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
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 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 entrance conference was held the early afternoon of 10/13/17 with the Hospital Chief Executive Officer and the Hospital Clinical Director. The purpose and process of the complaint survey were explained and an opportunity given for questions. The survey was conducted to determine the facility's compliance with 42 CFR §482, Conditions of Participation for Hospitals. An exit conference was held the early afternoon of 10/19/17 with the Hospital Chief Executive Officer and other administrative staff. Preliminary findings of the survey were presented and an opportunity given for discussion. All questions were answered. An opportunity was also provided for the facility to provide evidence of compliance with those requirements for which non-compliance was found during the survey. No	A 000	A 000 Submission of this plan of correction is not an admission that the citations are correct or that the Hospital violated the rules. The Hospital submits this plan of correction in response to the deficiency statement in accordance with the rules and survey procedures. Hospital leadership reviewed and confirmed that they began investigating Patient #1's allegations immediately, and during the week of 10/09/2017, they self-reported them to the state survey agency and then CMS, which led to the survey. Hospital leadership also reviewed and confirmed that the CMS 2567 was the first notification the Hospital received of an immediate jeopardy. Hospital leadership reviewed policies and processes, made changes, provided immediate and extensive training, and implemented ongoing monitoring to confirm staff's understanding of procedures and compliance. For details, please see the responses to A 083, A 144, A 395, and A 396.	10/20/17 11/01/17 11/10/17

REVIEWED
NOV 14 2017
BY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: CEO

(X6) DATE: 11/9/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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	Continued From page 1 such evidence was either alleged or proffered. The staff was thanked for their time and cooperation during the survey process. Complaint intake TX00271526 was substantiated and deficiencies were cited. The following Conditions of Participation were not met: CFR 482.12 Governing Body CFR 482.13 Patient Rights CFR 482.23 Nursing Services Based on observations, interviews and document review it was determined that the deficient practices found posed an Immediate Jeopardy to the health and safety of patients that caused harm, likelihood for harm, serious injury, and death. It was determined that: 1) The hospital failed to ensure a safe setting for patients in that a 17-year old male who had been placed on special precautions for potential sexual aggression, had unsupervised access to and entered a female patient room the late evening of 10/08/17 at a time when all adolescent patients had room time with lights out. The next day the female reported sexual abuse and emergently evaluated for sexual assault at a medical hospital. Clinical and administrative staff members had been unaware of the 17-year old patient's precautionary status until surveyor inquiry. At the time of survey, night shift staffing left three rooms with patients on sexual precautions unsupervised at times when staff completed room	A 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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	Continued From page 2 checks in an angled-off patient hallway. Hospital staff failed to document patients' location and behavior for close to one hour the evening of 10/09/17. The patients were on suicide precautions, had displayed active suicidal, depressive, and/or sexually inappropriate behavior during the course of their hospitalization, and/or were noted with poor insight and judgment. None of the six mental health technicians assigned to work the nights shift on the adolescent unit had evidenced training and demonstrated competence to target the specific developmental needs of the adolescent patient population. This failure presents a risk for serious patient harm or death and is in violation of facility policies regulations. Cross refer: A0144 2) The hospital failed to ensure that nationally accepted standards of nursing were followed and failed to ensure that a registered nurse supervised and evaluated the nursing care for each patient. The nurses failed to conduct nursing assessments after two female patients disclosed distraught over sexual abuse and/or observation of sexually inappropriate behaviors during current hospitalization. These deficient practices were not consistent with nationally accepted standards of practice, hospital policy, and state regulations and have the likelihood to	A 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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	Continued From page 3 cause serious harm to all patients seeking inpatient treatment for issues related to their psychiatric illness. Cross refer: A0395 3) The hospital failed to ensure that the adolescent patients' treatment plans were updated and addressed serious patient concerns that included the patients' sexual abuse related emotional statuses, potential sexual aggressive behaviors, and/or physical conditions that effected the patients' health and well-being on a daily basis. This failure presents a risk for serious patient harm or death and is in violation of facility policy regulations. Cross refer: A0396.	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that an effective governing body was responsible for the conduct of the hospital. On 10/09/17, a female adolescent patient had made an emotional disclosure about a male patient's presence in her room that resulted in an unwanted sexual encounter the night before. Hospital administration investigated the incident and was unaware of the male patient's order for staff to observe patient for potential sexual agression until surveyor inquiry	A 043	A 043 The Governing Body reviewed the survey findings and directed the CEO and senior leadership team to take actions as needed to address cited deficiencies and to provide routine reports on process changes made. For details, please see the response to A 083.	11/03/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 043	Continued From page 4 during the onsite survey. Cross refer: 482.12 (e)	A 043	A 083 ACTIONS & EDUCATION:	
A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: The hospital's governing body failed to ensure that services provided on the hospital's adolescent unit meet the health and safety of patients. Male Patient #3 was allowed to stay in a room approximately five steps across the hallway to a female patient's room. On 10/07/17, a physician ordered Patient #3 to be observed for potential sexual aggression. Approximately 24 hours later, Patient #3 was left unsupervised by staff and entered Patient #1's room. The next day, Patient #1 was sent to a medical hospital for emergent examination due to sexual assault . Clinical and administrative staff were unaware of the physician's order for sexual acting out behavior observation for Patient #3 until surveyor enquired about it during the onsite survey. Findings included: Patient #3's Physician's Certificate of Medical	A 083	The Human Resources Director and Nurse Manager confirmed to the CEO that on 10/15/2017 they provided disciplinary counseling to the RN who incorrectly transcribed the physician's order for SAO precautions for Patient #3 and also provided retraining. The Human Resources Director and Nurse Manager confirmed to the CEO that on 10/13/2017 they terminated the RN who failed to document patient observation rounds accurately on Patients #1 and #3 as identified in the citation. Upon receipt of the deficiency statement, the Interim DON and designees reviewed 100% of the current open medical records to confirm that any patients demonstrating sexually aggressive behaviors had appropriate precautions ordered, the orders were correctly transcribed on the Patient Observation Checklists, and the nursing staff on duty were all aware of the ordered precautions. The Interim DON reviewed and affirmed that the policies "Observation Rounds" and "Handoff Communication" provided adequate direction to staff regarding correct performance and documentation of observation rounds and appropriate communication of critical patient information to other staff on duty and as part of the handoff process from shift to shift.	10/20/17 10/20/17 11/03/17 11/02/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 083	Continued From page 5 Examination for Mental Illness dated 10/02/17 reflected, "The patient slashed his mom's tires, threatened to kill himself by cutting his wrists then threatened to kill his mom and siblings...depressed and irritable mood, suicidal and homicidal ideation's, poor insight and judgment." Patient #3's Physician's Orders dated 10/07/17, timed at 2245, reflected, "Place patient on SAO-P [sexual acting out- perpetrator] precautions..." Patient #3's Patient Observation Checklist dated 10/07/17, 10/08/17, and 10/09/17 did not reflect the patient was on sexual acting put precautions. Patient #3's Nursing Note dated 10/07/17 did not reflect any documentation by nursing as to why the patient was placed on sexual acting out precautions per physician orders dated 10/07/17. Patient #1's Multidisciplinary Progress Note dated 10/13/17 (late entry) for Monday 10/09/17 at approximately 1730 reflected Patient #1 came to Personnel #5 during dinner and reported that "... [Patient #3] came into my room and touched me...then he started kissing me...I told him to stop but then he got on top of me and continued to kiss me...would not stop kissing me and kept telling me 'you know you want it'... he then took his pants off and then he took my pants off and my panties then patient got back on top of me and started kissing me more...then he stuck his thing in me, then took it out and stuck it in again and we had sex...do you think I'm pregnant...?"	A 083	The Interim DON developed a Transcription of Physician Orders Policy that provides specific direction to the RN staff on the process for fully transcribing physician's orders, which may include transmission of orders to pharmacy or dietary, addition of precaution orders to the Patient Observation Checklists, and/or completion of requisitions, and which also includes informing other staff of new orders. The Interim DON also revised the Sexual Acting Out Precautions Policy to include defining boundary violations and the potential of those behaviors as precursors to SAO behavior, additional interventions to prevent SAO behavior, and expectations for response to alleged or actual SAO incidents, including the movement of patients to alternate rooms and the investigation required. The new and revised policies were approved by the MEC and the Board. The Interim DON provided retraining to all RNs on management of SAO precautions with emphasis on: • Correct transcription of SAO orders to include the addition of the new precaution order on a Patient Observation Checklist, • Notation of the SAO precautions on the current Patient Pass-Along form for report to the next shift • Communication of any new order to all staff on duty • Signs/Symptoms of sexually aggressive behavior, and appropriate nursing interventions including changing the room assignment if needed to move a patient on SAO precautions farther from	11/03/17 11/02/17 11/03/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 083	other patients at risk and to a room where the patient on SAO precautions would not have a roommate • Documentation of rationale for special precautions and ongoing documentation of assessments/reassessments of patients • Requirement for maintaining appropriate observations/supervision of patients on SAO precautions, with emphasis on the RN's responsibility for correct assignment and oversight of nursing staff's performance of observation rounds • Updating the patient's treatment plan to reflect the special precautions.			
	Competency and understanding of expectations was assessed via post-test and signed attestation.			11/10/17
	The Interim DON provided retraining to all MHTs on the management of patients on SAO precautions with emphasis on: • Signs/symptoms of sexually aggressive behavior • Reporting patient behaviors to the RN • Maintaining appropriate observations/supervision of patients on SAO precautions • Correct process for handing off rounds to another MHT or an RN whenever staff needs to leave the unit or perform a task that would interfere with completion of rounds.			11/10/17
	Competency and understanding of expectations was assessed via post-test and signed attestation. Any nursing staff member who has not received the training by 11/10/2017 will not be allowed to work a shift until he or she has completed the training.			11/10/17
	The Interim DON reviewed and modified the nursing orientation to provide greater emphasis on nursing/MHT responsibilities in care of patients on precautions, including patients with sexually aggressive behaviors: • Correct transcription of SAO orders to include addition of the precautions to the Patient Observation Checklist • Notation of any new precautions on the Patient Pass-Along form for report to the next shift • Communication of any new order for precautions to all staff on duty • Signs/Symptoms of sexually aggressive behavior, and appropriate nursing interventions including changing a patient's room assignment, such as moving the patient farther away from other patients who might be at risk, and placing the patient in a room without a roommate • Documentation of rationale for special precautions and ongoing documentation of assessments/reassessments of patients • Requirement for maintaining appropriate observations/supervision of patients on SAO precautions, including the RN's responsibility for assignment and oversight of MHT performance of observation rounds • Updating the patient's treatment plan to reflect the special precautions.			11/10/17
	The Senior Leadership Team created a map of the units and a new process for reviewing all patients'			11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 083	room assignments each weekday morning in light of their precautions to confirm whether the room assignments are appropriate.			
	To enhance the ability to observe and monitor the milieu on each unit, the Senior Leadership Team implemented the practice of keeping the corner rooms in the units locked and not using them when census is low. When census on a unit increases to the point where the corner rooms need to be used, the unit will then be staffed with at least three nursing staff members to enable concurrent monitoring of the corner rooms and the day room.			11/10/17
	MONITORING:			
	For a period of at least three months or until full compliance is achieved, the Interim DON/designees are monitoring all patient records daily to determine 1) if any patients have SAO precautions ordered, 2) if those precaution orders have been correctly transcribed, 3) if the Patient Observation Checklists correctly reflect ordered precautions, 4) if the precautions have been noted on the Pass-Along Form, 5) if all staff have been informed of the SAO precaution order via communication from the RN transcribing the order or through shift report, and 6) if the patient's treatment plan has been updated to reflect the special precautions.			11/10/17
	For an initial period of 30 days or until full compliance is achieved, a member of the Senior Leadership Team is accompanying each nursing staff member doing observation rounds on at least one set of observations rounds each shift on each unit to monitor compliance with observation round documentation, to observe and confirm their competency, and provide any appropriate feedback. Documentation of the coaching/competency rounding is maintained on a new audit tool.			11/10/17
	After the initial 30 days, the Senior Leadership Team will continue monitoring at least one set of observation rounds on at least one unit every shift for an additional 90 days to confirm that the practice has been systematized. During this intensive monitoring process, any non-compliance will be addressed with feedback, re-education, and/or progressive disciplinary action as appropriate.			11/10/17
	The Interim DON provides results of record reviews and results of rounding with the nursing staff performing observation rounds to the Morning Leadership Meeting each weekday and aggregated results monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Body.			11/10/17
	Responsible Staff: Interim DON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 083	Continued From page 6 Patient #1's 10/09/17 physician orders, timed at 2015, reflected to transfer the patient to pediatric emergency care for evaluation. Personnel #3 stated during an interview on 10/13/17 at 1320 that the incident had been investigated by management staff. Personnel #3 was asked by the surveyor whether Patient #3 had been on sexual acting out precautions. Personnel #3 denied knowledge of it. During an interview on 10/13/17 at approximately 1430, Personnel #1 denied awareness of Patient #3's precautionary observation status for sexual acting out.	A 083		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the hospital failed to protect the rights of each patient and failed to provide a safe environment for 13 out of 13 patients (Patients # 1, #2, #3, #4, #6, #7, #9, #10, #11, #13, #15, and #17, and #18). 1) On 10/08/17, at a time when patients had to be asleep in their rooms according to the unit schedule, staff failed to supervise Patient #3, a male, who had unrestricted access to a female Patient #1's room, close-by. Patient #3 entered	A 115	A 115 Hospital leadership reviewed policies and processes, made changes, provided immediate and extensive training, and implemented ongoing monitoring to confirm staff's understanding of procedures and compliance. For detail, please see response to A 144.	11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 115	Continued From page 7 Patient #1's room and stayed for about six minutes before returning to the hallway. Approximately 20 hours later, Patient #1 disclosed unwarranted sexual encounter with Patient #3. Patient #1was emergently sent for a SANE (Sexual Assault Nurse Examiner) examination at a medical hospital. Until the surveyor's inquiry during the survey, clinical and administrative staff were unaware that Patient #3 had been placed on special precautionary observation level for potential sexual aggression approximately 24 hours prior to the incident. 2) Twelve out of thirteen patients on the hospital's adolescent unit (Patients # 1, #2, #4, #6, #7, #9, #10, #11, #13, #15, #17, and #18) were left without documentation of their location and behavior for more than 45 minutes on 10/09/17. The patients were on suicide precautions, had active suicidal and/or sexually inappropriate thoughts and/or behavior, and/or were noted with poor insight and judgment. 3) At the time of survey, none of the night-shift assigned mental health technicians had evidenced training to address age specific and developmental needs of the hospital's adolescent population.	A 115	A 144: 1) ACTIONS & EDUCATION: The Human Resources Director and Nurse Manager confirmed to the CEO that on 10/15/2017 they provided disciplinary counseling to the RN who incorrectly transcribed the physician's order for SAO precautions for Patient #3 and also provided retraining. The Human Resources Director and Nurse Manager confirmed to the CEO that on 10/13/2017 they terminated the RN who failed to document patient observation rounds accurately on Patients #1 and #3 as identified in the citation. Upon receipt of the deficiency statement, the Interim DON and designees reviewed 100% of the current open medical records to confirm that any patients demonstrating sexually aggressive behaviors had appropriate precautions ordered, the orders were correctly transcribed on the Patient Observation Checklists, and the nursing staff on duty were all aware of the ordered precautions.	10/20/17 10/20/17 11/03/17
A 144	Cross refer: A0144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting.	A 144	The Interim DON reviewed and affirmed that the policies "Observation Rounds" and "Handoff Communication" provided adequate direction to staff regarding correct performance and documentation of observation rounds and appropriate communication of critical patient information to other staff on duty and as part of the handoff process from shift to shift.	11/02/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure that a safe environment was provided for 13 of 13 patients (Patients # 1, #2, #3, #4, #6, #7, #9, #10, #11, #13, #15, #17, and #18). 1) Patient #3, a male, was placed on SAO-P (sexually acting out- perpetrator) precautions on 10/07/17 per physician's order. Neither clinical nor administrative staff was aware that Patient #3 was placed on special precautions for staff to observe the patient's potential sexual aggressive behavior. Without staff observation, Patient #3 entered a female patient's (Patient #1's) room, unrestricted, on the evening of 10/08/17, at a time when staff documented that the patients were in the day room and/or dining area. Patient #3 remained in Patient #1's room for about six minutes. Approximately 20 hours later, and after Patient #3's discharge, Patient #1 reported an unwarranted sexual encounter with Patient #3 to staff. Patient #1 was sent for emergency evaluation for sexual assault at a medical hospital. 2) Twelve out of thirteen adolescent patients on suicide precautions (Patients #1, #2, #4, #6, #7, #9, #10, #11, #13, #15, #17, and #18) were left without staff documentation of the patients' location and behavior for more than 45 minutes on 10/09/17. The patients had a history of suicide attempt(s) prior to admission, active suicidal ideation, depression, sexually inappropriate behavior during the course of hospitalization, and/or were noted with poor insight and	A 144	The Interim DON developed a Transcription of Physician Orders Policy that provides specific direction to the RN staff on the process for fully transcribing physician's orders, which may include transmission of orders to pharmacy or dietary, addition of precaution orders to the Patient Observation Checklists, and/or completion of requisitions, and which also includes informing other staff of new orders. The Interim DON also revised the Sexual Acting Out Precautions Policy to include defining boundary violations and the potential of those behaviors as precursors to SAO behavior, additional interventions to prevent SAO behavior, and expectations for response to alleged or actual SAO incidents, including the movement of patients to alternate rooms and the investigation required. The new and revised policies were approved by the MEC and the Board. The Interim DON provided retraining to all RNs on management of SAO precautions with emphasis on: • Correct transcription of SAO orders to include the addition of the new precaution order on a Patient Observation Checklist, • Notation of the SAO precautions on the current Patient Pass-Along form for report to the next shift • Communication of any new order to all staff on duty • Signs/Symptoms of sexually aggressive behavior, and appropriate nursing interventions including changing the room assignment if needed to move a patient on SAO precautions farther from	11/03/17 11/02/17 11/03/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 9 judgment. 3) None of the six mental health technicians (MHTs) assigned to work the night shift on the adolescent unit had evidenced training and demonstrated competence to target the specific developmental needs of the adolescent patient population. Findings included: 1) Patient #3's Physician's Certificate of Medical Examination for Mental Illness dated 10/02/17 reflected, "The patient slashed his mom's tires, threatened to kill himself by cutting his wrists then threatened to kill his mom and siblings...depressed and irritable mood, suicidal and homicidal ideation's, poor insight and judgement." Patient #3's Physician's MOT Orders and Preliminary Plan of Care dated 10/02/17, timed at 1100, reflected, "Precautions...assaultive, suicide...level of observation...Q15 minutes." Patient #3's Physician's Orders dated 10/07/17, timed at 2245, reflected, placed the patient on SAO-P (sexual acting out-perpetrator) precautions. Patient #3's Observation Checklist dated 10/07/17, 10/08/17, and 10/09/17 reflected Patient #3 was on 15-minute observation checks for suicide and assault. The documents did not reflect special observations for sexual acting out behavior. The checklist dated 10/08/17, at 2230	A 144	other patients at risk and to a room where the patient on SAO precautions would not have a roommate • Documentation of rationale for special precautions and ongoing documentation of assessments/reassessments of patients • Requirement for maintaining appropriate observations/supervision of patients on SAO precautions, with emphasis on the RN's responsibility for correct assignment and oversight of nursing staff's performance of observation rounds • Updating the patient's treatment plan to reflect the special precautions. Competency and understanding of expectations was assessed via post-test and signed attestation. The Interim DON provided retraining to all MHTs on the management of patients on SAO precautions with emphasis on: • Signs/symptoms of sexually aggressive behavior • Reporting patient behaviors to the RN • Maintaining appropriate observations/supervision of patients on SAO precautions • Correct process for handing off rounds to another MHT or an RN whenever staff needs to leave the unit or perform a task that would interfere with completion of rounds. Competency and understanding of expectations was assessed via post-test and signed attestation. Any nursing staff member who has not received the training by 11/10/2017 will not be allowed to work a shift until he or she has completed the training.	11/10/17 11/10/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4500 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 10 and 2245, reflected Patient #3 ate in the dining room. Personnel #3 was interviewed on 10/13/17, at 1320, and stated Personnel #12 was in charge of supervising the patients. Personnel #12's documentation "did not match what we saw on camera ...[Personnel #12] falsified the documents." On 10/18/17, at 1151, Personnel #6 was interviewed. Personnel #6 acknowledged that Patient #3 was not in the dining room at the time of the alleged sexual encounter incident. Patient #1's Preadmission Evaluation/Management (Psychiatric Diagnostic Evaluation with Medical Services) dated 10/05/17, timed at 1515, reflected, " ...parents found a noose made out of a belt and shoe strings under her pillow..[redacted]..past psychiatric history...sexually abused by [redacted] who is presently incarcerated for molesting and abusing...patient...precautions suicide...level of observation Q15 minutes..." Patient #1's Registered Nurse (RN) Admission Assessment dated 10/05/17, timed at 2045, reflected the patient was not sexually active. It noted the "...13 year old presents for anxiety and depression...consistently stated her intention to	A 144	The Interim DON reviewed and modified the nursing orientation to provide greater emphasis on nursing/MHT responsibilities in care of patients on precautions, including patients with sexually aggressive behaviors: • Correct transcription of SAO orders to include addition of the precautions to the Patient Observation Checklist • Notation of any new precautions on the Patient Pass-Along form for report to the next shift • Communication of any new order for precautions to all staff on duty • Signs/Symptoms of sexually aggressive behavior, and appropriate nursing interventions including changing a patient's room assignment, such as moving the patient farther away from other patients who might be at risk, and placing the patient in a room without a roommate • Documentation of rationale for special precautions and ongoing documentation of assessments/reassessments of patients • Requirement for maintaining appropriate observations/supervision of patients on SAO precautions, including the RN's responsibility for assignment and oversight of MHT performance of observation rounds • Updating the patient's treatment plan to reflect the special precautions. The Senior Leadership Team created a map of the units and a new process for reviewing all patients' room assignments each weekday morning in light of their precautions to confirm whether the room assignments are appropriate.	11/10/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 11 commit suicide by hanging..." Patient #1's Psychosocial Assessment Adolescent dated 10/07/17, timed at 0800, reflected, "Patient wrote suicide note...attempted to hang herself and cut herself once admitted...patient had a period of normality between 10-11 years old...sexually abused by [redacted] Patient #1's Observation Checklist dated 10/08/17 reflected, "Q15 minute checks...(no precautions listed)...2230 and 2245 patient interacting socially in the day area." On 10/18/17, at 1151, Personnel #6 was interviewed. Personnel #6 was asked to review Patient #1's observation record for 10/08/17. Personnel #6 stated based on the video footage the patient was in her room between 2230 to 2245 during the time of the alleged sexual encounter and verified the document incorrectly documented the patient was in in the day area interacting. The Multidisciplinary Progress Note dated 10/13/17 reflected Patient #1 approached Personnel #5 on 10/09/17 at about 1730 and reported that "...(Patient #3) came into my room and touched me...then he started kissing me...I told him to stop but then he got on top of me and continued to kiss me...would not stop kissing me and kept telling me 'you know you want it'...he then took his pants off and then he took my pants off and my panties... got back on top of me and started kissing me more...then he stuck his thing in me, then took it out and stuck it in again and we had sex...do you think I'm pregnant...?"	A 144	To enhance the ability to observe and monitor the milieu on each unit, the Senior Leadership Team implemented the practice of keeping the corner rooms in the units locked and not using them when census is low. When census on a unit increases to the point where the corner rooms need to be used, the unit will then be staffed with at least three nursing staff members to enable concurrent monitoring of the corner rooms and the day room. MONITORING: For a period of at least three months or until full compliance is achieved, the Interim DON/designees are monitoring all patient records daily to determine 1) if any patients have SAO precautions ordered, 2) if those precaution orders have been correctly transcribed, 3) if the Patient Observation Checklists correctly reflect ordered precautions, 4) if the precautions have been noted on the Pass-Along Form, 5) if all staff have been informed of the SAO precaution order via communication from the RN transcribing the order or through shift report, and 6) if the patient's treatment plan has been updated to reflect the special precautions. For an initial period of 30 days or until full compliance is achieved, a member of the Senior Leadership Team is accompanying each nursing staff member doing observation rounds on at least one set of observations rounds each shift on each unit to monitor compliance with observation round documentation, to observe and confirm their competency, and provide any appropriate feedback. Documentation of	11/10/17 11/10/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 12 Patient #1's Multidisciplinary Progress Note dated 10/09/17 at 1910 reflected the patient's physician was notified of " ...sexual allegations... [emergency care hospital] was contacted for an MOT (Memorandum of Transfer) and police. Officers arrived at approximately 2000 to speak to the patient. Nursing informed the patient's [family member] that the patient was about to be transferred to ...[emergency care hospital] and to meet Police there ....this nurse met with police officer ...patient was transported via ... [emergency medical services] ..." Patient #1's physician orders dated 10/09/17, timed at 2015, reflected an order to transfer " ... patient to... [pediatric emergency care] for evaluation...at 2030...discharge patient AMA (against medical advice)." Patient #1's (Pediatric Emergency Care) Emergency Department Provider Note dated 10/09/17 at 2334 reflected the patient had been admitted for "...concern for sexual assault prior to arrival...complains of lower abdominal and pelvic pain..." The notes timed at 0153 (on 10/10/17) reflected "...forensic examination completed..." Patient #1's (Pediatric Emergency Care) Child Life Specialist Progress Note dated 10/10/17, at 0220, reflected Patient #1 received a SANE (Sexual Assault Nurse Examiner) examination. On 10/13/17, at 1245, Personnel #5 was interviewed. Personnel #5 stated that on Monday, 10/09/17, at dinner time, Patient #1 told him that "one of the boys ...[Patient #3]" came into her	A 144	the coaching/competency rounding is maintained on a new audit tool. After the initial 30 days, the Senior Leadership Team will continue monitoring at least one set of observation rounds on at least one unit every shift for an additional 90 days to confirm that the practice has been systematized. During this intensive monitoring process, any non-compliance will be addressed with feedback, re-education, and/or progressive disciplinary action as appropriate. The Interim DON provides results of record reviews and results of rounding with the nursing staff performing observation rounds to the Morning Leadership Meeting each weekday and aggregated results monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Body. Responsible Staff: Interim DON 2) ACTIONS & EDUCATION: The CEO confirmed that on the last day of the survey he and the Interim DON reviewed video of the 45 minutes referred to in the citation and confirmed that, although the observation rounds were not documented, all 12 cited patients were in the dining hall eating dinner, safe, and under the supervision of two MHTs. It should also be noted that the surveyor was shown the video that demonstrated that although the documentation of rounds was not completed correctly, all patients were safe in the dining hall and under the direct supervision of nursing staff at the times	11/10/17 11/10/17 10/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 13 room and touched her. Patient #1 told Patient #3 "no" and "stop" and "pushed him off" but Patient #3 " ...continued to kiss me ...just kept kissing me ...touching me ...got up and pulled his pants down, pulled my jeans off and my panties, took his thing and stuck it in me, pulled it out, and stuck it back in, and we had sex." Personnel #5 stated that Patient #1 became very emotional at that time and asked Personnel #5 whether she was pregnant. Personnel #5 stated he told Patient #1 that "the nurses will keep you safe from here on." Patient #1's and Patient #3's rooms were approximately five to ten feet apart; the alleged incident happened on Sunday, 10/08/17 between 2230 and 2245. Personnel #5 stated he informed the nurses and administration of the reported incident. At the time of alleged incident, Patient #1's roommate, Patient #2, was not in her room although all patients had to be in their rooms with lights out as of 2200. Personnel #5 was asked by the surveyor whether Patient #3 was on precautions for sexual acting out behavior and stated he did not know. Personnel #5 stated he reviewed unit surveillance video footage and "we saw Patient #3 go into a female room at about 1040 [2240] and leave about 1043 [2243]." Personnel #1 stated during an interview on 10/13/17, at 1345, that Personnel #12, assigned to supervise 16 patients "was not where she was supposed to be ... the [unit] nurses acknowledged that they did not know where...[Personnel #12] was..." Personnel #1 acknowledged that Patient #1's room was in the same hallway and close to Patient #3's room. During an interview on 10/13/17, at 1430, Personnel #1 denied awareness of Patient #3's	A 144	noted in the deficiency statement. The Director of Clinical Services (DCS) took disciplinary action against the MHT on duty who failed to document the observation rounds while the patients were in the dining hall. The DSC also provided retraining. The Interim DON reviewed and affirmed that the policy "Observation Rounds" requires all patients to be observed a minimum of every fifteen (15) minutes with those rounds documented on the Patient Observation Checklist, even if the patients are together in the dining hall, the day room, or involved in a group activity. The Interim DON provided retraining to all nursing staff on the expectations for compliance with the Observation Rounds policy with emphasis on: • Mandatory documentation of observation rounds at least every fifteen (15) minutes, even if the patients are all together in a group such as in the dining hall • Handoff required when a staff member cannot complete observation rounds • Required RN supervision/responsibility for observation rounds by MHTs Competency was assessed via post-test and signed attestation. Any nursing staff member who has not received the training by 11/10/2017 will not be allowed to work a shift until he or she has completed the training. MONITORING:	11/07/17 11/02/17 11/10/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 14 order to be observed for sexual perpetrator behavior, Personnel #6 was interviewed by telephone on 10/17/17, at 1134. Personnel #6 stated Personnel #12, assigned to supervise the patients, had "left the unit." Personnel #8 was interviewed by telephone on 10/17/17, at 1222, and denied awareness of any incident but the unit was "usually short-handed." Personnel #8 stated that on Sunday, 10/09/17, the unit was staffed with one MHT "...and we should have had two...the patients were rambunctious...the other RN (Registered Nurse) tried to wrangle them...we can't make them go to their rooms." Personnel #8 stated she was not aware that Personnel #12 had left the unit and "...sometimes I did not see...[Personnel #12] but we have faith that the techs take care of the patients...it was a disorganized place...I guess, I was charge nurse ..." Personnel #8 denied awareness that Patient #3 had been on sexual acting out (SAO) observational status on 10/08/17. Observations on the hospital's adolescent patient unit on 10/18/17, at 0600, reflected one MHT, Personnel #21, supervised nine patients. Three rooms occupied with male patients on SAO precautions were not immediately visible to Personnel #21 while conducting room checks at an angled-off patient hallway. During an interview on 10/18/17, at 0630, Personnel #22 acknowledged the above	A 144	For an initial period of 30 days or until full compliance is achieved, a member of the Senior Leadership Team is accompanying each nursing staff member doing observation rounds on at least one set of observations rounds each shift on each unit to monitor compliance with observation round documentation, to observe and confirm their competency, and provide any appropriate feedback. Documentation of the coaching/competency rounding is maintained on a new audit tool. After the initial 30 days, the Senior Leadership Team will continue monitoring at least one set of observation rounds on at least one unit every shift for an additional 90 days to confirm that the practice has been systematized. During this intensive monitoring process, any non-compliance will be addressed with feedback, re-education, and/or progressive disciplinary action as appropriate. The Interim DON provides results of record reviews and results of rounding with the nursing staff performing observation rounds in the Morning Leadership Meeting each weekday and aggregated results monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Body. ADDITIONAL ACTIONS & MONITORING: Noting that all 12 cited patients who were in the dining hall were on suicide precautions, the Interim DON and DCS reviewed and confirmed the Hospital's policy on Suicide and Self Injury Prevention: Early Identification, Observation/Precautions,	11/10/17 11/10/17 11/10/17 11/08/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 15 observation and stated that nurses were expected to observe the milieu but it was "not realistic that the nurse always watches the patients when the tech [MHT] makes rounds." 2) Patient #1's Preadmission Evaluation/Management Timberlawn Mental Health System (Psychiatric Diagnostic Evaluation with Medical Services) dated 10/05/17, timed at 1515, reflected the patient had been admitted for suicidal ideation. Patient #1's level of observation was every 15 minute checks. Patient #1's observation checklist dated 10/09/17 reflected the patient was on every 15 minute observations for suicide precautions. There was no evidence of staff documentation regarding the patient's behavior and location for 1715, 1730, and 1745. The patient observation check list was left incomplete for that time. Patient #2's Physician's MOT (Memorandum of Transfer) Orders and Preliminary Plan of Care dated 10/05/17, timed at 1000, reflected the patient was on suicide precautions and staff was to observe her every 15 minutes. Patient #2's Observation Checklist dated 10/09/17 reflected, "Observation status 15 minute checks ...precautions suicide ..." The observation rounds document was left incomplete for 1715, 1730, and 1745. Patient #4's Physician MOT Orders dated 10/08/17, at 0119, reflected the patient was on detox and suicide precautions and was to be	A 144	Interventions and Response & Notification. Similar to the SAO Policy, the SP policy requires RNs to update each Patient's Observation Checklist to reflect the current precautions and level of monitoring, notify the staff member assigned to the patient of any change in precautions of monitoring level, document and communicate the patient's status in the Pass-Along Form and shift report, and update the patient's treatment plan. Additionally, RNs reassess each patient's suicidal and self-harm ideation every shift. The SP policy also includes the following directions for nursing staff when patients are on Suicide/Self-Injury Precautions (SP): • Limit the personal belongings allowed in the patient's room; • Provide the patient with access to linens during sleep time only; • Closely supervise patients with pencils during written activities; • Routinely conduct environmental safety checks for potential contraband, unlocked windows/doors, and other available means of self harm; • Encourage patient participation in unit programming; • Be vigilant for behaviors that indicate increased risk of suicide/self-harm and immediately communicate to the Charge Nurse any significant signs of concern, including: o Verbalized threats, intent, or other indications of planning of a suicide attempt; o Written notes, journaling, or other correspondence indicating suicide threat, planning, overwhelming loss, hopelessness; o Giving away personal items; o Isolating self from others;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 16 observed every 15 minutes. Prior to admission, Patient #4 reported he did not want to live any longer and wanted to commit suicide. The patient had used marijuana, Xanax, and "some other pill" within 24 hours prior to admission. Patient #4's Observation Checklist dated 10/09/17 reflected Patient #4's suicide precautions. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #6's Physician MOT Orders dated 09/30/17, timed at 0032, reflected admitting diagnoses that included Mood (Affective) Disorder. The patient was placed on suicide precautions to be staff observed every 15 minutes. Physician Orders dated 10/05/17 at 1235 reflected the patient was placed on "Sexual Acting Out" precautions. Physician Progress Note dated 10/06/17, at 0830, reflected Patient #6 displayed symptoms of sexual inappropriate behavior. Patient #6's Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide and sexual acting out. The patient's behavior and location were supposed to be documented every 15 minutes. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #7's Physician's Preadmission Examination orders dated 10/05/17, at 1618, reflected admitting diagnoses that included Major Depressive Disorder. Patient #7 was placed on 15-minute observation for suicide precaution. Physician Progress Note dated 10/09/17, at 1420, reflected the patient was sad, withdrawn, and had increased depressive symptoms. Patient #7's Observation Checklist dated 10/09/17 reflected	A 144	o Secretive behavior; o Dramatic change in affect/mood; and o Circumstantial life changes, such as loss of a pet, family member, or girlfriend/boyfriend. The Interim DON covered all precautions, including suicide precautions, in the retraining described above for RNs and MHTs on managing SAO precautions. The retraining also included maintaining appropriate observations and supervision of patients on precautions, and handing off rounds appropriately whenever a staff member doing observation rounds needs to leave the unit or perform a task that would interfere with completion of rounds. Competency and understanding were assessed via post-test and signed attestations. The Interim DON reviewed and confirmed that nursing orientation covers implementation, management, and observation/supervision of patients under any precautions. As described above, the Senior Leadership Team created a map of the units and a new process for reviewing all patients' room assignments each weekday morning in light of their precautions to confirm whether the room assignments are appropriate. This review takes into account whatever precautions have been ordered for each patient. Also as described above, to enhance the ability to observe and monitor the milieu on each unit, the Senior Leadership Team	11/10/17 11/10/17 11/10/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 17 the patient's suicide precautionary status. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #9's Physician MOT Orders dated 09/24/17, timed at 0921, reflected the patient was admitted with diagnoses including Major Depressive Disorder. He was placed on suicide precautions. Physician Orders dated 10/05/17, at 1400, required staff to observe the patient for sexual acting out behavior. Physician Progress Note dated 10/07/17, at 1159, reflected Patient #9's statement that his "depression meds [medications] are not working ...still expressing thoughts to harm self." Patient #9's Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide and sexual acting out behavior. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #10's Physician MOT Orders dated 10/04/17 at 1525 reflected the patient's admitting diagnoses that included Major Depressive Disorder. The patient was placed on 15-minute staff observations for suicide precautions. Physician Progress Notes dated 10/09/17, at 1219, reflected the patient was anxious. His judgement and insight were "poor." Patient #10's Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #11's Physician MOT Orders dated 10/05/17 at 2244 reflected the patient was admitted with diagnoses that included Major	A 144	implemented the practice of keeping the corner rooms in the units locked and not using them when census is low. When census on a unit increases to the point where the corner rooms need to be used, the unit will then be staffed with at least three nursing staff members to enable concurrent monitoring of the corner rooms and the day room. During the 120 days when Senior Leadership Team members are monitoring observation rounds by accompanying nursing staff members on a set of observations rounds, Senior Leadership Team members are evaluating the nursing staff performance with regard to whatever precautions apply to each patient and providing feedback and further education as indicated. The Interim DON provides results of rounding with nursing staff to the Morning Leadership Meeting each weekday and aggregated results monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Body. Responsible Staff: Interim DON 3) ACTION & EDUCATION: The Interim DON reviewed the Nursing Orientation program and confirmed that new nursing staff members receive extensive training on policies and procedures for taking care of patients with mental health and substance use disorder conditions.	11/10/17 11/10/17 11/06/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 18 Depressive Disorder. He was placed on 15-minute observational staff rounds for suicide. Physician Progress Note dated 10/07/17, at 1056, reflected Patient #11 had suicidal ideation, was depressed, sad, flat, worried, and was noted to have poor judgement and insight. The Daily Nursing Flow Sheet dated 10/08/17, at 2015, reflected the patient was isolative and did not interact with other patients. Patient #11's Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #13 was hospital admitted on 10/03/17, at 1922, according to the patient's Physician MOT Orders. Admitting diagnoses included Major Depressive Disorder. Physician Progress Note dated 10/07/17, at 1055, reflected the patient was sad, flat, and depressed. Her judgement and insight were physician noted to be "poor." Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide. Daily Nursing Flow Sheet dated 10/09/17, at 1750, reflected the patient was discharged. There was no documented evidence that staff observed the patient's behavior and location during the last 30 minutes prior to her discharge. The observation rounds document was left blank for 1715, 1730, and 1745. The rounds check timed at 1800 noted the patient's discharge. Patient #15" Physician MOT Orders dated 10/07/17 at 1510 reflected the patient was admitted with Major Depressive Disorder. He was placed on suicide precautions with 15-minute	A 144	The Interim DON enhanced the Nursing Orientation program to include age-specific training related to adolescent growth and development. The Interim DON provided age-specific training related to adolescent growth and development to all RNs and MHTs assigned to the Adolescent Unit. Competency was assessed via post-test. MONITORING: The HR Director is responsible for reviewing 100% of new nursing staff members' training files at the completion of orientation to confirm that any RN or MHT that may be assigned to the adolescent unit has completed training on adolescent growth and development. Aggregated results will be reported monthly to the Quality Council and quarterly to the Governing Body. Responsible Staff: Interim DON	11/06/17 11/10/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 19 staff observation rounds. Patient #15's Intake Assessment dated 10/07/17 at 1932 reflected the patient witnessed violence and experienced family loss. He had been using hallucinogens, stimulants including cocaine and crystal meth, marijuana, alcohol, and opiates for up to three years prior to his admission. Patient #15 had attempted to commit suicide "numerous" times since the age of 13, and methods included overdosing, suffocation, eating plastic or glass, slashing of throat, hanging, and access to firearms. Physician Progress Note dated 10/09/17 at 1429 reflected the patient was hearing voices and had suicidal ideation. He was noted to be anxious, and with poor judgement and insight. Patient #15's Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #17's Physician MOT Orders dated 10/05/17 at 0347 reflected she was admitted with diagnoses that included Major Depressive Disorder. Patient #17 was placed on suicide precautions with 15-minute staff observation rounds. Patient #17's Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide. The observation rounds document was left blank for 1715, 1730, and 1745. Patient #18's Physician's MOT Orders dated 10/07/17 at 0527 reflected admitting diagnoses that included Major Depressive Disorder. The patient was placed on detox and suicide precautions with 15-minute staff observation rounds. Daily Nursing Flow Sheet dated 10/08/17	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 20 at 1205 reflected the patient did not have any medical problems. Daily Nursing Flow Sheet dated 10/08/17 at 1945 reflected the patient had "superficial and deep cuts over lower and upper extremities." Physician Progress Note dated 10/09/17 at 1430 reflected the patient minimized her symptoms ...still says she is not depressed despite significant self-harm ..." Patient #18's Observation Checklist dated 10/09/17 reflected the patient's precaution status for suicide. The observation rounds document was left blank for 1715, 1730, and 1745. On 10/18/17 at 1151 Personnel #6 was interviewed by telephone. Personnel #6 further reviewed the 10/09/17 observation record and verified the 1715, 1730 and 1745 rounds were not completed and left blank for Patients # 2 and #4. Personnel #15 acknowledged the above findings on 10/19/17 at approximately 1130. The policy titled Patient Observation/Level of Observation dated 03/2017 reflected "level of observation will consist of monitoring every 15 minutes...patients on fifteen minute checks can expect to be checked a minimum of every fifteen minutes to maintain safety...behavior codes will be completed on all patients at each check... to ensure patient safety, as well as, to provide a process for observing and documenting patient location and behavior...visually observe patients when behind closed doors by...knocking on bedroom and bathroom doors...announce that they are stepping into the room for rounds...open the door and visually observe the safety of the patient.....notify Charge Nurse/Nursing	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 144	Continued From page 21 Supervisor/Team Leader before leaving an area...hand off the Patient Observation Rounds forms to person responsible for completing observations in your absence..." 3) Personnel #21 interviewed on the hospital's adolescent unit on 10/18/17, at 0600, and stated the night shift was staffed with one nurse and one MHT. Personnel #21 stated he/she had started to work the adolescent unit "last week" and denied age specific training for the adolescent unit. Personnel #16 was asked by the surveyor to review Personnel #21's employee file during an interview on 10/18/17, at 1020. Personnel #16 denied that Personnel #21 had received training and demonstrated competence that target the specific developmental needs of the adolescent patient population. Personnel #16 reviewed five additional employee files (Personnel #11, #17, #18, #10, and #19) during an interview on 10/19/17, at 1005. Personnel #16 stated the MHTs were assigned to work night shift on the adolescent unit. Personnel #16 denied that that the MHTs had training and demonstrated competence that targeted the specific developmental needs of the adolescent patient population	A 144		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or	A 385	A 385: Hospital leadership reviewed policies and processes, made changes, provided immediate and extensive training, and	11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 385	Continued From page 22 supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on interview and record review, the hospital failed to have an organized nursing service. Nursing failed to reassess and evaluate two of two female patients (Patients #1 and #2) after emotional disclosure of experiencing and/or observing sexually inappropriate behavior by their unit peers. Patient #1, a 13 year old female made an outcry on 10/09/17 that Patient #3, a 17 year old male, entered her room and had a sexual encounter with her on the evening of 10/08/17. Patient #1 was not assessed/evaluated by the nurse after her outcry. Patient #2 made an outcry that she was having flashbacks of past sexual abuse after seeing peers being sexually inappropriate. No further nurse assessment/evaluation was found after the original outcry was made. Cross refer: A0395 Nursing failed to update and address physical and/or emotional needs of six of six patients' care plans (Patients #1, #2, #3, #24, #25, and #15) for their mental and physical well-being. 1) Patient #1's past history of sexual abuse with interventions/goals, 2) Patient #2's flashback from past sexual abuse cause by visualizing peers engage in sexually inappropriate behavior,	A 385	implemented ongoing monitoring to confirm staff's understanding of procedures and compliance. For details, please see responses to A 395 and A 396.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 385	Continued From page 23 3) Patient #3's SAO-P (sexually acting out-perpetrator) precautions, 4) Patient #24's SAO-P precautions, 5) Patient #25's inability to safely digest milk and dairy products without stomach ache, 6) Patient #15's lactose intolerance that caused nausea, vomiting, rash, and diarrhea. Cross refer: A0396	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure 2 of 2 patients (Patient #1 and Patient #2) were reassessed and/or evaluated by a Registered Nurse. 1) Patient #1, a 13 year old female, made and outcry on 10/09/17 that Patient #3, a 17 year old male, entered her room and had a sexual encounter with her on the evening of 10/08/17. Patient #1 made the outcry after Patient #3 was discharged. Patient #1 was not assessed/evaluated by the nurse after her outcry. 2) Patient #2 made an outcry that she was having flashbacks of past sexual abuse after seeing peers being sexually inappropriate. No further nurse assessment/evaluation was found after the	A 395	A 395: ACTIONS & EDUCATION: The Interim DON reviewed and affirmed that the policy "Assessment and Reassessment of Patients" correctly directs the RN staff on expectations for documentation of assessments/reassessments following any actual or alleged incident. The Interim DON provided retraining to all RNs on assessment expectations as outlined in the policy with emphasis on: • Assessment of patients for any actual or alleged incident • Reassessment, at least once and until issue is resolved, following any actual or alleged incident • Documentation of all assessments and reassessments Competency was assessed via post-test.	11/05/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 395	Continued From page 24 original outcry was made. Findings included: Review of the hospital Policy titled, "Assessment and Reassessment of Patients" with a review date of 03/2017 reflected, "The Registered Nurse will assess each patient at a minimum every shift and more often as deemed necessary...assessment will include the patient's mental and physical status...findings will be documented...more frequent assessments of patients may be needed when the patient is having a physical problem, change of condition...RN will assess the patient and document findings in a progress note..." The Texas Board of Nursing (2017) noted "Professional nursing involves the observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes..." (http://www.bon.texas.gov/practice_scope_of_practice_rn.asp). 1) Patient #1's Preadmission Evaluation/Management....(Psychiatric Diagnostic Evaluation with Medical Services) dated 10/05/17, timed at 1515, reflected, "Per intake...13 year old was discharged from...two weeks ago...parents found a noose made out of a belt and shoe strings under her pillow. [redacted]	A 395	MONITORING: For a period of at least three months or until full compliance is achieved, the Interim DON/designee is monitoring the records of patients involved in any actual or alleged incidents to verify there are nursing assessments and reassessments documented in the record. Results of record review are reported each weekday in the Morning Leadership Meeting and aggregated data is reported monthly to the Quality Council and Medical Executive Committee and quarterly to the Governing Body. Any non-compliance is being addressed with additional training and/or disciplinary action as appropriate. Responsible Staff: Interim DON	11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 395	Continued From page 25 [redacted]..past psychiatric history...sexually abused by[redacted] who is presently incarcerated for molesting and abusing...patient...precautions suicide...level of observation Q15 minutes..." The 10/09/17 (6A-6P) daily nursing flow sheet, timed at 0800, reflected, "Patient is alert/oriented times 4...patient is calm and compliant with medications and shift assessment...denies suicidal and homicidal thoughts...hallucinations and pain...no issues or distress noted at this time." The Multidisciplinary Progress Note dated 10/09/17 at 1910 reflected Dr...was notified of "sexual allegations." "...Hospital was contacted for an MOT (Memorandum of Transfer) and police..." Officers arrived at approximately 2000 to speak to the patient. Nursing informed the patient's...that the patient was about to be transferred to... Hospital and to meet Police there. Patient #1's...told nursing that he refused to allow the patient to return to (Timberlawn) after the assessment at...Hospital. The patient was discharged against medical advice (AMA)...(cont) multidisciplinary progress note timed at 2100 reflected, "This nurse met with police officer who was leaving to meet...at hospital and explained physicians orders and...response...patient was transported via...transport...alert/oriented times 4...at 2245 staff member called facility...refused to sign, discharge paperwork...was released by hospital to parent's custody." No nursing assessment of the patient was documented after Patient #1's outcry.	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 395	Continued From page 26 The Multidisciplinary Progress Note dated 10/13/17 (late entry) for Monday 10/09/17 at approximately 1730 reflected, "Patient came to (Personnel #5) during dinner and reported that patient (Patient #3) came into my room and touched me...then he started kissing me...I told him to stop but then he got on top of me and continued to kiss me ...would not stop kissing me and kept telling me "you know you want it" he then took his pants off and then he took my pants off and my panties then patient got back on top of me and started kissing me more...then he stuck his thing in me, then took it out and stuck it in again and we had sex...anything else you want to report...no, but do you think I'm pregnant...I don't know but I'm going to make sure the nurses know your concerns and that you are safe and checked out...patient said ok, thank you." No patient assessment was found for Patient #1. On 10/18/17, at 1151, Personnel #6 was interviewed by telephone. Personnel #6 was asked to review Patient #1's medical record. Personnel #6 was asked to review the multidisciplinary note dated 10/13/17, late entry for 10/09/17 and the nursing note dated 10/09/17, timed at 1912 to 2245. Personnel #6 verified a nursing note which addressed the nursing assessment of the patient after her outcry could not be found. 2) Patient #2's Precaution Notification Alert dated 10/05/17 reflected, "Precaution indicators...suicidal ideation's with multiple plans...sexual victimization...indicators history of	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 395	Continued From page 27 rape...history of cutting..." The Psychiatric Evaluation dated 10/05/17 timed at 1009 reflected, "Depressed, suicidal, cutting...patient is also dealing with rape by ex-boyfriend in 2016..." The RN Admission Assessment dated 10/06/17 timed at 0220 reflected, "States she has been suicidal and hopeless...states she has been sexually abused several times by family and close friends...states she really has been suppressing her feelings and now she feels she cannot go on anymore...." The Psychosocial Assessment-Adolescent dated 10/06/17, timed at 1050, reflected, "15 year old female...reports suicidal ideation has been there for about three months...reports thoughts of slitting throat or shooting self...in December 2016 patient reports rape by boyfriend...reports molestation by cousin...when patient was 7..." The 10/07/17 Multidisciplinary Progress Note, timed at 2300, reflected, "Reports increased anxiety 10/10 and increased past flash backs after I saw some kids sexually acting out...brought back memories about my sexual abuse experience...spent time providing emotional support...almost 30 minutes to calm down..." No further documentation or assessment was found in the medical record which addressed the flash backs the patient suffered related to past sexual abuse. On 10/18/17 at 1130 Personnel #6 was interviewed by telephone. Personnel #6 was asked to review Patient #2's medical record. The 10/07/17 nursing note was reviewed by Personnel	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 395	Continued From page 28 #6. Personnel #6 verified no follow-up assessment and/or further interventions were provided for the patient after she disclosed having flashbacks after witnessing peers being sexually inappropriate.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure 6 of 6 patients' (Patients #1, #2 #3, #24, #25, #15) care plan was updated and/or addressed 1) Patient #1's past history of sexual abuse with interventions/goals, 2) Patient #2's flashback from past sexual abuse cause by visualizing peers engage in sexually inappropriate behavior, 3) Patient #3's SAO-P (sexually acting out-perpetrator) precautions, 4) Patient #24's SAO-P precautions, 5) Patient #25's inability to safely digest milk and dairy products without stomach ache, 6) Patient #15's lactose intolerance that caused nausea, vomiting, rash, and diarrhea. Findings included:	A 396	A 396: ACTION & EDUCATION: The Director of Clinical Services (DCS) reviewed and affirmed that the policy "Treatment Planning" provides correct direction to staff on the expectation that all problems identified during the intake and admission assessments must be included in the patient's treatment plan. They further confirmed that the policy reflects the expectation that any issues that arise after admission are added to patients' treatment plans. The Interim DON and DCS provided retraining to all RNs and Social Services staff on the expectation for inclusion of all identified problems in the patient's treatment plan, including those medical problems identified after the patient's initial assessments. Competency was assessed via post-test. MONITORING: For a period of 90 days, the DON and DCS are monitoring 100% of treatment plans following initial development and reviews to confirm that all problems have been addressed in the treatment plan. Audit results are presented at the Morning	11/02/17 11/10/17 11/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 396	Continued From page 29 1) Patient #1's Preadmission Evaluation/Management (Psychiatric Diagnostic Evaluation with Medical Services) dated 10/05/17, timed at 1515, reflected, "Per intake...13 year old was discharged from...two weeks ago...parents found a noose made out of a belt and shoe strings under her pillow.. [redacted] ...fixated and obsessed with suicide, [redacted] ..past psychiatric history...sexually abused by [redacted] who is presently incarcerated for molesting and abusing...patient...precautions suicide..." [redacted] The 10/05/17 Initial Nursing Treatment Plan dated 10/05/17 timed at 1735 revealed, identified active problem, "SI (suicidal ideation's) plan to hang herself or slit her throat, cut wrists...identified problem danger to self, self-injurious..." No problem was identified which addressed patient's sexual abuse history and [redacted] concerns. The Interdisciplinary Master Treatment Plan dated 10/07/17 reflected, "Master problem list...depression, suicidal ideation's, self-harm..." The Psychosocial Assessment Adolescent dated 10/07/17 timed at 0800 reflected, "Patient wrote suicide note...attempted to hang herself and cut herself once admitted...patient had a period of normality between 10-11 years old...sexually	A 396	Leadership Meeting each weekday and aggregated data is presented monthly to the Quality Council and Medical Executive Committee and quarterly to the Governing Body. Non-compliance with expectations is being addressed through additional retraining and/or disciplinary action as appropriate. Responsible Staff: Interim DON	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 396	Continued From page 30 abused by [redacted] On 10/18/17 at 1151 Personnel #6 was interviewed by telephone. Personnel #6 was asked to review Patient #1's medical record. Personnel #6 verified the medical record did not address the patient's history of sexual victimization. Personnel #6 reviewed the initial and master treatment plan. Personnel #6 verified the documents had no documentation which identified the patients past sexual/physical abuse and sexual identity concerns. 2) Patient #2's Precaution Notification Alert dated 10/05/17 reflected, "Precaution indicators...suicidal ideation's with multiple plans...sexual victimization...indicators history of rape...history of cutting..." The Psychiatric Evaluation dated 10/05/17 timed at 1009 reflected, "Depressed, suicidal, cutting...patient is also dealing with rape by ex-boyfriend in 2016..." The RN Admission Assessment dated 10/06/17 timed at 0220 reflected, "States she has been suicidal and hopeless...states she has been sexually abused several times by family and close friends...states she really has been suppressing her feelings and now she feels she cannot go on anymore...." The 10/06/17 Initial Treatment Plan timed at 0220 reflected, "Suicidal Ideation, Depression..." The document which includes interventions and goals did not address patient's recent rape/molestation.	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 396	Continued From page 31 The 10/07/17 Multidisciplinary Progress Note timed at 2300 reflected, "Reports increased anxiety 10/10 and increased past flash backs after I saw some kids sexually acting out...brought back memories about my sexual abuse experience...spent time providing emotional support...almost 30 minutes to calm down...10/08/17 at 0005...patient in bed...respiration even and unlabored..." No further documentation or assessment was found in the medical record which addressed the flash backs the patient suffered related to past sexual abuse. No interventions and/or goals were found in the medical record. The Interdisciplinary Master Treatment Plan dated 10/07/17 reflected, "Psychiatric Problem...Unstable Mood, Danger to Self, Major Depressive Disorder..." The interventions and goals did not address the patients' recent rape/molestation and/or recent event which involved flashbacks from seeing peers be sexually inappropriate. On 10/18/17 at 1130 Personnel #6 was interviewed by telephone. Personnel #6 was asked to review Patient #2's medical record. Personnel #6 verified the treatment plan did not address the flashbacks Patient #2 had after witnessing peers being sexually inappropriate. The care plan, treatment plan was not updated and did not address the event and/or provide interventions and goals to address flashbacks of being raped/molested. 3) Patient #3's Physician's Certificate of Medical Examination for Mental Illness dated 10/02/17	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 396	Continued From page 32 reflected, "The patient slashed his mom's tires, threatened to kill himself by cutting his wrists then threatened to kill his mom and siblings...depressed and irritable mood, suicidal and homicidal ideation's, poor insight and judgement." The Physician's Orders dated 10/07/17 timed at 2245 reflected, "Place patient on SAO-P (sexually acting out-perpetrator)..." The Interdisciplinary Master Treatment Plan dated 10/05/17 reflected, "Unstable mood, suicidal ideation and homicidal ideation..." No update which included interventions, goals was found regarding the sexually acting out precautions Patient #3 was placed on 10/07/17. On 10/18/17 at 1206 Personnel #6 was interviewed by telephone. Personnel #6 was asked to review Patient #3's medical record. Personnel #6 verified the patient was placed on sexually acting out precautions on 10/07/17 at 2245. Personnel #6 verified the care plan/treatment plan did not address the sexually acting out precautions ordered. 4) Patient #24's Physician Psychiatric Evaluation dated 10/08/17 at 1500 reflected the patient's psychiatric diagnoses that included Major Depressive Disorder, Severe, with Psychosis. Physician's Orders dated 10/13/17 at 1435 reflected the patient was placed on SAO-P. Multidisciplinary Progress Notes dated 10/13/17, untimed, unsigned, unauthenticated, reflected	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 396	Continued From page 33 "the therapist was informed during a family session with another patient that...[Patient #24] entered her room one night and that he might have kissed her or something..." Personnel #7 was interviewed on 10/18/17 at 0817. Personnel #7 was asked to review the patient's care plan and stated the SAO-P precautions were not on Patient #24's treatment plan. Patient #24 was placed on SAO-P after a female patient reported that Patient #24 had entered her room and "kissed her or something." 5) Patient #25 was observed by the surveyor on the hospital's adolescent unit day room on 10/18/17, at 0711. Patient #25 told the surveyor that her stomach hurt "every time" she drank milk or ate cheese. Patient #25 stated she had told a nurse about her stomach pain after eating cheese and "we eat a lot of cheese here." Personnel #24 stated on 10/18/17, at 0715 that Patient #25 "hasn't said anything." Personnel #24 informed Patient #25 that changes in the patient's dietary regimen were made at that time. Patient #25's Nutrition Consult dated 10/12/17 at 1200 reflected the patient had "...stomach ache... [secondary to] eating lots of cheese..." Recommendations included for the "registered dietician to follow up per treatment team consultation prn [as needed]." Patient #25's Interdisciplinary Master Treatment Plan dated 10/14/17 did not address Patient #25's milk or milk product intolerance without gastrointestinal discomfort.	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD DALLAS, TX 75228

(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 396	Continued From page 34 6) Patient #15's Intake Assessment dated 10/07/17 at 1932 reflected the patient's allergies included lactose intolerance. Patient #15's Physician MOT (Memorandum of Transfer) Orders dated 10/07/17 at 2030 reflected Patient #15 had "no known drug or food allergies." RN Admission Assessment dated 10/07/17 at 2045 reflected the patient was lactose intolerant and reacted with "nausea, vomiting, rash, and diarrhea." Patient #15's Master Treatment Plan Updated dated 10/15/17 did not reflect the patient's lactose intolerance. The document did not reflect a nurse signature. Personnel #6 acknowledged the above findings during an interview on 10/18/17 at approximately 1130.	A 396		