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B 000	INITIAL COMMENTS An unannounced Full CMS Survey was conducted by Federal contract surveyors, in conjunction with state surveyors, from 4/20/15 to 4/22/15. The census on the first day of the survey was 136; the sample of the active patients was 10. In addition to the B-tag survey, the Federal contract surveyors were asked to investigate a complaint from an anonymous person employed at the facility who was concerned about patient safety and the lack of qualifications of the staff in charge at the facility. The Federal surveyors were asked to investigate the latter issue. While conducting the B-tag survey, the surveyor found no evidence to indicate that the allegations of unqualified administrative staff was substantiated. No deficiencies were cited on the 2567 that related directly to the complaint in that area.	B 000		
B 103	482.61 SPEC MEDICAL RECORD REQS FOR PSYCH HOSPITALS The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. This CONDITION is not met as evidenced by: Based on record review, observation and interview, the facility failed to: I. Provide Master Treatment, including alternative interventions, for one (1) of two (2) active sample	B 103		

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

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

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patients (B7) on the Geriatric Unit, and 1 active sample patient (F19) on the Chronic Adult Psychiatric Unit. Although the treatment plan for each patient included multiple group therapies, both patients were not cognitively capable at times of attending the groups listed on their unit's schedules. The patients regularly and repeatedly did not attend the groups. Both patients spent many hours without any structured activities in his/her rooms or wandering around the units. Patient non-participation in assigned treatment modalities negates the clinical effectiveness of the patients' treatment goals and objectives, potentially delaying their improvement. (Refer to B125I)

II. Provide placement of hospitalized patients into milieus that contain (1) patients not yet hospitalized or (2) research patients hospitalized and possibly not receiving necessary medications. The potential for physical harm to the acutely ill patients is quite high.

1. The Adolescent Unit provides care to youngsters who are APOWW (apprehended by police officer without a warrant). These persons may or may not be determined to require hospitalization within 24 hours of their arrival. Staff on the unit estimate that about half of the APOWW persons are sent out after their evaluations. Thus, throughout the day seriously mentally ill persons may be sharing meals, groups etc. with persons not seen as mentally ill. The potential for harm to the acutely ill patients is therefore quite high.

There may also occur APOWW persons who are adults. Administrator estimates that 10% to 20%

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B 103	Continued From page 2 of these persons are assessed as not requiring acute care hospitalization yet are present throughout their stay with acutely mentally ill patients. There is a likelihood that other patients may be victimized by these persons who are not patients. 2. Patients hospitalized with other patients who are not on medications and who might require medications to modify their symptoms. There is a research program present at the facility called Pillar Research Program. The nature of this research program is to assess patient responses to double blind medication interventions. The patients are typically hospitalized on the Lewis 1 Unit amid acutely ill mental patients, but, on occasion, may be placed on the Bloss Unit (Adult Intensive Care). Again the nursing staff and pharmacy staff do not know who is or is not receiving medications aimed at lessening their symptomatology. The potential for assaults, property destruction, and other behavioral issues is present and there is a likelihood of victimization of patients not in this research program. (Refer to B125II)	B 103		
B 108	482.61(a)(4) DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history. This STANDARD is not met as evidenced by: Based on medical record review and staff	B 108		

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interview, it was determined that for eight (8) of ten (10) active patients (Patients A5, B7, B8, D1, D2, E1, E2 and F19), the facility failed to ensure that the Psychosocial Assessments provided a description of the specific and individualized role of the social work staff in treatment and discharge planning for these patients. The absence of this information prevents the treatment team from addressing critical patient needs during the course of hospitalization and formulating the patients' discharge plans, ensuring safe re-entry into the community.

Findings include:

A .Medical Record Review:

1. Patient A5: The Psychosocial Assessment, dated 4/12/15, had as the social services interventions - "group therapy, D/C (? discontinue) case mgmt (? management), planning." There was no description of the type of group therapy that was going to be provided or on what the discharge planning would focus.

2. Patient B7: The Psychosocial Assessment, dated 3/15/15, had as the social services interventions - "group therapy to stabilize changes in mood and behaviors; aftercare." There was no description of the patient's specific discharge planning needs.

3. Patient B8: The Psychosocial Assessment, dated 3/3/15, had as the social services to be provided - "group, individual and family therapy to stabilize changes in mood and behavior and aftercare planning". There was no patient specific description of what the focus for family therapy would be or the specific anticipated

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discharge planning efforts would be.

4. Patient D1: The Psychosocial Assessment, dated 4/93/15, had as a description of the role of the social work staff - "discharge planning, group therapy and individual therapy, supportive services." No patient specific focus was provided.

5. Patient D2: The Psychosocial Assessment, dated 4/12/15, had as social services role - "group therapy, family therapy, D/C planning." No patient specific focus was described.

6. Patient E1: The Psychosocial Assessment, dated 4/15/15, had as the role for social services - "Social work, group therapy, discharge planning." No patient specific focus was provided.

7. Patient E2: The Psychosocial Assessment, dated 4/8/15, had as the role of the social work staff - "group therapy, psycho-education, case management, D/C planning." No patient specific focus for these efforts was provided.

8. Patient F19: The Psychosocial Assessment, dated 4/10/15, had as the role for social service efforts - "Social work, group therapy, discharge planning." No patient specific focus for these efforts was described.

B. Staff Interview:

On 4/21/15, at 10:00 a.m., the Director of Social Services was interviewed. She was shown the findings described in Section A above. The Director agreed that these statements of the role

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B 108	Continued From page 5 or efforts of the social services staff were not individualized or patient specific.	B 108		
B 122	482.61(c)(1)(iii) TREATMENT PLAN The written plan must include the specific treatment modalities utilized. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility failed to ensure that for three (3) of ten (10) active patients (Patient A5, D1, and E2), their Master Treatment Plans contained the interventions that would be utilized by the psychiatrist and/or the nursing staff. This failure results in an inability of the patient or the other members of the treatment team to know what modalities or interventions would be attempted by these disciplines during hospitalization. Findings include: A. Medical Record Review: 1. Patient A5: The Master Treatment Plan, dated 4/10/15, failed to include a description of the psychiatrist's interventions. 2. Patient D1: The Master Treatment Plan, dated 4/6/15, failed to include a description of the interventions of the psychiatrist and the responsible nursing staff. 3. Patient E2: The Master Treatment Plan, dated 4/8/15, failed to include a description of the interventions of the psychiatrist and the responsible nursing staff.	B 122		

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B 122	Continued From page 6 B. Staff Interview: On 4/21/15, at approximately 9:30 a.m., the clinical director was interviewed. The findings described in Section A. above were discussed. He agreed that Treatment Plans should include the interventions of the various members of the treatment team.	B 122		
B 125	482.61(c)(2) TREATMENT PLAN The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included. This STANDARD is not met as evidenced by: I. Based on record review, observation and interview, the facility failed to provide active treatment, including alternative interventions, for one (1) of two (2) active sample patients (B7) on the Geriatric Unit, and 1 active sample patient (F19) on the Chronic Adult Psychiatric Unit. Although the treatment plan for each patient included multiple groups, both patients were not always cognitively capable of attending the groups listed on the unit's activity schedule. The patients regularly and repeatedly did not attend the groups. Both patients spent many hours, without any structured activities, in their rooms or wandering around hallways on their specific units. Patient non-participation in assigned treatment modalities negates the clinical effectiveness of the patients' treatment goals and objectives, potentially delaying their improvement.	B 125		

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B 125	Continued From page 7 Findings include: A. Patient B7 1. Patient B7 was admitted on 3/25/15. According to the Psychiatric Evaluation, dated 3/25/15, it stated "Patient brought in from NH (nursing home) last night. Here 3/12/15 - 3/20/15 and D/C (discharged) to nursing home. There was wandering of patient reported and patient was easily agitated. Patient became combative with staff trying to draw blood. Reportedly slept very little while there "---" disorganized, distrustful of caregiver "---" judgment poor." 2. Patient B7 was observed lying on bed with eyes closed on 4/20/15 around 12:25p.m. while most of patients were in dayroom eating lunch. When asked why B7 was not out eating lunch, MHT#1 stated, "[S/he] seldom comes out of [his/her] room. [S/he] just lies on his/her bed all day." When asked how [s/he] gets [his /her] meals, MHT#1 stated, "[Name of patient] just eats in [his/he] r room." 3. On B7's Master Treatment Plan, dated 3/25/15, an identified problem was "aggressive acting out behavior requiring the use of seclusion/restraint." The listed intervention included "1:1 [one to one] with patient to explore triggers for aggressive feelings and behavior, patient to attend psycho-education groups on anger management, patient to attend activity therapy groups to provide skills in coping, anger management, conflict resolution, patient to attend goal setting to assist patient in setting production goals." For the problem of "out of contact with reality," some of the listed interventions were: "Goals and wrap-up group" to assist patient in setting productive	B 125		

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goals, psycho-education groups on memory processing, safety & [and] trust, getting needs met, process groups to provide the opportunity to express thoughts feelings, activity therapy groups to provide patient skills in order to increase reality orientation, and individual/family therapy involving all his discharge planning.
There were no updates on B7's treatment plan to address the patient's inability and/or unwillingness to consistently participate in the therapy groups offered

4. In an interview on 4/15 around 12:15 p.m., RN #1 was asked for a copy of patient B7's activity schedule. RN #1 stated, "We just have a unit schedule. All patients on the unit are expected to attend the groups listed on the schedule." When asked if patient B7 attended any groups, RN #1 stated, "[Name of patient] stays in his/her room most of the time. We do try to encourage all patients to go to the groups, but we can't force them."

5. A review of the progress notes of groups offered by social work staff revealed that between 4/13/15 and 4/19/15, patient B7 did not participate or attend 10 of 14 groups offered. These groups were: "Process/Education Group" at 11:00 a.m. and 2:00 p.m. on 4/1315 and 4/15/15; same group on 4/16/15 at 2:00 p.m., on 4/17/15 at 11:00 a.m.; both groups on 4/15/15 at 11:00 a.m. and 2:00 p.m., and on 4/17/15 at 11:00 a.m. and 2:00 p.m.
On 4/17/15, patient was documented at 2:00 p.m. as attending the "Process/Education Group", but patient's round's sheet stated "Patient sat near group with eyes closed. Pt [patient] then came to group. Pt irritable."

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During the period of 4/13/15 and 4/19/15, patient B7 was documented on the "Daily Therapy Documentation" sheet as not attending four (4) of the seven (7) Recreation Therapy groups offered 7 days per week on the unit between the hours of 7:45 a.m. to 10:45 a.m. The dates were 4/13/15, 4/14/15, 4/15/15 and 4/18/15. There was no documentation in the Master Treatment Plan on whether the patient attended this group on 4/16, 4/17 and 4/19.

6. In an interview with patient B7 on 4/20/15, at 1:00 p.m., [s/he] was asked what [s/he] did all day. [S/he] stated, "I stay in my room most of the day."

7. In an interview on 4/20/15, at 1:55 p.m., MD #1 was asked if he was aware of patient B7's isolation in [his/her] room most of the day. MD #1 stated "[Name of patient] is significantly impaired. At one time [name of patient] would not sleep. I'm working with [his/her] medication. [Name of patient] does isolate self in room. I'm looking into a placement for [him/her]."

B. Patient F19

1. Patient F19 was admitted on 4/9/15. According to the Psychiatric Evaluation, dated 4/9/15, it stated that "Patient answered door with butcher knife in hand at private resident. Talking nonsense, irrelevant responses to the TBL (Timberlawn Bloss) [The patient's unit]. APOWW [apprehended by police without a warrant]." (In Texas a patient can be put in a facility for up to 48 hours for evaluation for treatment. Patient has the option of signing self into the facility if a physician

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feels patient needs treatment or physician can apply for a court order if patient opposes.) The evaluation goes on to say that patient still "talking in word salad stage of communication "----" unable to assess - appears to talk disorganized, unable to assess due to pt [patient] talking nonsense."

2. Patient F19 was observed wandering up and down the hallway on 4/20/15, at 11:50 a.m., while a process therapy group was being held in the lounge. When asked if patient F19 was supposed to be in that group, RN #2 said, "All the patients are expected to attend all the groups on the unit, but [name of patient] just wanders the hallway most of the time." Census on this unit was 24 at the time. Only 15 patients were at the Process group. Six (6) of the nine (9) patients not at the group were observed in their beds with eyes closed.

3. On patient F19's Master Treatment Plan, dated 4/9/15, an identified problem was "out of contact with reality." The listed interventions included: "1:1 patient education regarding effects, benefits and side effects of Haldol, goals and wrap-up group to assist patient in setting productive goals, psycho-education to assist patient in setting productive goals, psycho-education groups on reality testing, grounding techniques to develop self-care skills, process groups to provide patient opportunity to express thoughts and feelings, activity therapy groups to provide patient skills in grounding, 1:1 patient education regarding illness to promo 1:1 patient education regarding illness to promote self-care and prevent relapse, and medication education groups to increase understanding of effects and side effects of prescribed medications."

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B 125	Continued From page 11 For the problem of "aggression toward others," some of the interventions groups were: "1:1 patient education regarding effects, benefits and side effects of Haldol, goals and wrap-up group to assist patient in setting productive goals, psycho-education groups on boundaries of anger management, impulse control to develop self-control skills, process groups to provide patient opportunity to express thoughts and feelings, activity therapy groups to provide patient skills in anger management, and 1:1 patient education regarding illness to provide self-control and prevent relapse." There was no documentation on the Master Treatment plan to address the patient's inability or unwillingness to attend these groups and any alternative measures that could be implemented to suit patient's needs and ability at present state of mind. 4. A review of the progress notes of groups offered by social work staff revealed that between 4/13/15 and 4/19/15, 14 groups conducted by social work staff on process and/or education were offered at 11:00 a.m. and 1:15 p.m. during the 7 day period. The patient was documented on 4/13/15, at 11:00 a.m., as "Quiet-non-participation" and at 1:15p.m. as "observed wandering the hallway, did not attend group." On 4/14/15, at 11:: 00a.m., group - "wandered aimlessly around the unit and through group area. Pt. appeared to be R1S, [responding to internal stimuli]." At 1:15p.m. - "Pt. in and out of group area, again wandering aimlessly throughout unit." On 4/15/15, at 11:00 a.m., - "Pt. wandered around unit and through group area. Pt appeared to be R1S, talking to self. " At 1:15 p.m., "Pt. again wandering aimlessly around unit, this time	B 125		

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talking loudly to himself and disrupting group multiple times." On 4/16/15, at 11:00 a.m. and 1:15 p.m. groups - "Pt. was verbally encouraged to attend group, but refused. On 4/17/15, at 11:00 a.m. - "Pt. came at end of group, sat in chair. No verbal participation in group." At 1:15 p.m. group - "walking around. Handout given. Handout left in room." 4/18/15, at 11:00 a.m. - "Pt. wandering around the unit aimlessly and appeared to be R1S." At 1:15p.m. group - "pt remained in room." On 4/19/15, at 11:00 a.m. group - "Pt. paced around the unit and in and out of group and up and down hallway. Pt. appeared to be R1S, talking to self." At 1:15p.m. group - "Pt. remained in room initially, was again observed to be pacing the hallway during group. Pt. then returned to room and appeared to be asleep."

During the period of 4/13/15 and 4/19/15, patient F19 was documented on the "Daily Activity Therapy Documentation" sheet as not attending four (4) of the five (5) Recreation Therapy Groups offered Monday through Friday on the unit from 3:00 p.m. to 4:00 p.m. The dates of the groups not attended were 4/13/15 - 4/16/15. There was no documentation in the chart of an Activity Therapy Group on 4/19/15.

II. Based on record review, observation and interview, the facility failed to provide placement of hospitalized patients into milieus that contain (1) patients not yet hospitalized or (2) research patients hospitalized and possibly not receiving necessary medications. There is a likelihood of physical harm to the acutely ill patients.

Findings include:

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A Record Review

1. The Adolescent Unit provides care to youngsters who are APOWW (apprehended by police officer without a warrant). These persons may or may not be determined to require hospitalization within 24 hours of their arrival. Staff on the unit estimate that about half of the APOWW persons are sent out after their evaluations. Thus throughout the day seriously mentally ill persons may be sharing meals, groups etc. with persons not seen as mentally ill. This arrangement presents a likelihood of harm to the acutely ill patients.

APOWW persons who are adults may also be present. The Administrator estimates that 10% to 20% of these persons are assessed as not requiring acute care hospitalization yet are present throughout their stay with acutely mentally ill patients. There is a likelihood that patients may be victimized by these persons who are not patients.

2. Patients hospitalized with other patients who are not on medications and who might require medications to modify their symptoms.

There is a research program present at the facility called Pillar Research Program. The nature of this research program is to assess patient responses to double blind medication interventions. The patients are typically hospitalized on the Lewis 1 Unit amid acutely ill mental patients but on occasion may be placed on the Bloss Unit (Adult Intensive Care) Again the nursing staff and pharmacy staff do not know who

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B 125	Continued From page 14 is or is not receiving medications aimed at lessening their symptomatology. There is a likelihood of assaults, property destruction, and other behavioral issues and there is a likelihood of victimization of patients not in this research program. B. Staff Interview On 4/22/15, at 3:40 p.m., the facility's administrator was interviewed concerning these placements of acutely mentally ill patients with persons who do not warrant hospitalization or are not receiving medications that might benefit them. She acknowledged that these situations are occurring.	B 125		
B 133	482.61(e) DISCHARGE PLANNING The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined that for two (2) of five (5) Discharge Summaries (Patient G2 and Patient G3), the facility failed to ensure that a statement about the clinical status of the patient at the time of discharge was present. This failure results in no information to the next treatment provider about what condition the patient was presenting when the decision to discharge was made. Findings include:	B 133		

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B 133	Continued From page 15 A. Medical Record Review: 1. Patient G2: The Discharge Summary, dated 4/5/15, did not contain any information about the patient's clinical status at the time of discharge. 2. Patient G3: The Discharge Summary, dated 3/13/15, did not contain any information about the patient's clinical status at the time of discharge. B. Staff Interview: On 4/21/15, at approximately 9:30 a.m., the Clinical Director was told of the findings described in Section A above. He agreed that this information should be present in a patient's Discharge Summary.	B 133		
B 136	482.62 SPECIAL STAFF REQS FOR PSYCH HOSPITALS The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning. This CONDITION is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide adequate numbers of registered nurses and mental health workers on the Dual/Psychiatric Adult units to create and maintain a therapeutic milieu. Per the Nursing Director, in an interview on 4/20/15, around 9:30 a.m., the Dual/Psychiatric	B 136		

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B 136	Continued From page 16 Unit was considered one unit with Dual patients on one side of a locked unit and Psychiatric patients on the other side of a locked unit. A Nursing station was located between these two units. In actuality, patients from one side did not mingle with patients on the other side. The two sides operated as separate units. Each side had its own groups and assigned staff. The total number of staff assigned to these units was split between the two sides, creating an inadequate number to meet all patients' needs. This inadequate staffing results in the likelihood of unsafe patient care and failure of the professional nurses to adequately provide direction and supervision of non-professional personnel (Licensed practical nurses and mental health workers) in the provision of patient care (refer to B150).	B 136		
B 144	482.62(b)(2) MEDICAL STAFF The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff. This STANDARD is not met as evidenced by: Based on medical record review, and staff and patient interviews, it was determined that the clinical director failed to adequately supervise and evaluate the care provided to patients at the facility. Specifically, the Medical Director failed to assure that: 1. The Treatment Plans contained interventions by all members of the treatment team. For details see B122.	B 144		

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B 144	Continued From page 17 2. Patients who were too cognitively impaired to consistently attend groups were provided alternative treatment methods of care which were addressed on their Master Treatment Plans. (For details see B125I) 3. Treatment of patients at the facility included a) Active medical treatment being provided during hospitalization, b) Acutely mentally ill patients were not co-mingled with persons not assessed as requiring hospitalization, and c) Acutely mentally ill patients were not co-mingled with research patients who possibly were on placebo medication in double blind studies. For specific details see B125II. 4. Discharge Summaries contained a description of the patient's clinical status at the time of discharge. For details see B133.	B 144		
B 148	482.62(d)(1) NURSING SERVICES The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. This STANDARD is not met as evidenced by: Based on review and interview, the Nursing Director failed to adequately supervise and evaluate the quality of nursing care provided to patients. Specifically, the Nursing Director failed to:	B 148		

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1. Ensure that for two (2) of ten (10) active patients (Patient D1, and E2) their Master Treatment Plans contained the interventions that would be utilized by the nursing staff. This failure results in an inability of the patient or the other members of the treatment team to know what modalities or interventions would be attempted by these disciplines during hospitalization.

Findings include:

A. Medical Record Review:

1. PatientD1: The Master Treatment Plan, dated 4/6/15, failed to include a description of the interventions of the responsible nursing staff.

2. Patient E2: The Master Treatment Plan, dated 4/8/15, failed to include a description of the interventions of the responsible nursing staff.

B In an interview on 4/21/15, at 3:45 p.m., the lack of nursing interventions on some of the active sample patients' Master Treatment Plans was discussed with the Nursing Director. She did not dispute the findings.

2. Assure that adequate number of registered nurses and mental health technicians were assigned to the Dual/Adult Psychiatric Units at all times in order to create and maintain a therapeutic milieu.

Per the Nursing Director, in an interview on 4/20/15, around 9:30a.m., the Dual/Psychiatric Adult Unit was considered one unit with Dual

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B 148	Continued From page 19 patients on one side of a locked unit and Adult Psychiatric patients on the other side of a locked unit. A nursing station was located between these two units. In actuality, patients from one side did not mingle with patients from the other side. The two sides operated as separate units. Each side had its own groups and assigned staff. The total staff assigned to these units was split between the two sides, creating an inadequate number to meet all the patients' needs. This inadequate staffing results in the likelihood of unsafe conditions and failure of the professional nursing staff to provide direction and supervision of non-professional nursing personnel (licensed practical nurses and mental health workers) in the provision of nursing care. (Refer to B150)	B 148		
B 150	482.62(d)(2) NURSING SERVICES There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide adequate numbers of registered nurses and mental health workers on the Dual/Psychiatric Adult units at all times to create and maintain a therapeutic milieu. Based on review and interview, the Nursing Director failed to assure that adequate number of registered nurses and mental health technicians were assigned to the Dual/Adult Psychiatric Units at all times in order to create and maintain a	B 150		

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B 150	Continued From page 20 therapeutic milieu. Per the Nursing Director, in an interview on 4/20/15, around 9:30 a.m., the Dual/Psychiatric Adult Unit was considered one unit with Dual patients on one side of a locked unit and Adult Psychiatric patients on the other side of a locked unit. A nursing station was located between these two units. In actuality, patients from one side from a locked unit did not mingle with patients from the other side. Each side had its own groups and staff. The total staff assigned to these units was split between the two sides, creating an inadequate number to meet all the patients' needs. There is a likelihood of unsafe conditions due to inadequate staffing and failure of the professional nursing staff to provide direction and supervision of non-professional nursing personnel (licensed practical nurses and mental health workers) in the provision of nursing care. Findings include: A. Record Review 1. RN and LVN (licensed vocational nurses, also called licensed practical nurses) staff work twelve hour shifts. MHW(Mental Health Workers) work 8 hour shifts. A review of 8 days of nurse staffing on the Dual/Psychiatric Adult Units for the period of 4/2/15 - 4/8/15 and 4/17/15 - 4/20/15 showed the following deficiency: 7 of the 8 day shifts had 1 RN and 1 LPN on duty. 2 of 8 night shifts had this staffing. 1 day shift of 8 and 5 of 8 night shifts had 2 RNs and 2 MHTs. The total bed capacity for both units was 33.	B 150		

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However, when 1 RN and 1 LVN are scheduled, one unit does not have a professional nurse. In this situation, the one RN has to cover both sides in providing treatment or documentation only the professional nurse can provide per facility policy. On the shift with 2 RNs and 2 MHTs, the staffing was 1 RN and 1 MHT for each side for about 16 -17 patients assigned to each unit.

2. The Nursing Needs Assessment sheet, dated 4/20/15, had a total census of 27. Average daily census was 29.

4 patients required diabetic checks,
2 were on seizure precautions,
14 on detox protocol,
4 patients were potentially assaultive (has occasionally demonstrated during hospitalization),
10 were low risk suicidal (has occasionally demonstrated during hospitalization),
4 patients were on assault precaution,
1 on elopement precaution,
1 patient under constant/line of sight supervision (was actually a every 5 min observation) and 26 were on every 15 - 30 minute supervision checks.

3. On 4/20/15, the "Precaution Checklist for 5 Minute Observation" for patient E2 was checked by a surveyor around 2:20 p.m. The sheet showed no documentation of E2 for about 35 minutes. This patient had been put on q 5 minute checks because [s/he] had threaten to harm [his/herself].

B. Staff Interview

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1. On 4/20/15, around 1:30 p.m., the Director of Nursing was interviewed. The focus then was why her name appears as the responsible person on the treatment plan of active sample patient D2. She reported that she covered in treatment team meetings because the nurse (Unit Berkett 1 Adolescent) was too busy to attend, thus indicating a possible lack of sufficient staff on other units.

2. In an interview with Licensed Practical Nurse (LPN) #1 on 4/21/15 at 1:30 p.m., s/he was asked about the nurse staffing pattern on the unit for the day. LPN #1 stated that the total census for 4/21/15, was 33 - 16 Dual patients and 17 Adult Psychiatric patients. LPN #1 stated that there was 1 RN who covered the Psychiatric Adult Unit and s/he (the LPN) covered the Dual Unit. Three mental health workers were assigned for the day shift - 1 MHT on each side and 1 float. The float answered phones, covered the other technicians for breaks, lunch and doing patient round.

3. In an interview on 4/21/15 at 2:00 p.m. with RN #3, [s/he] was asked if [s/he] felt 1 RN and 1 LPN was adequate staffing for both units. RN #3 stated it was difficult to get all the work done for both sides with that number of staff. RN #3 stated that there had been an admission. "RNs have to do the Nursing Assessments on all patients and admit any new patients. LPNs do not do these functions."

4. In an interview with MHT #1 on 4/21/15, at 2:10 p.m., [s/he] was asked how 1 technician can provide rounds every 5 minutes for 1 patient and

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B 150	Continued From page 23 15 minutes checks for about 16 -17 other patients. MHT #1 stated "It's extremely difficult. Patients are very needy. They want something to drink or towels, or time for doing their laundry. We also do vital signs." When asked how [s/he] can do all that and keep an eye on patient E1 who required checks every 5 minutes, MHT #1 stated, "I try to keep patient E1 in the dayroom so [s/he]'s in line of sight at all times." However MHT #1 admitted that a technician can get busy doing things for other patients and get behind in checking the patient every 5 minutes as evident in what happened on 4/20/15. 5. In an interview on 4/21/15, at 3:40 p.m. with the Director of Nursing, the shortage of staff on the Dual/Adult Psychiatric Units was discussed. She was told of the potential harm for patients, such as E1, who was suicidal (patient had expressed desire to harm self on 4/20/15, around 1:15p.m. per LPN #1. The Nursing Director did not dispute the findings.	B 150		
B 152	482.62(f) SOCIAL SERVICES There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the Director of Social Work failed to adequately monitor and evaluate the quality of social services provided to patients. Specifically, for eight (8) of ten (10) active patients (Patients A5, B7, B8, D1, D2, E1, E2 and F19), the Social Work Director failed to ensure that the Psychosocial Assessments provided a description	B 152		

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of the specific and individualized role of the social work staff in treatment and discharge planning for these patients. The absence of this information prevents the treatment team from addressing critical patient needs during the course of hospitalization and formulating the patients' discharge plans, ensuring safe re-entry into the community.

Findings include:

A .Medical Record Review:

1. Patient A5: The Psychosocial Assessment, dated 4/12/15, had as the social services interventions- "group therapy, D/C (? discontinue) case mgmt (? management), planning." There was no description of the type of group therapy that was going to be provided or on what the discharge planning would focus.

2. Patient B7: The Psychosocial Assessment, dated 3/15/15, had as the social services interventions - "group therapy to stabilize changes in mood and behaviors; aftercare." There was no description of the patient's specific discharge planning needs.

3. Patient B8: The Psychosocial Assessment, dated 3/3/15, had as the social services to be provided - "group, individual and family therapy to stabilize changes in mood and behavior and aftercare planning". There was no patient specific description of what the focus for family therapy would be or the specific anticipated discharge planning efforts would be.

4. Patient D1: The Psychosocial Assessment, dated 4/93/15, had as a description of the role of

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the social work staff - "discharge planning, group therapy and individual therapy, supportive services." No patient specific focus was provided.

5. Patient D2: The Psychosocial Assessment, dated 4/12/15, had as social services role - "group therapy, family therapy, D/C planning." No patient specific focus was described.

6. Patient E1: The Psychosocial Assessment, dated 4/15/15, had as the role for social services - "Social work, group therapy, discharge planning." No patient specific focus was provided.

7. Patient E2: The Psychosocial Assessment, dated 4/8/15, had as the role of the social work staff - "group therapy, psycho-education, case management, D/C planning." No patient specific focus for these efforts was provided.

8. Patient F19: The Psychosocial Assessment, dated 4/10/15, had as the role for social service efforts - "Social work, group therapy, discharge planning." No patient specific focus for these efforts was described.

B. Staff Interview:

On 4/21/15, at 10:00 a.m., the Director of Social Services was interviewed. She was shown the findings described in Section A. above. The Director agreed that these statements of the role or efforts of the social services staff were not individualized or patient specific.