews sometimes without knowing the cause of death and whether it was a suicide, from medical causes, or an accident. S/he stated that s/he revisits the review after the coroner's report/autopsy are received and sometimes gets a physician in for a later review. The Risk Manager was unable to provide evidence of a subsequent review or of a physician review. Of the 6 deaths reviewed (Sample Patients #11, #12, #13, #14, #16, #21), the Risk Manager was	S 006		

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S 006	Continued From page 29 only able to provide a review for 4 of the patients (#11, #12, #13, #21). S/he provided background notes s/he had done in anticipation of conducting a review of the death of Sample Patient #14. Review of the case reviews conducted by the Risk Manager revealed that they were all conducted from a risk assessment point-of view, rather than from a multidisciplinary clinical case review point of view. Of the the 4 reviews, only 1 had a psychiatrist participant in the review. All of the reviews included nursing managers from other units, but no nursing staff who had worked with/knew the patient. Review of each case review report revealed a pattern of the treatment teams not addressing significant issues, such as job loss. financial stressors, pain control, and lack of family support in the care plan or taking those things into consideration follow-up care and housing situations were arranged.	S 006		
S 007	~ Survey Details This REGULATION is not met as evidenced by: 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 18, Psychiatric Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 12. NURSING DEPARTMENT. The facility shall provide nursing services in conformance with the standards established in Chapter IV, Part 12, Nursing Services. Chapter 4, General Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 12. NURSING SERVICES 12.100 12.101 ORGANIZATION AND STAFFING (1) There shall be a nursing department. The nursing department shall be organized formally to provide complete, effective care to each	S 007	In addition to the actions described under S 0008 and S 0009, the facility took the following actions with respect to nursing staff assessments and reassessments of patients' conditions: The CEO directed the Director of Nursing to revise the patient observation rounds policy by adding more precise language about nurses' assessment/reassessment of patients. This clearer language emphasizes that all patients should be reassessed by an RN if they exhibit medical and/or behavioral changes including repositioning, snoring, and unusual breathing patterns of sleeping patients.	11/29/2013

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S 007	Continued From page 30 patient. (2) The nursing service department shall be under the direction of a registered nurse qualified by education and experience to direct effective nursing care. 6) The director of nursing shall be responsible for ensuring that all nursing staff have the qualifications, skills and experience necessary to deliver the care assigned in accordance with professional standards of practice and facility policy and procedure. 12.102 PROGRAMMATIC FUNCTIONS (1) There shall be written nursing procedures that establish the standards of performance for safe, effective nursing care of patients. These procedures shall be reviewed periodically and revised as necessary. (2) Nursing staff shall conduct initial and ongoing assessments and screenings of the patient ' s physical, cognitive, behavioral, emotional and psychosocial status in sufficient scope and detail to meet the needs of the patient, according to facility policy and professional standards of practice. The Requirement is NOT MET as evidenced by: Based on review of medical records and facility documents and staff interviews, the director of nursing services failed to ensure that nursing staff adequately assessed and documented patient changes in conditions care and complied with related policies and procedures. Findings: 1. The nursing staff failed to adequately reassess and document the findings for Sample Patient #1 when there was evidence of a change of condition. The facility ' s Reassessment Policy read:	S 007	The CEO directed the Director of Nursing to have 100% of nurses complete a competency check-off on assessment/reassessment of patients. The Director of Nursing/designees provided retraining and competency checks to all nurses on assessment/reassessment of patients. The checklists are in the master training files. This training covered the assessment and reassessment of patients' general physical and mental condition, signs and symptoms of change in condition, expectations for corresponding documentation, and notification of physicians of changes in patients' condition, including but not limited to: 1. Vital signs 2. Oxygen saturation level 3. Emesis (including color, quantity and quality) 4. Any additional change in patient condition 5. Notification of physician and orders received The Director of Nursing also re-educated nurses on issues that can arise when patients are prescribed multiple medications, particularly medications with sedative effects, and on the need to initiate on-going assessments of patients on multiple medications when the patients appear sedated. The Chief Medical Officer presented a revised Clinical Institute Withdrawal (CIWA) Assessment form for assessing patients going through alcohol detox and a new Clinical Opiate Withdrawal Scale	

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S 007	Continued From page 31 " 2. Each Patient is reassessed daily (every 24 hours) and/or as the patient's condition warrant, by an RN. Any condition change noted must be reported to the RN. 3. Reassessment is done to determine the patient's response to treatment or when a change occurs each shift." a) Review on 09/18/13 of the medical record for Sample Patient #1 revealed that the patient was a young adult admitted on 7/18/13 with history of diagnoses of Episodic Mood Disorder, Multiple Substance Abuses including Opiates, Cocaine and Benzodiazepines, Victim of Sexual Abuse and Insomnia. The patient was treated with Valium and Vistaril for anxiety, fentanyl patches for pain, and the psychoactive medications, Lexapro and Neurontin The patient was found on 7/27/13 at approximately 9:30 a.m. not breathing, no pulse, cyanotic and in full rigor mortis in his/her room. (Rigor mortis occurs when the limbs of the corpse becomes stiff and difficult to move or manipulate. In humans, it commences after about three to four hours, reaches maximum stiffness after 12 hours, and gradually dissipates until approximately 48 to 60 hours after death). However, the record showed that 15 minute checks were documented and showed the patient slept all night from approximately midnight with loud snoring. Prior to the patient's being found dead, nurses were documenting that the patient was very sedated and several doses of Valium were withheld because of over-sedation, but no nurse initiated additional vital signs to reassess the patient's condition. During the night prior to the patient being found dead, the record showed that the patient was "snoring" very loudly after having gone to bed in a condition characterized as very sedated. There was no evidence that the patient was assessed by nursing staff during the night with attempts to arouse the patient or	S 007	(COWS) Assessment form for assessing patients going through opiate detox to the Medical Executive Committee (MEC) for approval. The CIWA and COWS Assessment forms contain criteria for nurses to use in assessing and scoring withdrawal symptoms of patients going through detoxification. The MEC approved the forms and emphasized the importance of: 1. Nurses notifying the physician of any change in patient condition or of high scores on the CIWA or COWS assessment. 2. Nurses documenting their assessment and observations, including their withholding of additional medications and conducting of close patient monitoring while waiting for additional physician orders. The Director of Nursing trained 100% of the RNs on the use of the revised CIWA and the new COWS assessment forms. The Director of Nursing is monitoring completion of 100% of CIWA and COWS forms as described further below. The CEO directed the Director of Education and Process Improvement to conduct additional Mock Code Blue Drills to reinforce nurse competency for patient assessment/reassessment. The Mock Code Blue Drills are conducted using various scenarios to provide nursing staff a variety of potential patient circumstances where nurses practice assessment and critical-thinking processes. Ten Mock Code Blue Drills have been completed: two mock drills were conducted in July (7.31.13—Unit 2 and the Adolescent Unit), three mock drills in August (8.26.13—Unit 1, 8.29.13—Unit 1 and Intake), three mock drills in	

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S 007	Continued From page 32 check vital signs (including oxygenation status). In addition, earlier in the evening prior to the patient's death, the patient had at least two episodes of emesis and required medication for that. There was no documentation of a physical assessment when the emesis events happened, and there was no documentation of the nature, amount and contents of emesis in the record. Further review of the medical record revealed that the patient was receiving Melatonin for sleep, Valium and Vistaril for anxiety, Neurontin and Lexapro for anxiety and depression and Fentanyl transdermal patches for pain. On the two days prior to the patient being discovered deceased on the morning of 07/27/13, the patient received the following medications that had a central nervous system depressing effect: 07/25/13: 3 mg Melatonin 100 mcg fentanyl transdermal patches 40 mg Lexapro Valium 50 mg Neurontin 1800 mg Vistaril 75 mg 07/26/13: 100 mcg fentanyl transdermal patches 40 mg Lexapro Valium 10 mg Neurontin 1800 mg Vistaril 75 mg b) Review of the "Mosby's 2012 Nursing Drug Reference, 25th Edition," revealed the medications all had central nervous system (CNS) depression effects which can cause drowsiness and vital sign changes and respiratory depression. There were interactions among some of the medications that potentiated the actions of the various CNS depressants as	S 007	September (9.5.13—Adolescent medical response, 9.16.13—Gymnasium and Unit 2), and two mock drills in October (10.16.13—Adolescent Unit and 10.26.13—Unit 1 and Adolescent Unit). Mock drills are to continue at least twice a month. Findings confirm that nursing staff benefit by practicing critical thinking skills on various patient scenarios. The Director of Education and Process Improvement reports mock drill outcomes monthly at the Committee of the Whole and MEC meetings, and quarterly to the Board of Directors. Quiet Room Use: The Director of Nursing developed a new Quiet Room form that lists the criteria for use of the Quiet Room, emphasizes the limited use of the Quiet Room, and includes a reminder to continue patient observation rounds in accordance with procedure during the short duration a patient is in the Quiet Room. The CEO directed that nursing staff use the new Quiet Room form as a checklist and teaching tool, including during new employee orientation and annual competencies. The Director of Nursing provided training on the new Quiet Room form to 100% of all nursing staff with evidence of this retraining placed in the master training files. Each weekday the Director of Nursing is reviewing nurses' assessment/reassessment documentation, including 100% of any CIWA or COWS forms, for patients admitted on and receiving pain	

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S 007	Continued From page 33 well as extending the half-life of the Valium. In addition, the half-life (time required for half of the amount of the medication to be secreted from the body) for Valium was 20-50 hours per dose. Note that the patient had 5 - 10 mg doses on 07/25/13, which was the day the patient began to show significant sedation. By the morning of 07/26/13, the patient was so sedated that s/he only received a 4:05 a.m. PRN dose of Valium. The morning and evening and PRN doses of Valium were held due to the patient's level of sedation, but the patient continued to receive the other CNS depressing medications Lexapro, Fentanyl, Neurontin and Vistaril throughout that day. The patient was found to be deceased at about 9:30 a.m. on 07/27/13. c) Review of, "Taylor's Clinical Skills Nursing," copyright 2008, pages 745 - 751 stated standards of nursing care regarding respiratory assessment and measuring blood oxygenation with the use of a pulse oximeter. The standard states " Many medications affect the function of the respiratory system. Many medications depress the respiratory system. The nurse should monitor patients taking certain medications, such as opioids, for rate and depth of respirations." The standards state that "a range of 95% to 100% is considered normal," when assessing blood oxygenation with a pulse oximeter. Review of the patient's vital signs revealed that the patient had pulse oximeter reading on admission on 07/18/13 of 99% oxygen saturation. On 07/20/13 and 07/23/13, the patient's oxygen saturation had declined to 94%, which as below the normal range. On 07/26/13, the day prior to the patient's death, the patient's oxygen saturation level was 93% at 8:30 a.m. and declined to 90%, far below the normal range, by 7:45 p.m. Despite the patient's	S 007	medications. The review is to confirm completeness of assessment/reassessment documentation and appropriate actions taken in accordance with policy based on a patient's response to medications, change in condition, and/or high score on a CIWA or COWS assessment. The Director of Nursing provides a summary report of audit results to the monthly meetings of the Committee of the Whole and the MEC, and the quarterly meetings of the Board of Directors.	

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S 007	Continued From page 34 decreased oxygen saturation and extreme sedation, no reassessments of the patient were conducted after the 7:45 p.m. pulse oximeter reading, even though the patient was on multiple medications, including an opioid, that had respiratory and central nervous system depressing effects. d) On 09/25/13 at 9:20 a.m., BHA #3, was interviewed by telephone about observation rounds conducted for Sample Patient #1 on the night shift (11 p.m. to 7:30 a.m.) on the night of 07/26-27/13. The BHA stated that the patient was snoring loudly, once asleep at approximately 12:00 a.m. S/he stated that s/he was concerned about the loud snoring, which s/he stated was able to be heard "even at the nurses' station." The BHA stated that s/he went to the charge nurse (RN #5) and medication nurse (RN #3), who were both at the nurses' station and notified them of his/her concern about the loud snoring. S/he stated that s/he did not see either of the nurses respond to his/her information and go to check on the patient at that time. S/he stated that the charge nurse (RN #5) took over part of his/her rounds at approximately 1 a.m., including the rounds for Sample Patient #1. S/he stated s/he resumed rounds on Sample patient #1 at approximately 6 a.m., and recalled that at 6 a.m., the patient was no longer snoring loudly. The BHA (#3) stated that s/he continued to make rounds until the end of the shift and did final hand-off rounds with the on-coming shift BHA (#4) as the shift was ending at 7:30 p.m. e) On 09/26/13 at 1:20 p.m., RN #5, who was no longer an employee of the facility, was interviewed by telephone, about observation rounds conducted for Sample Patient #1 on the night shift (11 p.m. to 7:30 a.m.) on the night of 07/26-27/13. S/he confirmed that Sample Patient #1 was snoring loudly during the night	S 007		

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S 007	Continued From page 35 and that the noise could be heard even at the nurses station. S/he had no memory of the BHA (#3) asking him/her to check on the patient. S/he stated that s/he did make rounds on the patient for part of the night. S/he stated that this was his/her first night working on that unit, so s/he was not familiar with the sleeping habits of Sample Patient #1, including whether the snoring was typical or unusual for that patient. S/he recalled that the patient had appeared very drowsy at about 11:45 p.m. when s/he came up to the medication window requesting Valium. S/he stated she refused to give the patient the Valium because of his/her level of sedation, but did not take vital signs or call the provider. S/he confirmed that s/he did not go in to the patient's room to do an assessment or to initiate vital signs for the patient. S/he stated s/he was a newly graduated nurse and that it was his/her first nursing job. f) On 09/26/13 at 11:55 a. m., during an interview with the president of the medical staff, the care and medical record of Sample Patient #1 was discussed. The medical director stated that s/he and another provider had conducted an independent review of the case, since they had not cared for the patient. During the interview, the expectations for nurses to initiate additional vital signs or other assessments of this patient, related to over-sedation, loud snoring at night and the documentation of the patients episodes of vomiting was discussed. S/he agreed that nurses should have initiated reassessment of the patient, provided accurate documentation and even contacted the doctor about concerns related to these issues. g) On 09/19/13 at 11:05 a.m., the Nurse Educator was interviewed and the expectations for documentation of patient symptoms and reassessment of the patient when there was	S 007		

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S 007	Continued From page 36 evidence of a possible change of condition was discussed. S/he stated that nurses should have reassessed the patient related to increased sedation symptoms and very noisy snoring during sleep. In addition, s/he stated that the nurses did not adequately document the episodes of emesis, including times, whether witnessed, nature of the emesis and quantity, as s/he would expect as a standard of nursing care and documentation.	S 007		
S 008	~ Survey Details This REGULATION is not met as evidenced by: 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 18, Psychiatric Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 13. PHARMACEUTICAL SERVICES. The facility shall provide pharmaceutical services in conformance with the standards established in Chapter IV, Part 13, Pharmaceutical Services. Chapter 4, General Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 13. PHARMACEUTICAL SERVICES 13.102 PROGRAMMATIC FUNCTIONS (5) Medication Administration. Medications shall be identified with at least the name, strength, and dosage. Prior to administration, the name, strength, dosage, frequency and route of administration on the patient order shall be checked. The facility shall develop and implement policies and procedures regarding: (a) the review of patient drug profiles. (b) safe administration of drugs and biologicals. Only persons who are authorized by law and the facility and are appropriately trained shall administer medications. (c) monitoring and documenting the effects of	S 008	Patient Assessment/Reassessment: The CEO directed the Director of Nursing to have 100% of nurses complete a competency check-off on assessment/reassessment of patients. The Director of Nursing/designees provided retraining and competency checks to all nurses on assessment/reassessment of patients. The checklists are in the master training files. This training covered the assessment and reassessment of patients' general physical and mental condition, signs and symptoms of change in condition, expectations for corresponding documentation, and notification of physicians of changes in patients' condition, including but not limited to: 1. Vital signs 2. Oxygen saturation level 3. Emesis (including color, quantity and quality) 4. Any additional change in patient	11/29/2013

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S 008	Continued From page 37 medication, including but not limited to, the process for monitoring the first dose of a medication that has been identified as one with the potential for serious adverse reactions. (d) identification and reporting of adverse reactions, interactions, and medication errors. The Requirement is NOT MET as evidenced by: Based on document review and interviews the facility failed to ensure that staff Registered Nurses administered medications per physician orders. Transdermal Fentanyl patches were administered to Sample Patient #1 at a more frequent time interval than ordered by the patient's physician. Nursing staff also failed adequately assess the patient's change of condition that may have been related to the combinations of medications being administered. The facility also failed to investigate the medication regime and medication administration variances that may have contributed to the death of Sample Patient #1. Findings: 1. Registered nursing staff did not administer Fentanyl per a physician's order. Nursing staff changed a patient's transdermal Fentanyl patch sooner than the 72 hour time interval ordered by the patient's physician. a) On 09/19/13 at 3:26 p.m., review of the medical record for Sample Patient #1 was conducted. The patient was admitted to the facility on 07/18/13. Upon admission the patient had been prescribed Fentanyl for chronic pain issues. The patient's record revealed a physician order for Fentanyl Patch, 100 micrograms, q (every) 72 hours was received on 07/18/13. The record reflected that this medication was ordered to be discontinued on 07/21/13. The medical record revealed the	S 008	condition 5. Notification of physician and orders received The Chief Medical Officer presented a revised Clinical Institute Withdrawal (CIWA) Assessment form for assessing patients going through alcohol detox and a new Clinical Opiate Withdrawal Scale (COWS) Assessment form for assessing patients going through opiate detox to the Medical Executive Committee (MEC) for approval. The CIWA and COWS Assessment forms contain criteria for nurses to use in assessing and scoring withdrawal symptoms of patients going through detoxification. The MEC approved the forms and emphasized the importance of: 1. Nurses notifying the physician of any change in patient condition or of high scores on the CIWA or COWS assessment. 2. Nurses documenting their assessment and observations, including their withholding of additional medications and conducting of close patient monitoring while waiting for additional physician orders. The Director of Nursing trained 100% of the RNs on the use of the revised CIWA and the new COWS assessment forms. The Director of Nursing is monitoring completion of 100% of CIWA and COWS forms as described further below. The CEO directed the Director of Education and Process Improvement to conduct additional Mock Code Blue Drills to reinforce nurse competency for patient assessment/reassessment. The Mock Code Blue Drills are conducted using various scenarios to provide nursing staff	

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S 008	Continued From page 38 medication was discontinued on this date (7/21/13) by a physician order as the patient reported s/he "flushed" one of the Fentanyl patches. A new physician order for Fentanyl Patch, 100 micrograms, q 72 hours, was documented in the patient's record on 07/22/13 at 8:45 p.m. The Medication Administration Record (MAR) for Sample Patient #1, completed by nursing staff, revealed Fentanyl, 100 micrograms, in the form of a transdermal patch, was administered to Sample Patient #1 on 07/19/13 at 10:00 a.m. to the patient's left chest area. Review of the MAR reflected Fentanyl, 100 micrograms was placed "on" the patient on 07/22/13 at 8:45 p.m. The MAR reflected that Fentanyl, 100 micrograms was placed on the patient again on 07/25/13 at 9:00 a.m. and on 07/26/13 at 9:00 a.m. The doses documented on 07/25/13 and 07/26/13 reflected the Fentanyl patches were administered to the patient 24 hours apart, not 72 hours apart as ordered by the patient's physician. No documentation could be found in the patient's medical record indicating that nursing staff had received a new order for Fentanyl from a physician or that nursing staff had contacted a physician to obtain a new/different order for this medication. The same disbursement of Fentanyl patches were confirmed on the Fentanyl 50 mcg Patch Inventory Activity form and the Control II Narcotics form for the same dates. Further - there was no documented evidence that the used patches were retrieved by nursing staff prior to administration of the new patches. 2. Registered Nursing staff did not use standards of nursing documentation when documenting activities around administration of Fentanyl patches, or "missing" Fentanyl patches, a Schedule II, Controlled Substance. Registered nursing staff did not document skin assessments of Sample Patient #1 prior to the	S 008	a variety of potential patient circumstances where nurses practice assessment and critical-thinking processes. Ten Mock Code Blue Drills have been completed: two mock drills were conducted in July (7.31.13—Unit 2 and the Adolescent Unit), three mock drills in August (8.26.13—Unit 1, 8.29.13—Unit 1 and Intake), three mock drills in September (9.5.13—Adolescent medical response, 9.16.13—Gymnasium and Unit 2), and two mock drills in October (10.16.13—Adolescent Unit and 10.26.13—Unit 1 and Adolescent Unit). Mock drills are to continue at least twice a month. Findings confirm that nursing staff benefit by practicing critical thinking skills on various patient scenarios. The Director of Education and Process Improvement reports mock drill outcomes monthly at the Committee of the Whole and MEC meetings, and quarterly to the Board of Directors. The Director of Nursing and the Director of Education and Process Improvement re-educated 100% of nursing staff (RNs and BHAs) on patient observation rounds as follows: 1. 100% of nursing staff were trained on the revised patient observation rounds policy. 2. 100% of nursing staff had the observations competency checklist signed off by the nurse manager, nurse supervisor, or training ambassador. Competency demonstration included the use of the flashlight in order to watch the rise and fall of the patient's chest for three breaths; repositioning the patient when rise and fall of the chest is not easily discernible, the patient is snoring, or the patient has breathing difficulty; and	

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S 008	Continued From page 39 administration of Fentanyl patches. a) Review of Mosby's 2012 Nursing Drug Reference, 25th edition, stated under dosage and routes, that Fentanyl transdermal patch should be applied to a "flat surface on upper torso and wear for 72 hr; apply new patch on different site for continued relief. " b) Review of, "Taylor's Clinical Skills Nursing," copyright 2008, pages 236-239, stated standards of practice for nurses when applying transdermal patches to patients. The standard states the patient's skin should be assessed prior to placing patches and that skin should be clean, dry, and free of hair. The standard states specific medication patches could have specific instructions of where to place patches and that nursing staff should refer to the manufacturer's instructions to determine where to place patches. The standard states transdermal patches should not be placed on "irritated or broken skin" and that placement of patches should be rotated. The standard states nurses should write their initials, date, and time of administration on the label side of the patches. The standard states prior to administration of patches, patients should be assessed for "old patches", which should be removed, folded in half and disposed of per the facility's policy. The standard states, "Document the administration of the medication immediately after administration, including date, time, dose, route of administration, and site of administration on the MAR or record using the required format." The standard goes on to state, "Ongoing assessment is an important part of nursing care to evaluate patient response to administered medications and early detection of adverse effects. If an adverse effect is suspected, withhold further medication doses and notify the patient ' s primary healthcare provider. Additional intervention is based on type of reaction and patient assessment."	S 008	arousing the patient and checking vital signs when a physical or mental change has occurred with the patient. Monitoring/Tracking: Each weekday, the Director of Nursing is reviewing nurses' assessment/reassessment documentation, including 100% of any CIWA or COWS forms, for patients admitted on and receiving pain medications. The review is to confirm completeness of assessment/reassessment documentation and appropriate actions taken in accordance with policy based on a patient's response to medications, change in condition, and/or high score on a CIWA or COWS assessment. The Director of Nursing provides a summary report of audit results to the monthly meetings of the Committee of the Whole and the MEC, and the quarterly meetings of the Board of Directors. Medication Administration: The Director of Nursing reviewed and confirmed the accuracy and completeness of the Hospital's medication administration policies. The Director of Nursing re-educated nursing staff on the process for reporting a medication variance or potential error, and clarified what is a variance and what should be reported as follows: 1. All medication orders that are not written on the MAR as the physician prescribed are considered to be a variance. 2. Additionally, all medications that are administered incorrectly, or not as the physician prescribed, are considered to be	

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S 008	Continued From page 40 c) The FDA put out public health alerts in 2005 and again in 2007 stating "the [adverse event] reports indicate that patients are continuing to incorrectly use the fentanyl patch by replacing the patch more frequently than directed in the fentanyl patch instructions, applying more patches than prescribed, or applying a heat source to the patch, all resulting in dangerously high fentanyl levels in the blood. The fentanyl patch contains fentanyl, a very potent narcotic pain medicine. It is only intended for treating persistent, moderate to severe pain in patients who are opioid-tolerant, meaning those patients who take a regular, daily, around-the-clock narcotic pain medicine. This is extremely important because patients who are opioid-tolerant are more resistant to the dangerous side effects of narcotic pain medicines than patients who only occasionally take these medicines. For patients who are not opioid-tolerant, the amount of fentanyl in one fentanyl patch of the lowest strength is large enough to cause dangerous side effects, such as respiratory depression (severe trouble breathing or very slow or shallow breathing) and death ...Healthcare professionals who prescribe and patients who use the fentanyl patch should be aware of the signs of fentanyl overdose including the following: trouble breathing or slow or shallow breathing; slow heartbeat; severe sleepiness; cold, clammy skin; trouble walking or talking; or feeling faint, dizzy, or confused. If these signs occur, patients or their caregivers should get medical attention right away." d) Review of the full package insert for Duragesic (fentanyl) patches revealed the following information and instructions for use: Duragesic (Fentanyl) contains a high concentration of Fentanyl, a Schedule II controlled substance, which is subject to misuse, abuse, addiction, and criminal diversion. Fatal respiratory depression could	S 008	a medication variance. 3. Any staff member identifying a medication variance or potential error should complete an Incident Report and return it to his/her supervisor. 4. The supervisor then forwards the Incident Report to the Director of Nursing. 5. Following the Director of Nursing's review, the Director of Risk Management and the Director of Education and Process Improvement also conduct a review. 6. All medication variances are reported to the monthly meetings of the Committee of the Whole and the MEC, and to the quarterly meetings of the Board of Directors. 7. The Director of Nursing works with the specific nurse involved with the variance(s), and identifies and analyzes what happened and any trends (as applicable) with the pharmacist in order to attempt to prevent reoccurrences. The clarification of what constitutes a reportable medication variance was addressed in the Committee of the Whole meeting. The Director of Nursing re-educated all nursing staff on the medication administration process. Training included but was not limited to: 1. Medication variances from the prescribing phase 2. Medication variances from the transcription phase 3. Medication variances from the administration phase 4. Medication variances through the monitoring phase 5. Nurses notifying the physician, informing the physician about	

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S 008	Continued From page 41 occur in patients who are not opioid-tolerant and in patients that are opioid-tolerant even if DURAGESIC is not misused or abused. Schedule II opioid substances, including Fentanyl, have the highest potential for abuse and risk of fatal overdose due to respiratory depression. Respiratory depression has been reported with use of DURAGESIC in patients who are opioid-tolerant, even when DURAGESIC has been used as recommended and not misused or abused. Persons at increased risk for opioid abuse include those with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). Patients at increased risk may still be appropriately treated with modified-release opioid formulations; however, these patients will require intensive monitoring for signs of misuse, abuse, or addiction. The patch may be used continuously for 72 hours, and each patch should be applied to a different skin site after removal of the previous transdermal patch. Patches should be applied to intact, non-irritated, and non-irradiated skin on a flat surface such as the chest, back, flank, or upper arm. If the patch falls off before 72 hours, dispose of it by folding in half and flushing down the toilet. A new patch may be applied to a different skin site. Proper disposal of Duragesic is advised in order to prevent adverse reactions, including death, associated with accidental secondary exposure to Duragesic. Dispose of used patches by folding the adhesive side of the patch to itself, then flush the patch down the toilet immediately upon removal. e) Lab results from a drug screen dated 07/19/13, at the time of admission, showed Sample Patient #1 was positive for benzodiazepines, cocaine, and opiates. In the Discharge Summary for the patient, the physician stated the patient had a history of	S 008	polypharmacy concerns, and initiating additional patient monitoring The MEC voted to eliminate Fentanyl patches from the formulary. Any new patient admitted with a Fentanyl patch must have the patch removed, and an alternative pain medication must be prescribed. During the MEC meeting on 9/24/2013, all physicians were encouraged to check on their patients' controlled substance prescriptions through review of an online medication verification database. Physicians can access the database and confirm a patient's currently prescribed narcotics and dosages, regardless of who the prescribing physician is. Utilization of the medication verification website provides physicians with information about medications prescribed to their patients so the physicians are well-informed of potential polypharmacy concerns and accurate medication dosages before they order additional medications or make changes in their patients' medications. Follow-up email correspondence to the physicians reminded them about using this medication verification website. The CEO confirmed that the pharmacist regularly uses this website to check for polypharmacy issues and is responsible for discussing polypharmacy concerns with the prescribing physician. The Director of Nursing developed a form and is monitoring to confirm the pharmacist is checking the website as indicated. The Director of Nursing developed a new policy on "Medication Patches," which was	

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S 008	Continued From page 42 attention deficit hyperactivity disorder, major depressive disorder, and a history of substance dependence. f) Review of the medical record for Sample Patient #1 revealed documentation by a Registered Nurse on 07/19/13, that Fentanyl patches were placed on the patient's "left chest area." No further documentation was found in the record indicating where subsequent patches were placed, so no evidence was documented that the patches were "rotated" or placed on a different site, per the manufacturer's directions. g) Review of the initial nursing assessment for Sample Patient #1, dated 07/19/13, revealed a skin assessment was documented by nursing staff. The medical record contained no other documentation of skin assessments by nursing staff, including no assessment of the patient's skin prior to placing fentanyl patches, per the manufacturer and per standards of nursing care. h) Review of the initial nursing assessment dated 7/19/13 for Sample Patient #1 revealed the patient's pain level was 5/10 on the facility's pain scale upon admission. A nursing note dated 07/23/13 at 2:15 p.m., stated the patient was "groggy and sluggish" was lying down during the day shift" and "complained of pain." A nursing noted dated, 07/25/13 at 3:30 p.m., documented a quote by the patient during this shift that, "I still have pain, anxiety." A nursing note dated 07/25/13 at 5:50 a.m., documented the patient complained of "back pain, spasms, took meds," and returned to bed and fell asleep. No documentation was found in the medical record of the patient's level of pain or further description of pain on these dates. No documentation was found in the medical record on these dates of PRN medications being administered to the patient for pain or other attempts to address patient-reported pain.	S 008	approved by the MEC. The new policy clearly articulates: 1. That Fentanyl patches are not allowed at this Hospital. Those patients presenting with a Fentanyl patch will have the patch removed, and the treating physician will prescribe an alternate medication if needed. 2. The correct process for administering, monitoring, accounting for, and destroying other medication patches, including conducting daily skin assessments; initialing, timing, and dating the patch; and documenting the skin assessment and presence or absence of a patch. 3. That daily skin assessments may be increased if a patient has a change in condition that warrants an additional assessment. 4. The requirement for nurses to contact a physician if a patient exhibits an unusual or unexpected response to a medication patch, or if a patient appears to have lost a medication patch, and to obtain new orders about the patch. The Director of Nursing trained 100% of RNs on the new Medication Patches policy, which includes the correct process for administering, monitoring, accounting for, and destroying the patches; conducting skin assessment; validating the location of the patch on the patient, and the time, date and the nurse's initials on the patch; contacting the physician in the event of a problem with a patch; and documenting the assessment, any issues, and any communication with a physician in the medical record. The Director of Nursing also trained 100% of RNs on documenting the date, time and location of the patch and removal of the patch in	

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S 008	Continued From page 43 i) Review of, "Taylor's Clinical Skills Nursing," copyright 2008, pages 555 - 590 stated standards of nursing care regarding pain. The standards state an accurate assessment of pain is necessary to "guide treatment/relief interventions and evaluate the effectiveness of pain control measures. " The standard states the Registered Nurse should document pain assessment and other significant issues such as pain relief and patient responses. Documentation should include a rating of pain as well as a description of pain provided by the patient. j) A Nursing note documented on 07/26/13 at 10:40 p.m. stated the patient had emesis x2 and vomited up his/her most recent medications. The note went on to state the patient was "still having difficulties coping and may be withdrawing from excessive amounts of narcotics in system." No further nursing documentation was found to support what "excessive narcotics" meant. The nurse's note further stated the patient would continue to be monitored in a quiet room every 15 minutes and the current treatment plan would stay enforced. No documentation was found in the record that the patient's physician was contacted, even with a suspicion by nursing staff of excessive narcotics in the system nor that they suspected the patient may be in withdrawals. k) A nursing note dated 07/27/13 at 5:50 a.m., stated the patient was at the medication window at 11:45 p.m., requesting medications s/he had refused earlier at 9:00 p.m., and was falling asleep standing at the med window. The note further stated while the patient was at the medication window drinking Boost, s/he was falling asleep. No documentation by nursing staff was found indicating nursing staff contacted the patient's physician regarding the patient's status.	S 008	the MAR. Training also reviewed the process for administering oral medications. Monitoring/Tracking: The pharmacist monitors medication patch administration and communicates with the Director of Nursing to confirm proper administration of medication patches. The Director of Nursing audits 100% of documentation on patients with any medication patches, including reviewing the MAR in addition to other locations in the medical record, to confirm compliance with the new medication patch policy. All medication variances are reported monthly at the Committee of the Whole and MEC meetings, and quarterly to the Board of Directors. All trends are referred to and addressed through the Nursing and Pharmacy Departments and subcommittees formed as indicated depending on the identified issues. The Director of Nursing is monitoring the Nursing assessments/reassessments, including 100% of any CIWA or COWS forms used for patients undergoing detoxification, for documentation accuracy and completeness, with results/trends/variances reported monthly at the Committee of the Whole and MEC meetings, and quarterly to the Board of Directors. The Director of Nursing is auditing 100% of assessments of patients admitted on pain medication to confirm documentation accuracy and completeness. Results are reported monthly in the Committee of the Whole and the MEC meetings, and quarterly to the Board of Directors.	

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S 008	Continued From page 44 l) A nursing note dated 07/21/13 at 3:15 p.m., stated the patient "lost " his/her Fentanyl patches (plural) as s/he flushed them down the toilet. The nurse documented the patient then denied flushing Fentanyl patches (plural). The note stated a skin check of the patient and a room check were completed. The nursing note did not state the absence of Fentanyl patches on the patient. The nursing note, as written, indicates both Fentanyl patches were flushed down the toilet by the patient. m) Review of a physician order dated 07/21/13, stated for nursing staff to apply Fentanyl patches (100 micrograms) and to "date, time, and check each shift for placement." This order was followed by a physician order, from the same physician, to discontinue Fentanyl as the patient was "removing and throwing away" the patches. n) Review of a nursing note dated 07/26/13 at 3:00 p.m., quoted the patient as stating, "Do I get a patch now? This one fell off. " No further documentation from nursing staff was found regarding a fentanyl patch falling off, if the patch was reapplied to the patient, if the patient's physician was notified of this, or if pharmacy was contacted to aid nursing staff with reapplying the patch or obtaining another patch. o) There was no documentation by nursing staff in the patient's medical record that Fentanyl patches were visualized daily, or at any interval, to ensure patches remained in place, were intact, that patches had not been removed, etc. even with a physician's order on 07/21/13 to do so and with evidence of the patient " flushing " patches. p) Review of the facility's medication administration policy stated nothing about the administration of patch medications, labeling of patches, or documentation regarding placement	S 008		

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S 008	Continued From page 45 of patches on patients. Section titled, "Administration," stated licensed nursing staff must know the "correct medication, usual dosing, route of administration, appropriate time, expected effects, contraindications, early signs of untoward effects and toxicity, and possible interactions with other drugs or food of the medication they are administering." The policy further stated nursing staff would verify the medication matches the physician's order, and that the medication is being administered at the "proper time, in the prescribed dose, and by the correct route." Nothing in the policy addressed how patches were to be administered, skin checks conducted integrity of patient's skin who was receiving medication via patches, or rotation of patches administration sites. q) On 09/20/13 at 12:37 p.m., an interview was conducted with the facility's previous Director of Nursing, who was functioning as the Chief Clinical Officer and Interim Chief Executive Officer (Interim CEO) to discuss issues regarding Fentanyl patches for Sample Patient #1. The Interim CEO stated s/he learned after the patient's death, that the patient reported to staff a missing Fentanyl patch sometime between 07/22/13 and 07/25/13. The Interim CEO stated s/he learned that staff found a medication patch in the courtyard and placed it back on the patient. When asked how staff knew this was a fentanyl patch and that it was the patch missing from Sample Patient #1, s/he stated the patient was the only patient on any kind of medication patch on this date. S/he confirmed the patches were not being labeled by nursing staff at this time. The Interim CEO confirmed there was no documentation of this incident in the medical record for Sample Patient #1, including no documentation that the patient's physician was informed of the incident. The Interim CEO confirmed there was no documented communication with pharmacy	S 008		

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S 008	Continued From page 46 regarding placing the found patch on the patient. The Interim CEO stated Registered Nurses did not document the presence of medication patches, including fentanyl patches, each day when patients were assessed. S/he stated when removing fentanyl patches; this was not documented as a waste by nursing staff even though the habit was for nurses to discard used fentanyl patches into a red sharps container. The Interim CEO confirmed no documentation that on 07/26/13, when 2 fentanyl patches were placed at 24 hours, the existing 2 patches were documented as removed and discarded. S/he stated the new documentation for RN use regarding fentanyl had not yet gone through the "chain of command for approval," so was not being used by nursing staff. r) On 09/23/13 at 2:11 p.m., the nurse manager that had retrieved the patch from the outside exercise court sometime between 07/22/13 and 07/25/13 was interviewed. She stated that the patch was not initiated or dated, but s/he was certain that it was the patient's fentanyl patch, because of the appearance and the fact that no other patient was currently on that type of patch (Note: two patches had been applied). When asked if s/he consulted with the physician or the pharmacist before re-applying the patch, s/he stated that s/he only re-applied the patch after consultation with either the CCO/Interim CEO or the Acting DON. She stated that the patch did not appear to be damaged or adulterated in any way that would have put the patient at risk. s) On 09/23/13 at 3:58 p.m., the Corporate Clinical Director stated that the lack of documentation of the event was unacceptable, the patches should have been initialed and dated. S/he also expressed concern that the patch had been re-applied to the patient. The facility Nurse Educator also stated his/her concerns about the lack of initialing and dating the patches and the lack of documentation of	S 008		

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S 008	Continued From page 47 the entire loss/retrieval/re-application of the transdermal fentanyl patch episode. They both state that the new fentanyl policy would specifically address these issues and would be followed up with staff re-education about the use of all patches. t) Review of the facility's document titled, Medical Executive Committee Meeting Minutes dated 09/24/13, revealed a discussion had occurred at this meeting regarding the use of fentanyl patches in the facility. The meeting minutes stated a need for a fentanyl protocol and process to be established for the facility as one did not currently exist. Meeting minutes reflected the medical staff voted unanimously to remove fentanyl from the facility formulary and that while admitted, patients who had been receiving fentanyl would be placed on alternative medications. Prior to this vote, administration had complied a fentanyl patch order form which included instructions to nursing staff on how to apply these patches, to write that date and time of administration and the nurses's initials on each new patch, and to dispose of patches by placing them in the red sharps container on the nursing units. No documentation or discussion was found in the meeting minutes of the Medical Executive Committee or the Committee of the Whole regarding placement and documentation required of nursing staff for any other patches used in the facility . u) On 09/24/13 at 11:23 a.m., an interview was conducted with the facility's contracted pharmacist who stated patches other than fentanyl are used in the facility. No policy or guidance produced that indicated how RNs were to apply, label and document all patches used for patients. v) Review on 09/25/13 of the autopsy/coroner's report for Sample Patient #1 revealed that the patient's death was caused by complications of	S 008		

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S 008	Continued From page 48 acute fentanyl toxicity. 2. The nursing staff failed to adequately reassess and document the findings for Sample Patient #1 when there was evidence of a change of condition that may have been related to the medications the patient was receiving. The facility's Reassessment Policy read: " 2. Each Patient is reassessed daily (every 24 hours) and/or as the patient's condition warrant, by an RN. Any condition change noted must be reported to the RN. 3. Reassessment is done to determine the patient's response to treatment or when a change occurs each shift." a) Review on 09/18/13 of the medical record for Sample Patient #1 revealed that the patient was a young adult admitted on 7/18/13 with history of diagnoses of Episodic Mood Disorder, Multiple Substance Abuses including Opiates, Cocaine and Benzodiazepines, Victim of Sexual Abuse and Insomnia. The patient was treated with Valium and Vistaril for anxiety, fentanyl patches for pain, and the psychoactive medications, Lexapro and Neurontin The patient was found on 7/27/13 at approximately 9:30 a.m. not breathing, no pulse, cyanotic and in full rigor mortis in his/her room. (Rigor mortis occurs when the limbs of the corpse becomes stiff and difficult to move or manipulate. In humans, it commences after about three to four hours, reaches maximum stiffness after 12 hours, and gradually dissipates until approximately 48 to 60 hours after death). However, the record showed that 15 minute checks were documented and showed the patient slept all night from approximately midnight with loud snoring. Prior to the patient's being found dead, nurses were documenting that the patient was very	S 008		

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S 008	Continued From page 49 sedated and several doses of Valium were withheld because of over-sedation, but no nurse initiated additional vital signs to reassess the patient's condition. During the night prior to the patient being found dead, the record showed that the patient was "snoring" very loudly after having gone to bed in a condition characterized as very sedated. There was no evidence that the patient was assessed by nursing staff during the night with attempts to arouse the patient or check vital signs (including oxygenation status). In addition, earlier in the evening prior to the patient's death, the patient had had at least two episodes of emesis and required medication for that. There was no documentation of a physical assessment when the emesis events happened, and there was no documentation of the nature, amount and contents of emesis in the record. Further review of the medical record revealed that the patient was receiving Melatonin for sleep, Valium and Vistaril for anxiety, Neurontin and Lexapro for anxiety and depression and Fentanyl transdermal patches for pain. On the two days prior to the patient being discovered deceased on the morning of 07/27/13, the patient received the following medications that had a central nervous system depressing effect: 07/25/13: 3 mg Melatonin 100 mcg fentanyl transdermal patches 40 mg Lexapro Valium 50 mg Neurontin 1800 mg Vistaril 75 mg 07/26/13: 100 mcg fentanyl transdermal patches 40 mg Lexapro Valium 10 mg Neurontin 1800 mg	S 008		

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S 008	Continued From page 50 Vistaril 75 mg b) Review of the "Mosby's 2012 Nursing Drug Reference, 25th Edition," revealed the medications all had central nervous system (CNS) depression effects which can cause drowsiness and vital sign changes and respiratory depression. There were interactions among some of the medications that potentiated the actions of the various CNS depressants as well as extending the half-life of the Valium. In addition, the half-life (time required for half of the amount of the medication to be secreted from the body) for Valium was 20-50 hours per dose. Note that the patient had 5 - 10 mg doses on 07/25/13, which was the day the patient began to show significant sedation. By the morning of 07/26/13, the patient was so sedated that s/he only received a 4:05 a.m. PRN dose of Valium. The morning and evening and PRN doses of Valium were held due to the patient's level of sedation, but the patient continued to receive the other CNS depressing medications Lexapro, Fentanyl, Neurontin and Vistaril throughout that day. The patient was found to be deceased at about 9:30 a.m. on 07/27/13. c) Review of, "Taylor's Clinical Skills Nursing," copyright 2008, pages 745-751 stated standards of nursing care regarding respiratory assessment and measuring blood oxygenation with the use of a pulse oximeter. The standard states "Many medications affect the function of the respiratory system. Many medications depress the respiratory system. The nurse should monitor patients taking certain medications, such as opioids, for rate and depth of respirations," The standards state that "a range of 95% to 100% is considered normal," when assessing blood oxygenation with a pulse oximeter.	S 008		

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S 008	Continued From page 51 Review of the patient's vital signs revealed that the patient had pulse oximeter reading on admission on 07/18/13 of 99% oxygen saturation. On 07/20/13 and 07/23/13, the patient's oxygen saturation had declined to 94%, which as below the normal range. On 07/26/13, the day prior to the patient ' s death, the patient's oxygen saturation level was 93% at 8:30 a.m. and declined to 90%, far below the normal range, by 7:45 p.m. Despite the patient's decreased oxygen saturation and extreme sedation, no reassessments of the patient were conducted after the 7:45 p.m. pulse oximeter reading, even though the patient was on multiple medications, including an opioid, that had respiratory and central nervous system depressing effects. d) On 09/25/13 at 9:20 a.m., BHA #3, was interviewed by telephone about observation rounds conducted for Sample Patient #1 on the night shift (11 p.m. to 7:30 a.m.) on the night of 07/26-27/13. The BHA stated that the patient was snoring loudly, once asleep at approximately 12:00 a.m. S/he stated that s/he was concerned about the loud snoring, which s/he stated was able to be heard "even at the nurses' station." The BHA stated that s/he went to the charge nurse (RN #5) and medication nurse (RN #3), who were both at the nurses station and notified them of his/her concern about the loud snoring. S/he stated that s/he did not see either of the nurses respond to his/her information and go to check on the patient at that time. S/he stated that the charge nurse (RN #5) took over part of his/her rounds at approximately 1 a.m., including the rounds for Sample Patient #1. S/he stated s/he resumed rounds on Sample patient #1 at approximately 6 a.m., and recalled that at 6 a.m., the patient was no longer snoring loudly. The BHA (#3) stated that s/he continued to make rounds until the end of the shift and did final hand-off rounds with the	S 008		

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S 008	Continued From page 52 on-coming shift BHA (#4) as the shift was ending at 7:30 p.m. e) On 09/26/13 at 1:20 p.m., RN #5, who was no longer an employee of the facility, was interviewed by telephone, about observation rounds conducted for Sample Patient #1 on the night shift (11 p.m. to 7:30 a.m.) on the night of 07/26-27/13. S/he confirmed that Sample Patient #1 was snoring loudly during the night and that the noise could be heard even at the nurses station. S/he had no memory of the BHA (#3) asking him/her to check on the patient. S/he stated that s/he did make rounds on the patient for part of the night. S/he stated that this was his/her first night working on that unit, so s/he was not familiar with the sleeping habits of Sample Patient #1, including whether the snoring was typical or unusual for that patient. S/he recalled that the patient had appeared very drowsy at about 11:45 p.m. when s/he came up to the medication window requesting Valium. S/he stated she refused to give the patient the Valium because of his/her level of sedation, but did not take vital signs or call the provider. S/he confirmed that s/he did not go in to the patient's room to do an assessment or to initiate vital signs for the patient. S/he stated s/he was a newly graduated nurse and that it was his/her first nursing job. f) On 09/26/13 at 11:55 a. m., during an interview with the president of the medical staff, the care and medical record of sample patient #1 was discussed. The medical director stated that s/he and another provider had conducted an independent review of the case, since they had not cared for the patient. During the interview, the expectations for nurses to initiate additional vital signs or other assessments of this patient, related to over-sedation, loud snoring at night and the documentation of the patients episodes of vomiting was discussed.	S 008		

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S 008	Continued From page 53 S/he agreed that nurses should have initiated reassessment of the patient, provided accurate documentation and even contacted the doctor about concerns related to these issues. g) On 09/19/13 at 11:05 a.m., the Nurse Educator was interviewed and the expectations for documentation of patient symptoms and reassessment of the patient when there was evidence of a possible change of condition was discussed. S/he stated that nurses should have reassessed the patient related to increased sedation symptoms and very noisy snoring during sleep. In addition, s/he stated that the nurses did not adequately document the episodes of emesis, including times, whether witnessed, nature of the emesis and quantity, as s/he would expect as a standard of nursing care and documentation. 3. The facility failed to appropriately review the death event (Sample Patient #1) and insure corrections were made to avoid further serious medication errors of a like nature. a) On 09/19/13 at 4:09 p.m., an interview was conducted with the facility's former Chief Executive Officer (CEO), who also served as the facility's Director of Nursing (DON) and Director of Quality. The CEO was asked to review the medical record for Sample Patient #1 and to explain the administration of fentanyl patches at a 24 hour interval, on 07/25/13 and 07/26/13, instead of the 72 hour interval ordered by the patient's physician. The CEO could find no documented reason that the medication was administered at a 24 hour interval. When asked if this medication error was identified by the facility and reported internally as a medication error, s/he stated it was not reported as an "incident' or "event" and felt it did not constitute a medication error. The CEO stated the administration of the fentanyl patches for	S 008		

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S 008	Continued From page 54 Sample Patient #1 had been looked into by the facility and it was his/her opinion that this was not a medication error but a transcription error on the part of nursing staff. The CEO stated when s/he investigated this issue it was not determined which Registered Nurse had made the transcription error because "no one could remember" who did the transcribing of the medication administration record on the date in question. The CEO confirmed that because s/he believed this issue was not a medication error, it was not documented for discussion in Quality Meetings and was not reviewed further by facility staff. The CEO stated s/he had no documentation of this issue being discussed with nursing or other facility staff. e) On 09/19/13 at 4:25 p.m., the facility's Corporate Clinical Director, who was present when the former CEO was interviewed regarding the administration of Fentanyl patches, stated the administration/changing of the patches on 07/25/13 and 07/26/13 constituted a medication error as the patches were changed out at 24 hours instead of at 72 hours as the patient's physician ordered. The Director stated this incident should have been documented by the facility as a medication error so that it could be reviewed in Quality Meetings and corrections made. f) On 09/20/13 at 4:30 p.m., the Corporate Clinical Director provided the facility's current policy titled, "Medication Administration," revised 10/21/09, for review. The policy stated it was the responsibility of the night shift nursing staff to ensure that physician orders were transcribed accurately. g) On 09/20/13 at 10:28 a.m., an interview was conducted with Staff Physician #3 who stated s/he was one of the facility physicians who reviewed the medical record for Sample Patient	S 008		

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S 008	Continued From page 55 #1 as this patient died in the facility on 07/27/13. Physician #3 reviewed the change of the patches at 24 hours instead of the ordered 72 hour interval and stated s/he would view this as a medication error. Physician #3 stated s/he serves on the facility's Medical Executive Committee. h) Review of Committee of the Whole (COW) Meeting Minutes for January 2013 through August 2013 were reviewed. It was documented that the facility's Risk Manager presented information at these meetings each month regarding facility medication errors. July data regarding medication errors provided by the Risk Manager stated there were 6 medication errors in July with "omissions" as the highest category of errors. Nine medication errors were reported in June 2013 and all 9 errors "reached the patient." The fentanyl patch error was not included in the data presented to the Committee for the month of July.	S 008		
S 009	~ Survey Details This REGULATION is not met as evidenced by: 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 18, Psychiatric Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 26. PSYCHIATRIC PATIENT CARE SERVICES. The facility shall provide psychiatric patient care services in conformance with the standards established in Chapter IV, Part 26, Psychiatric Patient Care Services, Sections 26.101, and 26.102. Chapter 4, General Hospitals Promulgated by the State Board of Health Last amended 06/19/13, effective 08/14/13 Part 26. PSYCHIATRIC SERVICES	S 009	Patient Observation Rounds Process: The CEO, Director of Nursing, Director of Risk Management, and Director of Education and Process Improvement revised the Hospital's procedures regarding patient observation rounds. The revisions included adding the responsibilities of the nurse manager, charge nurse, nursing supervisor, and Hospital administration to oversee that appropriate and compliant patient observation rounds (including Quiet Room rounds) are being conducted. The CEO also revised the patient observation	11/29/2013

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S 009	Continued From page 56 26.101 ORGANIZATION AND STAFFING (1) General hospitals may provide psychiatric services; however, facilities that do not provide psychiatric or substance abuse services shall develop and implement a written plan for the referral of patients to treatment options. The following standards apply only if the facility provides psychiatric care. Psychiatric care includes, but is not limited to, the provision of the following as appropriate to the patient: psychiatric physician and nursing services, psychological services, social services, occupational therapy and recreational therapy. (3) Nursing Services (c) All nursing personnel assigned to care for specific populations, such as pediatric or geriatric patients, shall be trained, have the necessary experience and maintain current competency. Unexpected emergency events that require the use of nurses that lack the necessary training, experience or competency are exceptions; such events shall be documented and, where possible, planned for in the future. Inexpert nursing personnel in such events shall be assigned to the lowest acuity situations possible. (7) There shall be a sufficient number of qualified clinical and supportive staff to assess the needs of psychiatric patients, implement individualized active treatment care plans, and ensure a safe therapeutic environment for patients and staff. The Requirement is NOT MET as evidenced by: Based on document review, interviews, and observations, the facility failed to ensure the on-going physical safety of patients admitted to the facility. Patient safety observations were not conducted by facility staff per the facility's policy and expectations.	S 009	rounds policy and procedure by adding a "zero-tolerance" expectation of compliance to reinforce the importance of patient observation rounds and to put patient care staff on notice that noncompliance will subject staff members to additional training and possibly appropriate corrective action, up to and including termination. Training on the revised Patient Observation Rounds Process and monitoring actions are described further below. Administrator on Call (AOC) Process: The CEO reviewed and revised the Administrator on Call (AOC) process to have the AOC provide non-clinical support to the evening and overnight shifts to reinforce the importance of the patient observation rounds process. Hospital executives required to fulfill AOC duties include the CEO, CFO, Director of Risk Management, Director of Education and Process Improvement, Director of Plant Operations, Director of Business Development, Director of Intake, and Director of Clinical Services. The revised process provides for the AOCs to conduct a physical walk-through of Intake, Unit 1, Unit 2, and the Adolescent Unit to observe Unit Staff conducting patient observation rounds on each Unit. The AOCs also communicate with staff about the importance of quality patient care and potential employee concerns/issues. The revised process calls for the AOCs to do these walk-throughs on the following schedule: 1. To be physically present on the units during a portion of the evening and	

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S 009	Continued From page 57 The failure to perform adequate safety checks placed all patients at risk because of threats to their health and welfare going unidentified by staff. Findings: 1. Facility staff did not perform patient safety observations (15 minute checks) per the facility's policy. Sample Patient #1 who was found dead and in a condition of rigor mortis (indicating that the patient had a died hours prior to being discovered) despite patient observation rounds having been conducted. Despite subsequent staff training and re-education and implementation of additional video monitoring of staff performance of rounds, on 9/27/13, video observation of patient observation rounds conducted on the night shift of 09/23/13 to 09/24/13 on Sample Patient #22, revealed that the patient observation rounds were still not being conducted correctly per policy/procedure. a) Review on 09/18/13 of the medical record for Sample Patient #1 revealed that the patient was a young adult admitted with history of diagnoses of Episodic Mood Disorder, Multiple Substance Abuses including Opiates, Cocaine and Benzodiazepines, Victim of Sexual Abuse and Insomnia. The patient was treated with high doses of Valium and Vistaril for anxiety, Fentanyl patches for pain, and other psychotropic medications. The patient was found at approximately 9:30 a.m. not breathing, no pulse, cyanotic and in full rigor mortis in his/her room, despite documentation of having been checked every 15 minutes throughout the night and morning shifts. The record showed the checks were documented as completed and the patient slept all night from approximately midnight with loud snoring. At least a day prior to the patient being found dead, nurses documented the patient was very sedated and	S 009	night shifts for two weeks. 2. After the two-week period, to begin random in-house checks beginning 10/25/13 on off-hour shifts. 3. For the next 60 days, to report to an evening or night shift 1 time per day for every day the AOC is on call. This includes weekends. 4. After the 60-day period if nursing staff are rounding in compliance with policy, AOC expectations will return to the following process where the AOC must: a) Report to an evening or night shift 1 time per week for the week the AOC is on call (Mon-Fri). b) Report to a day, evening, or night shift 1 time per weekend for the weekend the AOC is on call (Sat, Sun, Holiday). c) Conduct a physical walk-through of Intake, Unit 1, Unit 2, and Adolescent Unit. d) Observe Unit Staff conducting rounds on each Unit. e) Communicate with staff about patient care and employee concerns or issues. f) To assure randomness to the monitoring process, the CEO also randomly checks rounding compliance 1x/week on a different day from when the AOC checks. Ambassador Rounding: The CEO reviewed and revised the patient observation rounds process by adding a designated training ambassador to assist nursing staff with observing, reinforcing, and educating staff performing patient observation rounds. The Director of Nursing selected the training ambassador from among Behavioral Health Associates (BHAs) that have	

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S 009	Continued From page 58 several doses of Valium were withheld because of over-sedation, but no nurse initiated additional vital signs to reassess the patient's condition. During the night prior to the patient being found dead, the record indicated that the patient was "snoring" very loudly after having gone to bed in a condition documented as very sedated and his/her Valium was withheld due to the symptoms. There was no evidence that the patient was reassessed by nursing during the night with attempts to arouse the patient or to check vital signs. b) Review on 10/08/13 of the medical reference book, "Stedman's Medical Dictionary, 28th Edition, Lippincott Williams & Wilkins, 2006, page 1699 revealed the following, in part: "rigor - rigidity, stiffness mortis - Stiffening of the body, 1-7 hours after death, from hardening of the muscular tissues as a consequence of the coagulation of the myosinogen and paramyosinogen; it disappears after 1-6 days or when decomposition begins; cadaveric rigidity, postmortem rigidity." c) On 09/24/13 at 11:30 a.m., the facility's policy titled, "Patient Observation Policy," revised 03/23/12 was reviewed. The policy stated all patients "are supervised, at a minimum, every 15 minutes," through rounds/observations by staff to ensure patient safety. The policy stated Behavioral Health Associates (BHAs) would observe patients every 15 minutes and specific information regarding the patient would be documented on the patient observation form. The policy stated each patient would have an individual observation form that would be completed and would be become part of the patient's medical record and the patient's identity would be verified, and the location of the patient and patient's behavior would be documented. The policy went on to state required documentation of patient activities	S 009	consistently demonstrated excellent rounding skills, communication skills, and role modeling skills. The ambassador conducts random visits on the different units and shifts seven days per week. The ambassador directly observes employees conducting rounds and reviews video camera tapes. In addition to giving the employee direct verbal feedback, written feedback when appropriate, and providing verbal feedback to the charge nurse and nurse supervisor as appropriate, the ambassador also monitors usage of the Quiet Room and observation rounds done on patients in the Quiet Room, and then submits a written report to the Director of Nursing after each visit. The Director of Nursing reviews the ambassador's reports each weekday. Monitoring/Tracking: For a period of 30 days, the CEO directed the Director of Nursing to monitor the training ambassador process through review of the ambassador's reports each weekday and submission of reports to the CEO each weekday and weekly. Monitoring results will also be reviewed by the Performance Improvement Committee at its monthly meeting. After 30 days, if it is determined that there is 100% compliance with rounding, the frequency of reporting to the CEO may be reduced, but will not be discontinued until it has been determined that the compliant rounding process and culture of safety are thoroughly ingrained. Staff Training: The CEO directed 100% of nursing staff (RNs and BHAs) to undergo training and complete a Return Demonstration on	

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S 009	Continued From page 59 when patients were awake during the day. The policy directed when patients were on bed rest or asleep, the BHAs would look for the rise and fall of the patient's chest, count at least 3 respirations, and make sure the patient "moved from his/her previous sleeping position" and document per the policy and the observation form. d) Review on 09/17/13 of an internal investigative document related to the death of Sample Patient #1, related to the Patient Observation Policy, 2 Behavioral Health Associates (BAHs) stated that they had not conducted patient observation rounds according to policy. In addition, it stated that staff were viewed on camera not conducting patient observation rounds according to policy. Staff were not visualizing the patient and were marking that the patient was asleep in the quiet room. e) On 09/18/13 at 12:46 p.m., an interview was conducted with the facility's Risk Manager who stated s/he had reviewed camera tapes of the room Sample Patient #1 was in on 07/26/13 and 07/27/13. The Risk Manager stated s/he "focused on the BHAs" to determine if they were conducting patient safety observations per policy. S/he stated the camera tape review reflected the observations were not being conducted per the facility's policy. S/he stated some observations were "fly-by's" meaning BHAs "glanced in the door" of the patient room and did not walk inside the room in order to observe the rise and fall of the patient's chest and to observe at least 3 respirations. The Risk Manager stated s/he reviewed the camera tape of Sample Patient #1's room and did not see the patient change position or move during the night shift and through the morning of 07/27/13. The Risk Manager stated she began reviewing the facility's patient observation policy with nursing staff and BHAs and obtained signatures from	S 009	patient observation rounds. Return Demonstrations were validated by the nurse manager, nurse supervisor, or BHA training ambassador. In addition, the training emphasized the limited use of the Quiet Room and the continued use of patient observation rounds when it is deemed appropriate to place a patient in the Quiet Room for a limited period of time. 100% of patient care staff performed a Return Demonstration competency on patient observation rounds. The Return Demonstration outlined key components concerning patient safety and the patient observation rounding processes, including: 1. Proper use of the flashlight when rounding on sleeping patients at night and the process for confirming three respirations and any change in a patient's position. 2. Informing the RN of any change in condition such as abnormal breathing (including snoring), and patient repositioning so the RN will assess/reassess the patient's condition. 3. Nurses were also re-trained by the Director of Education and Process Improvement to assess/reassess patient breathing, to take vital signs as appropriate including taking pulse oximeter reading, to attempt to rouse a patient when necessary, to notify the physician of changes in condition, and to document findings and actions. Monitoring/Tracking: Training was provided to 100% of all nursing staff with evidence of this retraining placed in the master training file. The Director of Nursing was responsible for confirming	

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S 009	Continued From page 60 staff indicating they understood the policy and expectations for conducting patient observations. The Risk Manager stated expectations for patient safety observations was also conducted with new staff nurses and BHAs and was also part of annual competencies. The Risk Manager stated since the death of Sample Patient #1, staff nurses and BHAs were informed that if it was found that patient safety observations were not conducted per the facility's policy, corrective action would be taken up to and including termination of employment. The Risk Manager stated since the death of Sample Patient #1, administrative staff increased their morning/daily review of camera tapes from the day/night before. S/he stated each morning s/he reviewed an hour of tape from each of the 3 facility units and documented the review which included the time staff entered a patient's room and when staff exited the room. The Risk Manager stated s/he documented if there were not 4 observations made of each patient room in a 1-hour time frame. S/he stated s/he also documented if staff was in a patient's room for less than 9 seconds as it would take at least this much time to conduct an observation including observing 3 respirations. The Risk Manager stated s/he also reviewed tapes to see that BHAs were documenting on the patient's observation sheets at the time of observation instead of later, which was identified as a problem by the facility. The Risk Manager stated since the death of Sample Patient #1, administrative review of camera tapes had increased and 3 staff members were reviewing tapes including him/herself, the former Chief Executive Officer, and the Plant Operations Director. The Risk Manager stated choosing the videos to review was random and that s/he received documentation of tape reviews from the former CEO and the Plant Operations Manager when their reviews were completed. The Risk Manager stated the facility's patient	S 009	that all staff received the training. New Employee Orientation: The CEO directed the Director of Education and Process Improvement to revise the New Employee Orientation process as follows: 1. To include a suicide prevention video that orients 100% of new employees on the importance of patient observation rounds. 2. To provide training on the revised patient observation rounds policy describing the Hospital's "zero tolerance" expectation and promoting the importance of patient observation rounds as one of the most critical functions performed by nursing staff. 3. To emphasize the limited use of the Quiet Room and the continued use of patient observation rounds when the use of the Quiet Room is deemed appropriate. 4. To include a patient observation rounds practice for all new hires of clinical staff. 5. To have a Return Demonstration competency on patient observation rounding incorporated into the training and overseen by a Registered Nurse. Annual Competencies Process: The CEO directed the Director of Education and Process Improvement to include patient observation rounds training in the Hospital's Annual Competencies process with nursing staff showing competency through Return Demonstration. The Director of Nursing is responsible for confirming the competency of all nurse managers and nurse supervisors in patient observation	

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S 009	Continued From page 61 observation policy and the safety observations document completed for each patient, were not changed since the patients' death. f) On 09/19/13 at 12:08 p.m., an interview was conducted with the facility's former, interim CEO who confirmed orientation for new staff nurses and BHAs had not changed since the death of Sample Patient #1, and that annual competencies regarding patient safety observations had not changed. The interim CEO stated staff had been re-educated using the same facility policy and documents. The interim CEO stated s/he did conduct some reviews of camera tapes after the death of Sample Patient #1, but as of approximately the first week of September, 2013, s/he no longer had rights to view tapes on facility computers, so s/he was no longer conducting tape reviews. g) On 09/27/13 at 11:16 a.m., an interview was conducted with the Corporate Clinical Director who stated the expectation after the death of Sample Patient #1 was that administrative staff would increase the review of camera tapes in order to monitor nursing staff and BHAs conducting patient safety observations per facility policy and per recent re-training of staff. The Director stated this had not happened and the daily review of a sample of tapes by the facility Risk Manager was not an increase of administrative monitoring of this issue. h) On 09/27/13 at 9:36 a.m., view of recent camera tapes was conducted with the facility's Risk Manager, the Corporate Clinical Director, and the facility's Staff Educator and Performance Improvement Specialist. At 10:28 a.m., the Risk Manager completed review of a random sample of tapes from the previous 24 hour period and documented the results of the	S 009	rounding and in overseeing patient observation rounding by other nursing staff members. Annual Competencies Training was provided to 100% of all patient care and nursing staff with evidence of this retraining placed in the master training files. Quiet Room Use: The Director of Nursing developed a new Quiet Room form that lists the criteria for use of the Quiet Room, emphasizes the limited use of the Quiet Room, and includes a reminder to continue patient observation rounds in accordance with procedure during the short duration a patient is in the Quiet Room. The CEO directed that nursing staff use the new Quiet Room form as a checklist and teaching tool, including during new employee orientation and annual competencies. The Director of Nursing provided training on the new Quiet Room form to 100% of all nursing staff with evidence of this retraining placed in the master training files. Video Camera Review Process: The CEO directed the Director of Plant Operations to make video camera review capability accessible to the entire Hospital leadership team to enable them to conduct periodic reviews of patient observation rounds. The CEO and Director of Plant Operations reviewed the physical location of all	

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S 009	Continued From page 62 review. Review of the tape of the Adult Unit 1 showed a BHA in patient room #2108 for 17 seconds on one observation, 9 seconds on the next observation of this patient, and finally only 4 seconds in the patient's room at 3:30 a.m. The Risk Manager stated when s/he reviewed a BHA in a patient room for less than 9 seconds, s/he thinks the patient was probably awake and spoke with the BHA or had some interaction to let staff know the patient was safe. The Risk Manager followed up on this 4 second patient safety observation and stated Staff BHA #1 documented at 3:30 a.m. that the patient in room #2108 was asleep. The Risk Manager stated this patient safety observation was not conducted per facility policy. S/he stated the expectations of staff, and recent retraining of staff, noted the BHAs did not spend enough time in the patient's room to observe 3 respirations. i) On 09/18/13 a document provided by the Interim Director of Nursing, outlining the actions taking by nursing after the death of Sample Patient #1 was reviewed. The document and accompanying documents detailed meetings held with staff to review expectations for following the Patient Observation Rounds policy/procedure, including having all staff sign an attestation that they would follow the policy. The attestation included the key elements from the policy, including, looking for the rise and fall of the chest, counting at least three respirations and making sure that the patient moved from his/her previous sleep position. There was evidence that all nursing staff had been re-trained regarding conducting patient observation rounds (15 minute checks) according to the policy by the time of the survey. j) On 09/27/13 at 2:26 p.m., during an interview with the Facilty's Risk Manager, the surveyor requested to review tapes of a patient "Quiet Room" to observe staff observations of patients	S 009	Hospital camera monitoring stations to confirm functionality of each camera reviewing station. The Director of Plant Operations added camera monitors to all Units and to the CEO's office to provide review accessibility to the CEO, Director of Nursing, and all Nursing Supervisors. Monitoring/Tracking: One randomly selected hour of patient observation rounds is reviewed daily by Nurse Managers/Supervisors, and weekly by the CEO, Director of Risk Management, and the Director of Education and Process Improvement. Observations are documented on the Video Camera Review of Staff Observation Rounds Form which was specifically developed by the Director of Nursing for this process. The CEO provides a summary report of audit results to the monthly meetings of the Committee of the Whole and the MEC, and quarterly to the Board of Directors. Summary of monitoring activities: 1. The Director of Risk Management monitors Incident Reports for ongoing compliance with regulatory requirements including nursing staff following patient observation rounds correctly. 2. The ambassador is conducting 40 hours of random monitoring of patient observation rounds during the week to check compliance with Hospital policy and regulatory requirements. The ambassador is submitting both competency checklists and summary reports to the Director of Nursing for review each weekday. 3. Managers are conducting daily video camera reviews for at least 1 hour out of the previous 24 hours, unit specific, with priority on checking rounds on high acuity	

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S 009	Continued From page 63 placed in this type of room. The Risk Manager stated s/he did not necessarily look for staff observations of these rooms even though each Quiet Room had a camera inside the room. Quiet Rooms were used in the facility for patients who required closer observation by staff, therefore the camera in the rooms. Tape review revealed that on 09/24/13, in the adolescent unit, a child, Sample Patient #22, was sleeping in a Quiet Room. Review of tapes reflected facility BHA #2 was not conducting patient safety observations per the facility's policy. The tape reflected that on 09/24/13 at 02:29:59, BHA #2 was in the patient's room for 11 seconds but did not shine the flashlight toward the patient in order to ensure observation of the rise and fall of the patient's chest and to observe 3 respirations. At 02:43:35, BHA #2 was observed in the patient's room for 6 seconds with the flashlight shining toward the ceiling not toward the patient. At 02:58:54 BHA #2 was observed in the patient's room for 5 seconds, and at 03:18:02, the BHA was observed in the patient's room for 9 seconds. At 03:44:56, the BHA was observed in the patient's room for 17 seconds but turned away from the patient at one point and looked at the door. At 04:14:37, BHA #2 was observed in the patient's room for 6 seconds. The observation time between 03:44:56 and 04:14:37 was almost 30 minutes, not the required 15 minute interval. At 04:31:47, BHA #2 was observed in the patient's room for 5 seconds holding the flashlight up toward the ceiling. At 04:45:20, the tape showed a green light shining into the room for a few seconds and no staff person entering the room. At 05:08:21, BHA #2 was observed opening the patient's door, which had been left slightly open, but did not step inside the room to observe the patient. Instead, the BHA stood at the threshold of the door and backed out of the room 3 seconds later. At 05:20:37, BHA #2 was observed in the patient's room for 5 seconds. No further review	S 009	patients; producing a summary report on the completed review form; and submitting the report to the Director of Nursing for review each weekday. 4. Nurse supervisors are also conducting video camera reviews of patient observation rounds during their shift (with a focus on high risk situations, including Quiet Room usage) and completing a summary report to be submitted to the Director of Nursing for review each weekday. 5. The nurse manager submits a completed Summary Report to the Director of Nursing after each shift. The Summary Report includes observations from video camera reviews, direct observation of nursing staff, and any retraining or corrective actions taken. 6. Each weekday, the Director of Nursing submits an Executive Summary Report to the CEO based on the nurse managers' Summary Reports, personal observations, and actions taken. 7. The Director of Nursing submits a completed weekly Summary Report to the CEO, which includes camera reviews and feedback from the training ambassador. 8. The weekly Summary Reports are also reviewed during the weekly Nurse Forum meeting. 9. Weekly reports are compiled and reported at the monthly meetings of the Committee of the Whole and the Medical Executive Committee, at FLASH meetings of the administrative leadership team each weekday, and at quarterly Board of Directors meetings. 10. Reports from the revised AOC process described above are given to the CEO each weekday until the end of the 60-day monitoring period. The CEO reports results/trends/variances as indicated to the monthly meetings of the	

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S 009	Continued From page 64 of this tape was conducted by the surveyor and the facility's Risk Manager. The Risk Manager confirmed the findings reflecting lack of correct patient safety observations by BHA #2 for approximately 3 hours while Sample Patient #22 was sleeping. The Risk Manager confirmed the necessity of staff using a flashlight while observing in Quiet Rooms, even though there was dim light provided in these rooms. k) On 09/27/13 at 3:10 p.m., review of the medical record for Sample Patient #22 was conducted and revealed this was a 9 year old male with a history of seizure disorder who had been moved to the Quiet Room. The Patient Rounds Observation sheets for Sample patient #22 dated 09/24/13 showed all safety observations were conducted by BHA #2 beginning at midnight through 4:30 a.m. and from 05:15 a.m. through 7:15 a.m. Documentation by BHA #2 reflected the patient was sleeping at each observation with the exception of the 3:30 a.m. and 4:00 a.m. observations when the patient was documented as "sleeping in bed." The observation sheet revealed that the observations conducted at 04:45 a.m. and 05:00 a.m. were conducted by other staff whose initial could not be matched with a signature. l) On 09/27/13, review of the facility's retraining documents for nurses and BHAs regarding patient safety observations was conducted. The documents were titled, "Patient Observation Rounds Expectations Acknowledgement." The documents restated expectations from the facility's patient safety observation policy and included the expectation that staff would look for the rise and fall of a sleeping patient's chest and observe at least 3 respirations for sleeping patients. Staff BHA #1 initialed and signed this document on 8/20/13 and Staff BHA #2 initialed and signed the acknowledgement on 7/30/13.	S 009	Committee of the Whole and the MEC, and to the quarterly meetings of the Board of Directors.	

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