DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454081	A. BUILDING ______ B. WING ______	C 05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD PO BOX 151489 DALLAS, TX 75315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey was conducted on site. An entrance conference was held with the Chief Executive Officer and other hospital designated staff members on the morning of 05/12/15. The hospital representatives were informed that this survey would be conducted according to the survey protocol in the State Operations Manual, Chapter 5, section 5100 and Appendix A, and according to 42 CFR 482 the Conditions of Participation for Hospitals. Survey findings were presented at an exit conference on the afternoon of 05/13/15 with the Chief Executive Officer and other hospital delegated personnel. The administrative representatives were given an opportunity to provide evidence of compliance with those requirements of which non-compliance had been found. None was provided to the surveyors. The	A 000	By submitting this Plan of Correction, the Facility does not admit that it violated the regulations. The Facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency. Upon completion of the exit conference held with the facility staff on 5/13/15, staff immediately developed a corrective action plan based on the preliminary findings as discussed in the exit conference. After receiving the CMS 2567, the hospital confirmed and enhanced the corrective action plan. The hospital took the actions detailed under each tag below.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 6/10/15

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

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A 000	Continued From page 1 hospital representatives were informed Complaint TX 00215994 and Complaint TX00216103 were substantiated with deficiencies cited. The following condition of Participation was not met: 42 CFR 482.13 Patient Rights	A 000	A 115: Beginning on 4/22/2015 during the survey and continuing after the exit conference, the Chief Executive Officer (CEO), Medical Director, Director of Social Services, and Director of Nursing Services reviewed and affirmed and/or revised the following documents pertinent to providing a safe environment. • Patient Assessment/Reassessment Policy • Assault Precautions Policy • Nursing Documentation Policy • Hand Off Communication • Staffing Plan • Patient Observation/Level of Observations • Storage of Oxygen • Contraband Policy • Occurrence/Incident Reporting The CEO, Medical Director, Director of Nursing, Director of Social Services and Director of Risk Management/Performance Improvement took the following actions to enhance patient safety: 1. Effective 5/6/2015, the CEO and DON revised the Nurse Staffing Plan for Burkett Building to include the division of two (2) units into four (4) units. Each of the four units is staffed as an independent unit. 2. Beginning 4/28/2015 and ongoing, the CEO directed admission staff to hold beds on the adolescent units for APOWW admissions.	06/18/15
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on record review, interview, and observation, the hospital failed to ensure a safe setting was provided for patients. 1) Current observations on the Bloss unit revealed not all patients in their rooms were observed by 2 of 2 technicians (Personnel #4 and #5) for 6 of 19 patient rooms (Room #142, #144, #148, #154, #158 and #160). 2) 2 of 2 patients (Patient #1 and Patient #2) were not adequately monitored/supervised. (Patient #1) and (Patient #2) had a sexual encounter without staff knowledge. 3) The Bloss Unit exceeded the allowed bed capacity of 24 beds for 05/07/15 and 05/08/15. Patients slept on couches and in chairs, therefore, patient privacy was not ensured. This practice placed patients and/or staff the likelihood for injury due to overcrowding. It further compromised the provision of care that meets the	A 115		

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A 115	Continued	A 115	3. Beginning 4/28/2015 and ongoing, the CEO directed admission staff to hold beds on the Bloss unit for APOWW admissions. 4. The CEO, Medical Director, Director of Nursing and Director of Admissions reassigned Lewis 1Unit as an Adolescent APOWW drop off assessment area beginning on 5/12/2015. 5. On 5/11/2015, the CEO, Director of Nursing and Director of Admissions developed a process for an APOWW Assessment area. 6. The DON began providing ongoing training on assessment/reassessment, nursing documentation, conducting and documenting rounds, and O2 storage. 7. The CEO and Director of Nursing added proper oxygen storage and verification of adequate volume of oxygen in each canister to the daily Leadership Environmental Rounds. 8. The Director of Nursing implemented monitoring of nursing documentation and rounds sheets. 9. On 5/13/2015, the CEO directed the Director of Plant Operations to survey and remove all plastic trash bags from patient care areas. 10. Immediately following the survey, the CEO, Medical Director, Director of Nursing and Director of Risk Management/Performance Improvement begin providing ongoing training to the direct care nursing staff regarding the hospital policy on contraband, which includes potentially dangerous items such as plastic trash bags. 11. Immediately following the survey, the CEO, Director of Risk	

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A 115	Continued From page 2 patients' psychomedical and psychosocial needs. 4) A plastic trash bag with the potential for use in self-harm was observed easily accessible to patients on 05/13/15 on the Geriatric Unit. (refer to A0142)	A 115	Management/Performance Improvement, and Director of Nursing implemented a process for monitoring the environment daily for contraband/other dangerous items. Through monitoring and reporting of audit results, leadership can evaluate the effectiveness of these processes and consider further improvements if necessary. For detail, please see the response to A142.	
A 142	482.13(c) PATIENT RIGHTS: PRIVACY AND SAFETY Patient Rights: Privacy and Safety This STANDARD is not met as evidenced by: Based on record review, interview, and observation, the hospital failed to ensure a safe environment and patient privacy in that: 1) Current observations on the Bloss unit revealed not all patients in their rooms were observed by 2 of 2 technicians (Personnel #4 and #5) for 6 of 19 patient rooms (Room #142, #144, #148, #154, #158 and #160). 2) 2 of 2 patients (Patient #1 and Patient #2) were not adequately monitored/supervised. (Patient #1) and (Patient #2) had a sexual encounter without staff knowledge. 3) The Bloss Unit exceeded the allowed bed capacity of 24 beds for 05/07/15 and 05/08/15. Patients slept on couches and in chairs, therefore, patient privacy was not ensured. This practice placed patients and/or staff the likelihood for injury due to overcrowding. 4) A plastic trash bag with the likelihood for use in self-harm was observed easily accessible to patients on 05/13/15 on the Geriatric Unit.	A 142	A 142: The CEO, Medical Director, Director of Nursing, Director of Social Services and Director of Risk Management/Performance Improvement took the following actions to provide patient safety: a. Beginning 4/28/2015 and ongoing, the CEO directed admission staff to hold beds on the adolescent units for APOWW admissions. b. Beginning 4/28/2015 and ongoing, the CEO directed admission staff to hold beds on the Bloss unit for APOWW admissions. c. The CEO, Medical Director, Director of Nursing and Director of Admissions reassigned Lewis 1Unit as an Adolescent APOWW drop off assessment area beginning on 5/12/2015. d. On 5/11/2015, the CEO, Director of Nursing and Director of Admissions developed a process for an APOWW Assessment area. e. On 5/13/2015, the CEO required the	06-18-15

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A 142	Continued From page 3 Findings included: 1) During the observations on the hospital's Bloss Unit on 05/12/15, between 1005 and 1045, one patient was locked in the Quiet Room, pounding on the door. Several patients were pacing down the long hallway leading to patient rooms. At 1017, the mental health technician walked half-way down the hallway but did not check all patient rooms. Patients were noted to be in Rooms 142, 144, 148, 154, 158, and 160. A female patient in Room 160 was noted to be directly opposite to Room 144, a male patient room. Personnel #5 was asked whether patients were allowed to be in their rooms with the door closed and stated, "No." The patient in Room 160 closed his door twice between 1010 and 1029. The hospital's Chief Operating Officer made rounds at that time and walked by Room 160's closed door without inquiring about the patient status and/or opening the door. At 1032, Personnel #5 walked by the closed door of Room 160. 2) Patient #2's admitting diagnoses dated 04/13/15, at 1000, reflected Bipolar Disorder Type 1, with Psychotic Features. Past Psychiatric History included Suicidal Ideation, Heroin and Cocaine Use. The Precaution Checklist dated 05/07/15, noted the patient was pacing in the large lounge between 2045 and 2345. The Precaution Checklist dated 05/08/15, (time	A 142	Director of Plant Operations to survey and remove all plastic trash bags from all patient care areas. The Chief Executive Officer (CEO), Medical Director, Director of Social Services and Director of Nursing Services reviewed, affirmed and/or revised the following documents to verify the requirements to provide a safe environment: • Patient Observation/Level of Observations • Sexual Aggression Precaution • Bed Capacity • Contraband The following actions were taken, beginning immediately following the survey and continuing to the completion date of 06/18/2015: 1. OBSERVATION ROUNDS: Policy and Process Changes: The Director of Nursing reviewed and affirmed that the Patient Observation/Level of Observation policy requires staff to observe and document on the patient observation record the location and behavior of each patient according to the level of observation they are assigned. The DON implemented a process for each Charge Nurse to review and verify that each Patient Observation Record indicates the appropriate precaution and has been completed by the MHT by signing the observation record at least two times per shift.	

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A 142	Continued From page 4 not legible) reflected Patient #2 was accused by another patient for entering her room and have consensual sex. The police were called to investigate and [the] patient was taken by police around 0435. The patient was documented "pacing in the large lounge" at 0030, 0045, 0010, 0115, 0145, 0200, 0215, 0230. The patient was documented taken by Police at 0435 and returning at 0815. Patient #1's Medical Record reflected the following: The 04/25/15, physician's pre-admission examination orders and preliminary plan of care timed at 0330, reflected, "PTSD (Post Traumatic Stress Disorder), Major Depressive Disorder...every fifteen minute suicide precautions..." The Discharge Planning Log dated 04/25/15, timed at 0915, reflected, "Reports biological parents physically, emotionally and sexually abused her since she was a child...reports being raped within last month..." The 05/08/15, Precaution Checklist reflected, "Close observation 15 minute checks...suicide precautions....location/behavior from 0000, 0015, 0030, 0045...0100, 0115...quiet ...room." The Multidisciplinary Progress Notes dated 05/08/15, timed at 00:30 reflected, "Spoke with (technician)...stated a man was in her (Patient #1's) room and he made her touch his privates... (technician) notified nurse...patient claimed she walked into her room and male patient was standing inside her room...told her to come here	A 142	The DON has implemented a process for the Nursing Supervisors to review and verify accurate completion of Patient Observation Records before the completion of each shift. The Nursing Supervisors document this check on their reports and provide the reports to the DON each weekday and to the Administrator-on-Call on weekends and holidays. Deficiencies identified by Charge Nurses or Nursing Supervisors result in immediate corrective coaching. Continued non-compliance results in progressive disciplinary action. Training: The DON re-educated MHTs, Charge Nurses, and Nursing Supervisors on the requirements for conducting rounds and documenting accurately on Patient Observation Records. The DON also educated MHTs, Charge Nurses, and Nursing Supervisors on the new oversight process where Charge Nurses verify and sign each observation record at least two times per shift, and Nursing Supervisors check and sign off on the Patient Observation Records each shift. Education was provided in staff meetings and one-on-one. Any relevant staff member who has not received the education by June 18, 2015 must complete the education before working another shift. The information provided during the above-mentioned training sessions has been incorporated into new-hire orientation and the annual refresher training.	

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A 142

Continued From page 5
and (male) threw her on the bed ...he must of heard something he just got up and left the room...at 0040...RN notified House Supervisor...at 0100...MD notified ...at 0115...nurse again spoke with patient...0220...police arrived on the scene...at 0420...stated she wanted to press charges against (male)."

During an interview, Patient #2 stated on 12/05/15, at 1010, that he and Patient #1 "had intercourse" and "people do it here all the time." Patient #2 denied a mental health technician provided oversight at that time. The patient was asked how easy it was to get from one patient room to another unnoticed by staff, and he answered, "Very easy."

On 05/12/15, at 2325, Personnel #7 was interviewed. Personnel #7 said (Patient #1) informed the MHT she was raped by a male patient.

On 05/12/15, at 2356, Personnel #10 was interviewed. Personnel #10 stated at the time the alleged event occurred he was in the office doing paperwork. Personnel #10 stated the unit was full with 24 patients plus APOWW's.

3) The Nursing Service Department Daily Patient Checklist dated 05/07/15, reflected, "24 patients on 3-11 with 3 APOWW's (apprehension by peace officer without warrant). The unit exceeded the 24 bed capacity by three patients (Patient #21, #22 and Patient #23).

The 05/08/15, Bloss Unit Assignment sheet from 6A to 6P reflected, "30 patients." The bed

A 142

Monitoring:

The Director of Nursing audits 100% of the Nursing Supervisor reports each weekday to verify compliance with documentation of patient observations.

The Director of Nursing reports results of the audits each weekday to the CEO, monthly to the Performance Improvement Committee and Medical Executive Committee, and quarterly to the Governing Board.

2. SEXUAL ACTING OUT PRECAUTIONS

Policy and Process Changes:

The Director of Nursing reviewed and revised the hospital policy and procedure Sexual Acting Out Precautions to verify that a patient may be placed on precautions at any time the patient is assessed to be at risk for sexual behaviors.

Training:

The Director of Nursing provided training to all RNs regarding the requirement to assess patients for the potential for sexual acting out and their ability to initiate sexual precautions and notify the physician as soon as possible. The assessment is documented on the nursing reassessment form each shift. The information provided during the above-mentioned training sessions has been incorporated into new-hire orientation and the annual refresher training.

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A 142	Continued From page 6 capacity was 24. This left six patient's without a bed. Personnel #14 stated on 05/12/15, at 1315, that 3 patients slept in the day area on the Bloss Unit at the time of the alleged incident on the unit for 05/07/15 to 05/08/15 (bed capacity 24). Personnel #14 was asked by the surveyor why the hospital puts more patients on the unit than they have beds for. Personnel #14 did not offer an explanation. Personnel #14 did verify 05/08/15, during the dayshift there were 30 patients on the Bloss unit and the unit did exceed the 24 bed capacity. On 05/12/15, at 2356, Personnel #10 was interviewed. Personnel #10 stated the unit was full 05/07/15 and 05/08/15 with 24 patients plus APOWW's. 4) Observations on the hospital geriatric unit's dining room on 05/13/15, at 12:20, noted ten patients were served lunch at a long table. At 12:40 a large black plastic trash bag was observed next to the locked trash can. Personnel #13 was observed removing the black plastic bag and agreed it was used for refuse of the lunch meal.	A 142	The Director of Nursing provided training to the LVNs and MHTs that they have the ability to notify the RN and/or MD if they have any concerns regarding a patient's behaviors. Training was provided in staff meetings and individually for those unable to attend a staff meeting. Understanding of the policy was acknowledged verbally and through written attestation. Any relevant staff member who has not received the education by June 18, 2015 must complete the education before working another shift. Monitoring: The Director of Nursing reports aggregated monitoring results for nursing assessments, documentation of risk precautions and reporting of occurrences to the Performance Improvement Committee (PI) and Medical Executive Committee (MEC) monthly, and to the Governing Board quarterly. 3. APOWW PATIENTS Policy and Process Changes: The CEO reviewed and revised the hospital policy Maximum Bed Capacity to state that the facility will not exceed maximum bed capacity by unit. Beginning 4/28/2015 and ongoing, the CEO directed Admissions to hold beds for APOWW clients in order not to exceed the unit bed capacity. On 5/12/2015, Lewis I Building was designated as an Adolescent APOWW	

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A 142	Continued From page 7	A 142	receiving area in order to remove APOWW's from the adolescent unit. The CEO, Director of Admissions, and Director of Nursing developed an action plan to renovate an area in the activities building to be designated as a permanent APOWW receiving center for Adult and Adolescent APOWW's. Renovation of the area began on 5/14/2015. The CEO, Director of Nursing and Director of Admissions reviewed and revised policy and procedure for APOWW Assessment and Admission to provide for assessment of APOWW clients for the most appropriate level of care in a timely manner. Training: The Director of Admissions provided training to the Admission staff on the revised policy on APOWW Assessment and Admission including the requirement to notify the CEO when units do not have any beds. The information provided during the above-mentioned training sessions has been incorporated into new-hire orientation and the annual refresher training. Monitoring: The Director of Admissions reviews and reports APOWW assessments and admissions to the CEO each weekday. The Director of Nursing reports census by unit to the CEO each weekday. Weekends and afterhours the Nursing Supervisor contacts the AOC to report	

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A 142	Continued From page 7a	A 142	census by unit. The CEO/designee reports aggregated data regarding daily census, volume of APOWW clients and bed capacity to the Performance Improvement Committee and Medical Executive Committee monthly, and to the Governing Body quarterly. 4. CONTRABAND: Policy and Process Changes: On 5/13/2015, the CEO required the Director of Plant Operations to survey and remove all plastic trash bags from all patient care areas. The CEO, Director of Nursing and Director of Plant Operations reviewed and affirmed the hospital policy on Contraband to verify that it includes items that patients could use to harm themselves or others, such as plastic bags. The CEO added an indicator on the Administrative Environmental Rounds Checklist to verify that no items considered contraband are unsecured on or near patient care areas. Rounds are completed by an administrator each weekday. The administrator doing the rounds is responsible for removing or securing any contraband so that it is not accessible to patients, documenting the items on the checklist, and discussing the items with relevant staff members. The CEO, DON, and the Director of Risk Management/Performance Improvement	

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A 142	Continued From page 7b	A 142	developed and initiated a Safety Specialist Program. Unit staff members applied and were appointed to each unit as Safety Specialists. They are responsible for promoting and managing patient safety on their assigned unit. The CEO, Director of Nursing and Director of RM/PI developed a description of duties and responsibilities of the Safety Specialist to include conducting safety audits, educating unit staff when safety concerns are identified, and communicating safety concerns to the Director of Nursing and/or the CEO immediately. The Nursing Supervisor is responsible for overseeing and confirming that another staff member is assigned to cover the Safety Specialist's other duties while the Safety Specialist conducts the safety audit and provides any indicated education. The Director of Nursing developed a checklist for the Safety Specialist to complete on his/her unit before the end of the shift. The Safety Specialist Checklist is forwarded to the CEO for review and compilation with the Safety Specialist Checklists from the other units. Training: The CEO, DON and/or the Director of Risk Management/Performance Improvement provided training to the appointed Safety Specialists on conducting safety surveillance, completion of the safety checklist, and the role and responsibilities of the Specialist. Understanding of the position and responsibilities was verified verbally and by written attestation. The information provided during the	

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A 142	Continued From page 7c	A 142	above-mentioned training sessions has been incorporated into new-hire orientation and the annual refresher training. Monitoring: In addition to the involvement of the administrators and Nursing Supervisors as described above, the CEO reviews each checklist and assigns corrective action as deemed necessary during the morning Flash meeting each weekday. The CEO will review identified safety concerns each weekday until resolved. The COO analyzes the data and reports results to the Patient Safety Committee, Performance Improvement, and MEC monthly, and quarterly to the Governing Body.	