Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

Northeast Division of Survey & Certification

July 27, 2017

Ms. helene Vartelas, CEO
Connecticut Valley Hosp
1000 Silver St
Middletown, CT 06457

Re: CMS Certification Number: 074003
Survey ID: MJCD11, 07/12/2017

Dear Ms. Vartelas:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider or supplier accredited by a CMS-approved Medicare accreditation program will be "deemed" to meet all of the Medicare Conditions of Participation (CoPs) for hospitals. In accordance with Section 1864 of the Act, State Survey Agencies may conduct at CMS's direction, surveys of deemed status providers on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

A survey conducted by the **State Of Connecticut Department Of Public Health(State Survey Agency)** at Connecticut Valley Hosp on July 12, 2017 found that the facility was not in substantial compliance with the following Conditions of Participation (CoPs) for hospitals.

42. C.F.R. §482.13- Patient's Rights

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction). You are not required to submit a plan of correction (PoC) for these deficiencies, but you may do so voluntarily. The PoC will not be reviewed to determine if it is acceptable. Copies of the Form CMS-2567, including copies containing a facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 C.F.R. §401.133(a). As such, if you choose to submit a PoC, it should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names.

The State Survey Agency will conduct an unannounced full survey of your facility to assess compliance with all the applicable Medicare conditions. If that survey indicates your facility is in substantial compliance with all of the applicable conditions, CMS will restore your deemed status and notify you in writing of this. If that survey indicates your facility is not in substantial compliance with one or more of the applicable conditions, then CMS will initiate action to terminate your Medicare agreement and will notify you in writing of this, including your opportunity to make timely correction of deficiencies identified.

In accordance with 42 CFR §498.3(d), this notice of findings is an administrative action, not an initial determination, and therefore formal reconsideration and hearing procedures do not apply.

If you have any questions, please contact Kathy Mackin at 617-565-1211.

Sincerely,

CAPT Hyosim Seon-Spada, DNP, USPHS
Branch Manager
Certification & Enforcement Branch

Enclosure: CMS-2567

cc: State Survey Agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	074003	A. BUILDING _____ B. WING _____	C 07/12/2017

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A 000	INITIAL COMMENTS An authorized substantial allegation survey concluded on 7/12/17 in response to Complaint # CT 21505. The following Condition of Participation was reviewed at Whiting Maximum Forensic Division: CFR 482.13 Patient Rights The Condition of Participation for Patient Rights was NOT met. Connecticut Valley Hospital (CVH) P.O. Box 351 1000 Silver Street Middletown, CT 06457 The census in Connecticut Valley Hospital Whiting Maximum Forensic Division: 92 The capacity in Connecticut Valley Hospital Whiting Maximum Forensic Division: 106 Whiting Maximum Forensic Division consists of 106 maximum security beds and 141 enhanced security beds. Services are provided to individuals who are admitted under the following categories: -Psychiatric Security Review Board commitment -Criminal court order for restoration of competency to stand trial -Civil commitment (voluntary or involuntary) -Transfer from the Department of Correction (DOC) (during period of incarceration or at end of sentence)	A 000		

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

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A 000	Continued From page 1	A 000		

Discharge options are dependent on legal status and the purpose of admission and include:

a. Transfer to another psychiatric hospital
b. Placement in Residential Treatment Facilities
c. Other outpatient treatment and housing placement
d. Return to DOC

The Division of Forensic Services is established to implement and coordinate specially-skilled evaluation and treatment services for individuals with serious mental illness and/or substance use disorders who become involved in the criminal justice system, and to serve the courts and other components of the criminal justice system. The efforts are intended to promote recovery and prevent or limit criminal justice system involvement to the extent possible, to promote public safety and to coordinate activities with other state and private agencies. Services within the Division span the continuum of the criminal justice system from pre-booking to end of sentence after incarceration and return to the community.

The five major components of the Division of Forensic Services provide clinical programming, specialized consultation and evaluation services, specific intervention programs to divert people from the criminal justice system and into treatment where possible, programs to help people re-enter community living successfully after a period of incarceration, and training and consultation to the criminal justice system.

Tour of the Whiting Maximum Facility identified

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A 000	Continued From page 2 that the facility was a separate building within CVH campus. In order to enter the patient care units and offices, the hospital requires inspection and inventory of all incoming property. All persons entering the gate are required to walk through a metal detector to ensure no contraband enters the facility. All items are required to be scanned through a metal detector and/or wanded. Contraband includes in part, alcohol, weapons, elctronic devices, explosives, mace, unauthorized or unidentifed substances, illicit/illegal substances and all tobacco products. The metal detector area is monitoried 24/7 by video surveillance and police officers. There is one entrance/exit into the patient care areas which has a double locked gate (sally port) controlled by the same police officer(s). Observation duing the survey identified that some patients are handcuffed/shackeled when transferred in or out of the Whiting Maximum Facility with police and/or Corrections Officers from the Department of Corrections. The Risk Assessment for Transportation identifies the patient's current status, occasion for level of security determination level of escort (which includes officer(s), nursing staff, transport belt, leg irons), level of hospital post, and clinical rationale. Patient records sampled for the Whiting maximum Building: 16	A 000		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by:	A 115		

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A 115	Continued From page 3 The Condition of Patient Rights was not met as evidenced by: 1. The hospital failed to protect and promote each patient's rights and/or failed to ensure that patients received care in a safe setting as evidenced by: a. The hospital failed to ensure that patients were free from all forms of abuse, neglect or harassment. The abuse included willful infliction of injury, unreasonable confinement, intimidation, or punishment. The abuse included physical abuse, mental abuse/anguish, sexual abuse, and/or exploitation; b. The hospital staff failed to report to administration suspected or actual abuse, neglect, or exploitation is occurring or has occurred; c. The hospital failed to report abuse, neglect, or exploitation to the appropriate to state agencies; d. The hospital staff violated their work rules and/or neglected their duties when they failed to maintain 2:1 constant observations; e. The hospital staff neglected their duties when staff used cellphones in a patient care area while performing constant observations; f. The hospital failed to follow their own policies regarding abuse, neglect, and exploitation. g. The hospital did not implement their abuse policy when staff made a threat about a patient; h. The hospital failed to protect patients from	A 115		

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A 115	Continued From page 4 abuse during investigation of allegations of abuse, neglect or harassment; i. The hospital failed to ensure that incidents of abuse, neglect, or harassment were reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurred; j. The hospital failed to obtain informed consent, failed to obtain a physician's order, and document the use of video monitoring as an intervention on the treatment plan for continuous in room monitoring; k. The hospital staff performing constant observations failed to carry a panic button in accordance with facility practice; l. The hospital failed to implement a restraint policy with least restrictive interventions; m. The hospital failed to ensure that patients were free from physical and mechanical restraints and/or restraints were not imposed as a means of coercion, discipline, convenience, or retlaiation by staff; n. The hospital staff failed to ensure that staff consistently monitored the video surveillance cameras in all views; o. The hospital failed to ensure there was adequate staffing to provide activities and groups; p. The hospital failed to ensure that the environment was safe regarding maintenance and integrity of ceiling tiles throughout the facility;	A 115		

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A 115	Continued From page 5 Please reference A130, A131, A144, A145, A154, and A165 2. Based on review of facility documentation and policy for the Whiting Maximum Forensic Division, the hospital failed to ensure that patient rights were protected and/or promoted. The finding includes: Review of the active inpatient census sheet dated 4/11/17 identified that the census of the Whiting Building was 92. The patients were not allowed to leave the building without police escort and can only leave for appointments or a medical hospital evaluation. Although the hospital had a policy on patient privileges which established standards and procedures for the granting and withholding of privileges at CVH and allowing for greater freedom and movement and access to programs and services in and about the hospital, on its grounds, and in the community consistent with due consideration of potential therapeutic and benefit and assessed level of risk, this policy and privilege level did not apply to the Whiting Maximum Security Service.	A 115		
A 130	482.13(b)(1) PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: 1. Based on a review of clinical records and a review of hospital documentation, the hospital	A 130		

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A 130	Continued From page 6 failed to ensure that all patients in Whiting have the right to participate in admission and discharge planning. The finding includes: Review of the active inpatient census sheet dated 4/11/17 identified that the census of the Whiting Maximum Building was 92. Thirty-five (35) of the patients' legal status included Psychiatric Safety Review Board (PSRB) Commitment. According to Connecticut General Statutes (CGS) Section 17a-582(e)(1), in part, when any person charged with an offense is found not guilty by reason of mental disease or defect pursuant to section 53a-13, the court shall order such acquittee committed to the custody of the Commissioner of Mental Health and Addiction Services who shall cause such acquittee to be confined, pending an order of the court pursuant to subsection (e) of this section, in any of the state hospitals for psychiatric disabilities or to the custody of the Commissioner of Developmental Services, for an examination to determine his mental condition. (e) At the hearing, the court shall make a finding as to the mental condition of the acquittee and, considering that its primary concern is the protection of society, make one of the following orders: (1) If the court finds that the acquittee is a person who should be confined or conditionally released, the court shall order the acquittee committed to the jurisdiction of the board and either confined in a hospital for psychiatric disabilities or placed with the Commissioner of Developmental Services, for custody, care and treatment pending a hearing before the board pursuant to section 17a-583; provided (A) the court shall fix a maximum term of commitment, not to exceed the maximum sentence that could have been imposed if the	A 130		

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A 130	Continued From page 7 acquittee had been convicted of the offense, and (B) if there is reason to believe that the acquittee is a person who should be conditionally released, the court shall include in the order a recommendation to the board that the acquittee be considered for conditional release pursuant to subdivision (2) of section 17a-584; or (2) If the court finds that the acquittee is a person who should be discharged, the court shall order the acquittee discharged from custody. Although the Integrated Treatment Plans for 15 clinical records reviewed identified that discharge planning was reviewed during the planning meetings, the hospital relied on the PSRB for a final decision. The PSRB, at the time of commitment, who takes jurisdiction over the acquittee and decides which hospital an acquittee is to be confined and when and under what circumstances an acquittee can be released into the community. The other Whiting Maximum patients' status included competency restoration, probate commitment, 45/60 day evaluation, and voluntary admission. 2. Based on clinical record review, review of hospital policies, and interviews for 4 of 15 patients (Patient #82, #WH6-15, #85, and #84), the hospital failed to ensure that patient specific Engagement Activities were documented in the clinical record. The findings include: a. Patient #82 was admitted on 2/16/17 for competency restoration with diagnoses of schizophrenia, neurocognitive disorder and borderline intellectual functioning. Integrated Treatment Plans dated 3/21/17 and 4/4/17 identified that Patient #82 exhibited aggressive	A 130		

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A 130	Continued From page 8 acts towards self and others and had impulsive behaviors necessitating periodic one-to-one continuous observations. Review of Patient #82's Engagement progress notes dated 3/15/17 and 3/16/17 identified comments on the patient's participation each shift. However, the Engagement progress notes failed to identify what engagement activities were specific to Patient #82. Interview with the VP of Patient Care Services on 4/17/17 at 11:45 AM and the Director of Regulatory Compliance on 4/17/17 at 1:00 PM identified that the Engagement activity progress note should be completed to address the patient's specific engagement activities. b. Patient #WH6-15 had diagnoses of schizoaffective disorder, neurocognitive disorder, personality disorder, and autism spectrum disorder. An Integrated Treatment Plan dated 3/29/17 identified that Patient #85 would be praised for appropriate responses to engagement. However, the treatment plan failed to identify what Patient #85's specific engagements were. c. Patient #85 was admitted with a diagnosis of schizophrenia. An Integrated Treatment Plan dated 4/6/17 identified that Patient #85 was psychotic and displayed occasional agitation. Review of Patient #85's Engagement progress notes dated 4/11/17, 4/12/17, 4/13/17, 4/14/17, 4/15/17 and 4/16/17 identified comments on the patient's participation each shift. However, the Engagement progress notes failed to identify what engagement activities were specific to Patient #85. d. Patient #84's diagnoses included alcohol dependence, paranoid schizophrenia,	A 130		

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A 130	Continued From page 9 hypothyroidism, and obesity. The integrated treatment plan dated 3/1/17 identified that the patient did not attend any groups on the unit. The treatment plan failed to identify that an engagement objective was added to the treatment plan. The Engagement Progress Notes dated 3/28/17 to 4/9/17 failed to identify the specific engagement activities. Interview with the VP of Patient Care Services on 4/17/17 at 11:45 AM and the Director of Regulatory Compliance on 4/17/17 at 1:00 PM identified that the Engagement activity progress note should be completed to address the patient's specific engagement activities. A hospital memo dated 12/3/12 identified that treatment teams will identify individuals who require an engagement objective added to their integrated treatment plan. The MHA/FTS observations shall be documented on CVH-674 form, Mental Health Assistant/Forensic Treatment Specialist Engagement Progress Note. 3. Based on clinical record review, review of hospital policies, and interviews for 1 of 15 patients (Patient #82), the hospital failed to ensure that the clinical record identified justification for a body search and failed to ensure that the search was documented in the clinical record. The findings include: Patient #82 was admitted on 2/16/17 for competency restoration with diagnoses of schizophrenia, neurocognitive disorder and borderline intellectual functioning. A physician order dated 2/20/17 directed to have a body check performed by police. Review of Integrated Progress notes dated 2/20/17 failed to identify	A 130		

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A 130	Continued From page 10 that a body search was conducted and failed to identify the reason for a body check. Interview with the VP of Patient Care Services on 4/17/17 at 11:45 AM identified that Patient #82 had a body search conducted by police on 2/20/17 due to a missing toothbrush, which was considered contraband. The VP of Patient Care Services identified that the body search should have been documented in the progress notes. 4. Based on review of the clinical record review and review of facility policy for 2 of 15 clinical records (Patient #84, Patient #86), the hospital failed to ensure that the treatment plan was conducted timely and/or was filed in the chart. The findings include: a. Patient # 84 was transferred from unit 4 to unit 6 on 3/22/16. An integrated treatment plan was completed on 3/1/17 and the next integrated treatment plan was not completed until 4/17/17 (47 days later). According to the Integrated Treatment Planning Process Policy, the treatment plan review should be done every 30 days and within 7 days of transfer to another unit, then per rules based on length of stay. b. Review of Patient #86's clinical records failed to identify an integrated treatment plan for March 2017. Subsequent to surveyor inquiry on 4/13/17, the staff obtained the 3/3/17 and 4/13/17 treatment plans for the chart. Interview with the Accreditation Manager at that time identified that the treatment plan had not been filed and could not explain why the integrated treatment plan had not been filed in the record.	A 130		

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A 130	Continued From page 11 5. Based on review of the clinical record and interview for Patient #18, the hospital failed to ensure that social work completed monthly notes. The finding incldues: a. Patient #81's diagnoses included schizoaffective disorder, antisocial personality disorder, polysubstance dependence, and asthma. Review of the patient's clinical record on 5/2/17 identified that the last monthly social work note was written on 3/27/17. The clinical record identified that Social Worker #1 was Patient #81's social worker. According to hospital documentation, the patient was removed from Social Worker #1's caseload on 4/28/17. Interview with the Supervising Social Worker, Social Worker #1's supervisor, on 5/2/17 identified that he was covering Social Worker #1's caseload and/or groups (while Social Worker #1s Clinical Manager is on vacation) while Social Worker #1 has been reassigned to another area. Further interview identified that that social work notes are written at least monthly and sometimes more often, if needed. Review of the clinical record lacked documentation of a social worker note on Patient #81 due approximately 4/27/17, one month after the last note.	A 130		
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request	A 131		

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A 131	Continued From page 12 or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on observations, review of the clinical record an interview for 2 of 15 records reviewed (Patient #81, #40) for patient rights, the hospital failed to obtain informed consent for in room video monitoring and/or a physician's order for video monitoring and/or document the use of video monitoring as an intervention on the treatment plan for continuous in room video monitoring. The findings include: 1. Patient #81's diagnoses included schizoaffective disorder, antisocial personality disorder, polysubstance dependence, and asthma. Observations during tour of Unit 6 on 4/10/17 at approximately 1pm identified a camera in the patient's room with continuous video monitoring of the patient from the nursing unit. Review of the clinical record failed to identify that the patient's conservator had given informed consent to have a camera in the patient's room and be continuously monitored. The Integrated treatment Plan also failed to reflect the use of continuous video monitoring as an intervention. The clinical record lacked a physician order or treatment plan intervention to include continuous video monitoring. Interview with MD #6 on 4/11/17 at 12:10pm identified that the patient was moved into his/her present room on 3/22/17 or 3/23/17 from another unit and the camera was already in the room and part of the unit so it was left on. Further interview identified that the patient's conservator was called on 4/10/17 and a	A 131		

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A 131	Continued From page 13 message was left. Review of the Electronic Monitoring/Surveillance System policy identified that the use of electronic surveillance in designated patient bedrooms is based on a physician's order for the purpose of increased patient monitoring. 2. Patient #40 was admitted to the hospital on 08/31/1995 with diagnoses that included schizoaffective disorder, autism spectrum disorder, osteoporosis, seizure disorder, recurrent aspiration pneumonia, psychogenic polydipsia, and a history of multiple fractures. Patient #40 had a legally appointed Conservator of Person (COP). Interview with Chief Executive Officer (CEO) and Acting Division Director on 4/10/17 at 9:30 AM identified that Patient #40 had a camera in his/her room with a continuous video feed to the secure nursing/FTS area on the unit as well as to the hospital police (security). Review of the clinical record failed to identify that the patient's conservator had given informed consent to have a camera in the patient's room and be continuously monitored. The Integrated treatment Plan also failed to reflect the use of continuous video monitoring as an intervention. The clinical record lacked a physician order or treatment plan intervention to include continuous video monitoring. Interview with MD #6 on 4/11/17 at 10:00 AM identified that the use of the camera pre-dated his/her arrival at the hospital in 2015, however, over the years he/she was aware of both patient and staff injuries and incidents which may have resulted in the use of the camera for further monitoring and protection.	A 131		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING	A 144		

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A 144	Continued From page 14 The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: 1. Based on review of facility documentation and interview, the hospital failed to ensure that when there was an increase in abuse and neglect allegations and an increase in incidents, recommendations and/or actions were identified. The findings include: Review of the Quality, Risk and Safety Committee meeting minutes dated 3/2/17 identified that allegations of abuse and neglect and the number of incidents had increased over the last quarter. Interview with the Director of Compliance and Performance Improvement on 4/12/17 at 1:45pm acknowledged that reporting of allegations and incidents had increased however, there were no recommendations identified and could not explain any facility's action to address the data. Review of the Patient Safety Event and Data Incident policy identified that the hospital will track and trend data to evaluate the effectiveness of the Incident Management System and to identify and manage individual and systemic patterns and trends. For incidents that involve alleged abuse, neglect and exploitation, trends shall be tracked in at least the following categories, type of incident, staff involved and staff present, patients directly and indirectly involved, location of incident, date and time of incident(s), cause of incident, and outcome of the investigation. The Quality, Risk and Safety Committee is responsible for analyzing data and making recommendations for corrective action.	A 144		

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A 144	Continued From page 15	A 144		

2. Based on observation, review of the clinical record and interview for 2 of 15 patients at risk for behaviors (Patient #81, #86), the hospital failed to ensure that staff performing constant observation carried a panic alarm (portable call alarm to alert staff) and/or failed to ensure staff was awake during their constant observation duty to ensure that care was provided in a safe setting and/or the level of observation orders were not consistent with facility policy. The finding includes:

a. Patient #81's diagnoses included schizoaffective disorder, antisocial personality disorder, polysubstance dependence, and asthma. A physician order dated 4/24/17 directed constant observation with male staff for risk of sexualized behavior or assault. Observation during tour on 4/24/17 at 9:10pm with DNS #2 identified FTS # 61 performing constant observation (staff to stay in the patient's line of sight at all times) of Patient #81 while sitting in the doorway. FTS #61 failed to carry a panic button while performing the constant observation. Interview with FTS #61 identified that he just relieved staff and didn't get a panic button. Interview with DNS #2 identified that it was facility policy/practice for staff to carry a panic button while assigned as a constant observer. Subsequent to surveyor inquiry, a panic button was immediately provided to FTS #61. The Special Observation policy failed to reflect that staff conducting special observation required a panic alarm.

b. Patient #86's diagnoses included psychosis

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A 144	Continued From page 16 and schizoaffective disorder with impulsive and assaultive behaviors. i. Observation during tour of Unit 2 on 4/10/17 at approximately 11:45am with the Chief of Patient Care Services identified Patient #86 on constant observation (staff to stay in the patient's line of sight at all times) and monitored by FTS #21. The physician orders dated 3/7/17 to 4/12/17 directed constant observation or C.O. The Special Observation policy only defines continuous monitoring and does not describe constant observation. Review of the integrated treatment plan dated 3/27/17 failed to identify that the patient required constant/continous observation. The Special Observation Policy identified that whenever a level of observation of continuous observation or greater is initially ordered, a focused treatment plan review is completed by the team on the next business day. ii. Observation of the patient with the Chief Operating Officer (COO) on 4/13/17 at 6:17am identified FTS #20 was assigned to perform constant observation of the patient (Patient #86). The patient was sleeping, FTS #20 was seated in the doorway leaned back in his chair with his eyes closed. As the surveyor and COO approached the FTS, his eyes opened. Interview with FTS #20 at that time denied having his eyes closed but was leaning back in his chair. Review of the Special Observation policy identified in part, that staff must be fully attentive to the patient at all times to assess for breathing and circulation during their observation assignment, sitting upright with both feet on floor. iii. Observation and interview with FTS #21 on 4/10/17 failed to identify that the FTS was	A 144		

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A 144	Continued From page 17 carrying a panic button in accordance with facility practice. Further interview identified that the FTS would wave his/her arms if he needed to call the nurse or other staff for assistance since the unit had video monitoring of the hallways. Further observations identified that the nursing desk contained video monitors viewing the common areas of the unit (dining room, day room, and hallways). During tour, the video monitor in the nursing station was not being monitored by any staff. Interview with the Chief of Patient Care Services on 4/10/17 identified that all staff conducting constant monitoring should carry a panic button. Subsequent to this observation, a panic button was provided to FTS #21. Further interview with the Chief of Patient Care Services identified that staff are usually in the nursing station but the other FTS had been conducting safety and census checks on the unit. The Special Observation policy failed to reflect that staff conducting special observation required a panic alarm. iv. Observation during tour on 4/25/17 at 8:45pm with DNS #2 identified 2 cups of liquid on the windowsill in Patient #86's bedroom. The patient was not in his/her room. Interview with DNS #2 at that time identified that patients are not allowed to have drinks in their room. Subsequent to surveyor inquiry, the drinks were removed from the patient's room. 3. Based on observations during tour and interview for three of five units (Unit 1, 2, and 6), the hospital failed to ensure that staff consistently monitored the video surveillance cameras and/or	A 144		

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A 144	Continued From page 18 failed to ensure that all staff watched all of the available camera views at each nursing unit and/or failed to ensure that staff were adequately trained and/or failed to provide adequate staffing to conduct all scheduled activities. The findings include: a. Based on observations during tour of the Whiting units on 4/10/16 between 12pm and 2pm, there was no staff in the nursing station monitoring the video monitors on units 1, 2, and 6. The cameras monitored patients and staff in the common areas and in one patient's room on units four and six. Additionally, the video monitors had the capability to view all nine camera views or select the number of views. Observations of the units identified that not all units consistently viewed all nine camera views. Unit staff were observed in the medication room, monitoring patients in the dining room or conducting safety checks. Interview with Chief of Patient Care Services at that time identified that staff should be in the nursing unit watching the cameras. Review of the facility Electronic Monitoring/Surveillance System identified that the electronic monitoring/surveillance system can greatly improve the security of the staff and patient. In order to be effective, the system needs to be properly maintained and monitored on a regular basis so that safety threats can be accurately assessed. Subsequent to inquiry on 4/10/17, all Whiting Maximum staff were instructed to maintain all nine camera views, an in room camera view if there is one on the unit, and post a staff member in the nursing unit at all times to monitor staff and patient interactions. b. Interview with RN #22 on 4/13/17 and review	A 144		

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A 144	Continued From page 19 of the actual staffing from 4/10/17 to 4/13/17 identified that although a FTS staff is now assigned in the nursing unit to view the video cameras to monitor staff and patient interactions, the staffing was not increased to ensure that services and interventions were maintained. Interview with RN #21 on 4/13/17 identified that all of the units have been short staffed and 3 patients requiring constant observations added to the workload, therefore patients were not able to go into the courtyard the previous shift due to inadequate staffing, only one staff instead of two staff monitored dining, and a group meeting was not conducted due to inadequate staffing. Interview with RN #22 on 4/13/17 identified that she was concerned with the inadequate staffing and is concerned if staff are able to get to a patient on time to keep them safe. Further interview identified that all of the aforementioned concerns had been forwarded to management and it was reported that nothing had been done or changed to address the issues. Interview with the Chief Operating Officer on 4/10/17 identified that although unit staff were monitoring the surveillance videos for patient and staff interactions, the campus police department also viewed the video from their office. Observation and interview with Police Officers (PO) #1 and #2 in the presence of the Chief of Patient Care Services on 4/11/17 identified that they can view the video monitors of the patient units in their "middle room" of the police booth, however, staff do not routinely watch these monitors and they are not staffed on the overnight shift to leave their station from the "main room". c. Observation during tour of Unit 6 on 4/25/17 at approximately 6:45am identified FTS #40	A 144		

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A 144	Continued From page 20 assigned to watch the video monitors within the nursing unit. Interview with FTS #40 identified that she had been out of a leave since January 2017 and the night shift was her first shift back to work. FTS #40 further identified that she had was told by RN # 35 to watch the monitor and patient interactions and that RN #35 would check in with her periodically since FTS #40 was not familiar with the patients. FTS#40 further identified that she was not informed that she was to observe for staff/patient interactions but told to "watch the monitors". Review of FTS #40's education transcript identified that training on camera assignment responsibilities and camera monitoring checklist and documentation was not completed until 4/27/17, two days later. 4. Based on observations during tour and interview of the Whiting Maximum Building, the hospital failed to maintain a safe environment free of accident hazards. The findings include: a. Observation during tour of Whiting unit 4 on 4/13/17 at approximately 6am identified that in two areas on the ceiling there were ceiling tiles observed to be sagging and not sealed which allows access to the ceiling above. One of the tiles had a corner missing and a piece of metal was exposed. Interview with RN #20 on 4/13/17 identified that workers were in the building on 4/12/17 running wires for a video monitoring system and probably disrupted the ceiling tiles. Further interview identified that a call was place for repair but there is not a maintenance worker scheduled on the night shift and that the repairs would have to wait until 7am. There were 21 patients on this unit and five patients were identified with suicidal ideation and/or self-harm	A 144		

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A 144	Continued From page 21 behaviors. Additionally, RN #20 noted that at times when there are issues with overflowing water or an overflowing toilet, repairs have to wait until 7am until a maintenance worker arrives unless the issue is considered an emergency. b. Additional observations on 4/15/17 throughout Whiting Units 1, 2, 3, 4, and 6 identified sagging ceiling tiles, multiple ceiling tiles with cracks or large chips of tile missing. Interview with the Director of Facilities on 4/15/17 identified that the ceiling tiles are almost fifty years old and they do not make these tiles, therefore the chips need to be filled with caulk or the tiles need to be nailed to prevent sagging and to prevent patient access to the ceiling above. 5. Based on observations and interview for 2 of 7 seclusion/restraint rooms, the hospital failed to ensure that the rooms were free from dirt, debris, and maintained for safety. The finding includes: a. Observations during tour of the Whiting units on 4/10/17 between 12:30 and 2pm identified dust and debris on the floors of the restraint/seclusion rooms on units 2 and 4. In addition, the seclusion room on Unit 2 had screws protruding from the radiator cover which posed a safety hazard. Interview with Chief of Patient Care Services on 4/10/17 identified that housekeeping staff has a schedule to clean the rooms and they are cleaned on a regular basis and could not explain why protruding screws were exposed on the radiator cover and have been that way for a while.	A 144		

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A 145	Continued From page 22	A 145		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: 1. Based on interviews, review of policies and procedures, review of recorded video feed, and review of hospital documentation (video surveillance log) of Patient #40's room camera activity from 2/27/17 to 3/22/17, observation and documentation identified acts of abuse including physical abuse, mental abuse, sexual abuse, neglect, and exploitation and/or it was identified that staff failed to report suspected or actual abuse, neglect, or exploitation is occurring or had occurred regarding Patient #40 and/or failed to report allegations of abuse, neglect, exploitation to appropriate state agency(ies) and/or staff violated work rules by using their cellphones in a patient care area and/or staff neglected their duties while performing constant observation and/or for Patients #40, 90, and WH4-1, the hospital failed to follow their own policies regarding abuse, neglect and exploitation. The findings include: a. Patient #40 was admitted to the hospital on 08/31/1995 with diagnoses that included schizoaffective disorder, autism spectrum disorder, osteoporosis, seizure disorder, recurrent aspiration pneumonia, psychogenic polydipsia, and a history of multiple fractures. Patient #40 had a legally appointed Conservator of Person (COP). i. A Treatment Plan Review Dated 3/22/17 dated	A 145		

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A 145	Continued From page 23 for February 2017 through March 2017 identified that Patient #40 continued to demonstrate problems with explosive affects, physical aggression, sexualized behaviors, impulsivity, and poor self-care. He/she had required intensive staff support to maintain safety and to ensure his/her ADLs are appropriately maintained. He/she required a physical intervention on 3/1/17 after becoming assaultive to staff. Objectives include that the Patient will use or attempt to use his/her personal preferences to better manage his/her frustrations and remain free of aggression to self and others as evidenced by a gradual reduction of acts of aggression and restraints. Additionally, Patient # 40 will participate in reality-based discussions regarding discharge planning for a minimum of five minutes, twice a week, over the next 3 months with staff. ii. Physician Orders dated 3/2/17 through 3/22/17 directed that Patient #40 have constant observation (CO) with two (gender specific) staff members for protection of self and others, water intoxication, activities of daily living (ADL), and targeting staff of the opposite sex (verbal and physical assaults). iii. In addition to CO, Patient #40 was monitored via continuous electronic video surveillance with a direct feed of the video image to the nursing station (no audio). There was also continuous video monitoring of the hallway outside of Patient #40's bedroom and throughout the unit (unit 6) for the same time period. Interview with MD #6 on 04/11/17 at 10:00 AM identified that Patient #40's video monitoring process was in place prior to MD #6 assuming care of Patient #40. In addition, review of the clinic record lacked current physician order, written consent by the COP, or	A 145		

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A 145	Continued From page 24 intervention on the integrated treatment plan for the video monitoring. iv. Interview with the hospital CEO on 4/10/17 at 9:31 AM identified that Patient #40's video monitoring was saved on file for the time period of 2/27/17 through 3/22/17. The CEO identified that multiple video images of staff interactions with Patient #40 were egregious with willful disregard of the hospital's abuse policies. Staff were observed taunting Patient #40, throwing food at the patient, and pouring water on his/her head. Staff held his/her arms (restraint), put an incontinent brief on his/her head, and put their feet on his/her bed, repeatedly. As of 4/10/17, the hospital had initiated an investigation, placed multiple staff members on administrative leave, re-educated staff on abuse and patient exploitation, contacted authorities, and were in the process of reviewing all existing video monitoring of Patient #40. The internal, hospital investigation was ongoing. v. Review of hospital documentation of an incident dated 3/21/17 identified that on 3/21/17 (time unknown), the Chief of Patient Care Services was notified by an unknown person of alleged staff abuse towards Patient #40, and that video monitoring would provide evidence of the abuse. Abusive acts towards Patient #40 included putting hand sanitizer in his/her lotion and shampoo bottles, salt in his/her coffee and hot sauce in food. Patient #40 was kicked and bullied. vi. Interview with the Director of Human Resources (HR) on 4/13/17 at 8:30 AM and on 4/18/17 at 2:00 PM identified that staff were reviewing all of the video monitoring of Patient	A 145		

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A 145	Continued From page 25 #40's room and the hallway between 2/27/17 and 3/22/17. Incidents of abuse, mistreatment, neglect and other concerns related to patient care were being logged. vii. Review of a Work Rule Violation Report dated and signed by the Chief of Patient Care Services on 03/21/17 at 4:00 PM identified that there was an alleged physical abuse of a client (Patient #40) including Work Rule Violation #19 (Physical violence, verbal abuse, inappropriate or indecent conduct and behavior that endangers the safety and welfare of persons or property is prohibited) as well as State Regulations #4, #8, #11, and #13. Persons that were notified (on 3/21/17) included the Acting Division Director and Master Sergeant #1. A description of the incident included that he/she had received a complaint that Patient #40 had been chronically abused on unit 6. The Chief of Patient Care Services was told that the patient had been given hand sanitizer rather than lotion to use for lubricant when engaging in sexualized behavior, given salt in his/her coffee, hot sauce in his/her food and hand sanitizer rather than shampoo. The patient was bullied and kicked. viii. Specific dates were not given, however, the Chief of Patient Care Services was referred to review tapes for the day shift on 3/12/17 and 3/21/17 (the same day). The tape of 3/12/17 identified RN #24 and FTS #23 were not in direct line of view of Patient #40 when performing CO. FTS #23 placed a sheet over Patient #40"s face. FTS #25 was standing behind the door using a cell phone. RN #24 and RN #26 were having a conversation with FTS #25 while he/she was using a cell phone and did not redirect the FTS to put the contraband away. FTS #25 placed a drink	A 145		

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A 145	Continued From page 26 towards his/her lips as if sipping from it or spitting in it and then gave it to Patient #40. FTS #25 placed his/her feet on the Patient's bed. The tape of 3/21/17 identified that FTS #23 and FTS #25 grabbed Patient #40 by the hands, held him/her on the bed while RN #24 forced a diaper on over his/her pants against his/her will. Several times, FTS #25 picked up a cookie from the floor and threw it at the Patient or on his/her bed. FTS #25 paced around Patient #40's bed pointing a diaper at him/her and, on two occasions, FTS #25 touched the patient on the leg with the diaper, clearly upsetting him/her as the Patient started pulling his/her legs away, trying to cover him/herself with blankets. FTS #25 went behind the Patient and placed the diaper on his/her head. RN #24 and FTS #23 sat in front of the Patient's room and observed FTS #25's behavior. RN #28 looked into the Patient's room and walk away. Following the documentation of the observation of tapes, the Chief of Patient Care Services identified the persons involved as RN #24, RN #28, and FTSs #23, #24, and #25. ix. A Nursing Staff Assignment/Supervisor's Report for 3/21/17 identified that RN #24, RN #28, and FTSs #23, #24, and #25 were working from 6:45 AM through 3:15 PM. An Incident Report included in the packet was dated and signed 3/22/17 at 11:00 AM and identified Alleged Patient Abuse that included physical, psychological, neglect, and violation of patient rights. The staff and Patient involved were documented. x. The Chief of Patient Care Services documented that he/she had seen staff abuse Patient #40 and other staff fail to report witnessing abuse. On 3/22/16 at 12:25 PM	A 145		

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A 145	Continued From page 27 Assistant Division Director documented that a Work Rule Violation Report had been generated on four employees indicated on the first page of the report. Other areas of the form were left blank with a notation that the investigation was pending. Addendum B (Investigation Section) identified the incident dates of 3/12/17 and 3/21/17 and referred to previous documentation. Unit Acuity and Staff Issues section identified that staff attitude and/behavior escalated the situation and staff failed to utilize correct CSS techniques. Actions taken to protect victim included that the Patient was being moved to another unit today (3/22/17) and 3 staff were placed on administrative leave. Furthermore, other staff may be moved dependent upon administrative review. xi. A Unit Director/Supervisor Check List for hospital Investigations of Abuse, Neglect, and Exploitation of Patients identified the following: Condition of patient assessed (blank); Appropriate medical care provided to patient (checked as not applicable(N/A), Alleged perpetrator removed from contact with patient (completed with three staff placed on administrative leave), Work Rule Violation Form completed (3/21/17, 4:00 PM), Incident Report competed and submitted to Division Directors office with Work Rule Violation by end of the shift (completed), Department of Division Director notified (completed), Public Safety notified (completed), Director of Recovery and Consumer Affairs notified, Statements taken from staff on unit prior to end of shift (no, per Labor Relations with reference to documentation dated 4/19/17). Documentation by Supervisor of Labor Relations dated 4/19/17 identified that due to possible tampering of evidence (video), witness	A 145		

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A 145	Continued From page 28 statements were not collected per Labor Relations. A facsimile transmittal was forwarded from the hospital to Labor Relations on 3/22/17 regarding the incident on 3/12/2017. xii. Review of the video surveillance tape on 4/13/17 identified that the incident on 3/21/17 (restraint, taunting and brief on head) began at approximately 11:37 AM and ended at approximately 11:42 AM. Review of Nursing Staff Assignment dated 3/21/17 for the 6:45 AM through 3:15 PM shift identified that RN #24, RN #28 FTS for the 6:45 AM through 3:15 PM shift FTS #25, and FTS #23 were working. Staffing for 03/22/17 for the 6:45 AM through 3:15 PM shift identified that RN #24 worked from 6:45 AM through 7:45 AM, FTS #25 worked from 6:45 AM through 8:15 AM and was assigned to care for Patient #40, and FTS #23 worked from 6:45 AM through 8:15 AM before being placed on administrative leave. RN #28 was not placed on administrative leave. xiii. Review of the clinical record identified that Patient #40 exhibited episodes of yelling and screaming on the evening and night shifts of 3/21/17 and early morning of 3/22/17 and was transferred from unit 6 to unit 4 on 03/22/17 at approximately 2:15 PM for administrative reasons. Documentation lacked evidence of education and/or support provided related to the transfer. xiv. A Monthly note dated 03/22/17 by MD #6 at 1:35 PM identified that the case was discussed with the accepting psychiatrist and, at the time of the transfer, Patient #40 was noted to be calm, at baseline, and in no physical distress. The note lacked documentation regarding the	A 145		

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A 145	Continued From page 29 circumstances of the transfer, recommendations for additional support, and/or assessment for potential of physical harm related to alleged abuse, mistreatment, and/or neglect. xv. The Chief of Patient Care Services and The Acting Division Director were aware of the allegation prior to 4:00 PM on 03/21/17 however, they failed to ensure that Patient #40 was free of contact with the identified staff until they were placed on administrative leave on 03/22/17. xvi. Interview with the Chief of Patient Care Services and the Acting Division Director on 04/12/17 at 3:30 PM identified that the Acting Division Director arrived at the hospital at 6:30 AM on 03/22/17 with the intent of placing the identified staff on administrative leave prior to their shift commencing at 6:45 AM, however, he/she was unable to secure representation from Labor Relations timely, and the staff worked until the administrative leave documents could be presented to each staff member privately. Interview with the Director of Client's Rights on 05/02/17 at 9:00 AM identified that, although he/she was not a clinician, he/she was asked to interact with Patient #40 to evaluate how he/she was acclimating to the change in units following the alleged incidents. In preparation for the interactions, the Director of Client's Rights identified that he/she reviewed portions of the video surveillance tape. During the interactions, he/she encouraged Patient #40 to discuss who, what, where, when, and/or how the alleged incidents of abuse, mistreatment, and/or neglect occurred, however, the patient did not respond to efforts to explore the alleged issues on unit 6.	A 145		

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A 145	Continued From page 30 Review of the Director of Client's Rights documentation of patient interviews identified that the first interview was conducted on 3/27/17 (6 days after the incidents were discovered) and continued on 3/30/17, 4/04/17, 4/07/17, 4/11/17, and 4/12/17. Segments of video monitoring of Patient #40 in his/her bedroom and of the hallway were reviewed with the Director of Human Resources on 4/13/17. With the assistance of the Director of Human Resources, names of staff members observed on the video were identified and the following was observed: xvii. On 2/27/17 at 5:43 PM, identified that Patient #40 was observed on his/her bed with Forensic Treatment Specialist (FTS) #31 and FTS #35 sitting in chairs next to the bed. FTS #31 had his/her feet resting on top of Patient #40's bed while FTS #32 entered the room and sat on Patient #40's bed. FTS #32 was observed reaching out and repeatedly tapping or poking Patient #40 on the arm, chest and lower legs in a manner consistent with taunting. Patient #40 responded by tapping FTS #32 back. FTS #32 continued to tap Patient #40 repeatedly until Patient #40 got out of the opposite side of the bed and was no longer visible on the video. At 5:45 PM, Patient #40 returned to his/her bed and FTS #32 returned and again, sat on Patient #40's bed and began pushing Patient #40's body forcefully. Patient #40 then pushed FTS #32 back. At 5:48 PM, FTS #32 and FTS #35 left the room and FTS #31 remained in the room with his/her feet on the bed.	A 145		

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A 145	Continued From page 31 xviii. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes identified that on 2/27/17 between 5:00 PM and 5:45 PM, Patient #40 was in the bedroom exhibiting repetitive ritual behaviors with no interventions identified. At 5:45 PM, FTS #24 documented that Patient #40 was threatening staff with a behavior of aggression against others. xix. A nurses note dated 2/27/17 at 10:00 PM by RN #24 identified that Patient #40 exhibited no aggression towards self or others besides a 15 minute spitting episode, and the patient had soiled him/her self and refused a shower. The plan included to continue to monitor and provide a safe environment. xx. In this time frame of 2/27/17, FTS #24, #31, #32 and FTS #35 were identified as present during some or all the abusive acts and did not appear to respond, or come to Patient #40's aid, and did not report the incidents of physical and psychological abuse to administration. b. On 3/1/17 at 7:00 AM Patient #40 was in bed and appeared to be agitated and screaming. FTS #25 was observed bending over the bed in close proximity to Patient #40's face. FTS #25 raised his/her right hand and appeared to push Patient #40's shoulder/left jaw area. In response, Patient #40 raised his/her left arm in an apparent defensive position. i. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes (author unknown) identified that on 3/1/17 at 7:00 AM	A 145		

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A 145	Continued From page 32 Patient #40 was awake and exhibiting repetitive ritualistic behaviors with no interventions identified. Although Patient #40 was on CO with two staff, the incident of physical and psychological abuse was not reported. ii. A Physician Order for restraints dated 03/01/17 at 10: 40 AM by MD #6 and RN #27 directed to place Patient #40 in Physical Restraint not to exceed 20 minutes, and mechanical restraint not to exceed 2 hours (4 point) due to imminent risk of assaultive aggression as evidenced by hitting, kicking, spitting. Physical and/or psychological risk considerations included, osteopenia and history of aspiration pneumonia. Discontinuation criteria included, calm, cooperative, and non-aggressive behavior. Review of restraint documentation dated 03/01/17 at 11:00 AM by RN #24 identified that Patient #40 was punching at staff, swinging, lunging, chasing, and spitting. The Patient was offered and refused a quiet area (refused and stormed out) and staff offered to talk with the Patient and he/she screamed and attempted to strike at the staff member. A Secure Guide Escort and Third Person Assist was implemented at 10:40 AM followed by a Physical Hold at 10:45 AM. Four Point Restraints were applied at 10:45 AM and discontinued at 12:25 AM. iii. Review of video surveillance of the restraint episode from 10:30 AM through 10:42 AM identified that Patient #40 was on the bed in his/her room. FTS #25 (involved in an incident of physical and psychological abuse of Patient #40 that AM) was visible behind the door. A lighted screen consistent with a cellular phone was	A 145		

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A 145	Continued From page 33 visible. FTS #25 and Patient #40 exited the room and entered the hallway at 10:35 AM. At 10:36 AM, Patient #40 returned to his/her room followed by FTS #25 and FTS #36. FTS #36 exited the bedroom at 10:37 followed shortly by FTS #25 and Patient #40 who was moving rapidly with arms extended. Patient #40 attempted to strike FTS #37, and FTS #25 placed his/her hands on the Patient's upper arm and wrist in what appeared to be a Secure Guide Escort Hold. The Patient pulled away and five other staff approached. Within one minute the patient sat on the floor. Immediately, the patient attempted to lie down on the floor and was curled up on the floor with approximately 5 staff surrounding him/her. At 10:39 AM a restraint bed was wheeled into the hallway and the Patient was lifted onto the bed. Four point restraints were applied. The Patient did not appear to resist. At 10:41 AM the patient was wheeled into the restraint room and out of view. iv. Review of the fifteen minute documentation of the Positive Behavioral Support Plan and/or Special Observations failed to validate the Behaviors of Concern documented prior to the initiation of restraints. The behaviors documented included repetitive ritualistic behaviors and, although the Patient required re-orientation away from ritualistic behaviors; aggressive, assaultive, or in-appropriate behaviors directed towards staff were not documented. Further review of restraint documentation identified that Patient #40 yelled, spit, and pulled at the restraints from 10:55 AM through 11:55 AM and then was lying down, quietly and asked to be released at 12:25 PM. Trazadone 100 mg and Valium 10 mg were ordered by MD #6 and administered by mouth at 11:30 AM. Patient #40 sustained ½ inch abrasion	A 145		

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A 145	Continued From page 34 at the back of his/her head during the restraint episode v. Review of a list of things that made it more difficult for the patient when he was already upset included being touched, people staring at him/her, yelling, and the time of year including the anniversary of the crime he/she committed (02/26/1995) The Patient had been subjected to physical and psychological abuse at 7:00 AM and the alleged perpetrator approached him/her later potentially causing the patient further mental anguish as evidenced by his/her aggressive response to the staff. A physical interaction involving touching by staff ensued resulting in four point restraint. Oral medications were not offered and/or administered until 11:30 AM, delaying the possible calming effect and prolonging the need for restraints. Documentation lacked evidence that the time of year in relation to the crime committed and/or other issues were considered prior to implementing or discontinuing physical and mechanical restraints. Review of the Seclusion/Restraint Patient Debriefing form dated 3/1/17 at 11:00 AM by RN #27 identified that Patient #40 refused to answer the 10 questions on the form, however, the form was signed and dated prior to the discontinuation of restraints at 12:25 PM, additionally, the Staff Debriefing form was completed at 11:15 AM prior to prior to the discontinuation of restraints at 12:25 PM. vi. On 3/1/17 at 1:10 PM Patient #40 was in bed while FTS #24 and FTS #27 were providing CO in Patient #40's room when FTS #25 (refer to incident of 7:00 AM, the same day) entered the room with a plate of food and was observed	A 145		

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A 145	Continued From page 35 eating the food with a spoon. Patient #40 reached out towards the plate of food and FTS #25 began to throw food from the spoon towards Patient #40's face four (4) times. The food landed on Patient #40's bed. Patient #40 was observed picking up and eating the thrown food. FTS #25 continued to eat food from the plate. vii. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes by FTS #25 identified that on 3/1/17 at 1:00 PM Patient #40 was eating with no observed behaviors of concern with interventions to offer food and fluids. At 1:15 PM FTS #25 documented that Patient #40 was eating with no concerning behaviors with interventions to offer food and fluids. At 1:30 PM FTS #25 identified that Patient #40 was yelling at staff with behaviors of concern identified as aggression against patients or staff. No interventions were identified. viii. Interview with the CEO identified that the plate of food was intended for Patient #40 and FTS #25's behavior of throwing food at Patient #40 was an abusive act and should not have occurred. On 3/1/17 at 7:10 PM, FTS #27 was observed displaying fighting type gestures towards Patient #40, which was observed by FTS #24. ix. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes by unknown staff identified that on 3/1/17 between 7:00 PM and 7:30 PM Patient #40 was in the bedroom resting, exhibiting repetitive ritual behaviors, and other psychotic behaviors with no interventions were identified.	A 145		

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A 145	Continued From page 36 x. On 3/1/17 at 11:08 PM, Patient #40 was in bed and FTS #2 and FTS #30 were observed sitting with their feet on Patient #40's bed. FTS #30 was observed using his/her feet to repeatedly push/kick Patient #40 until Patient #40 was pushed to the point where he/she fell out of the bed onto the floor. Patient #40 got his/herself off the floor, got back in bed, and FTS #30 was again observed to kick Patient #40 in his/her torso. xi. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes by unknown staff identified that on 3/1/17 at 11:00 PM Patient #40 was in the room resting exhibiting repetitive ritualistic behaviors and no interventions identified. Between 11:00 PM and 3/2/17 at 12:15 PM the observation sheet was incomplete. At 12:15 AM, FTS #24 documented that Patient #40 was hitting staff, showed aggression towards others, however, no interventions were identified. xii. A nurses note dated 3/2/17 at 6:00 AM RN #25 identified that Patient #40 yelled and screamed at staff threatening to assault them and spit at staff, but, eventually calmed down until 6:00 AM. The plan included to continue to observe and provide a safe environment. xiii. In this time frame of 3/1/17, FTS #2, FTS #25, FTS #27 and FTS #30 were identified as present during these abusive acts and did not to respond to, or come to Patient #40's aid and did not report the incidents of abuse to administration. c. On 3/7/17 at 5:57 AM Patient #40 was observed in bed, FTS #27 and FTS #31 were in	A 145		

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A 145	Continued From page 37 the patient's room. RN #25 was in the room and was observed to grab Patient #40, cover the patient's face with a bed sheet, and pulled Patient #40's arm and leg. Patient #40 rolled side to side and RN #25 was observed circling around the bed. Patient #40 appeared agitated and tried to protect him/herself by thrashing in the bed with a blanket and sheet. RN #25 pulled the sheet over Patient #40's head a second time while holding the patient down. Review of hallway video monitoring during this time frame identified that FTS #26 looked into Patient #40's room at the same time that RN #25 put a sheet over the patient's head. i. RN #25 and FTS #31 left the room. RN #25 returned to the room with a cup of liquid while FTS #26 was sitting with his/her feet on Patient #40's bed. RN #25 was observed to pour liquid on Patient #40. Patient #40 grabbed the cup and the cup fell to the floor. RN #25 was observed taking Patient #40's sheet off the bed, using the sheet to wipe the liquid off the floor and leaving the room. RN #25 returned to the room with a mop and rolling mop bucket. RN #25 was observed mopping the wet floor and then placed the dirty, wet, mop head on Patient #40's head, moving the mop back and forth in a jabbing motion. RN #25 was observed moving the mop from the floor to Patient #25's head approximately 3 times. ii. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes by an unknown staff person on 3/7/17 from 6:00 AM through 6:15 AM identified that the patient was initially awake in bed with interventions of concern that included repetitive, ritualistic behaviors and other psychotic	A 145		

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A 145	Continued From page 38 symptoms and, documentation by FTS #26 beginning at 6:30 AM through 7:00 AM that included behaviors of spitting, yelling, and kicking with behaviors of concern that included, ritualistic behaviors and other psychotic symptoms. iii. The Integrated Progress Note dated 3/7/17 at 6:00 AM by RN #25 identified that Patient #40 was loud and yelling frequently at the staff performing CO without provocation. When awake, the patient would engage in repetitive behaviors including refusal of clothing. RN #25 identified that he/she would continue to monitor and provide a safe environment. An RN Shift Note dated 03/07/17 at 2:00 PM by RN #24 identified that Patient #40 was disrobing, fixated on paper-shredding rituals, engaged in sexualized behavior, and screamed at staff, but was not physically aggressive towards staff or other patients. iv. In this time frame of 3/7/17, RN #25, FTS #26, and FTS #31 were identified as present during some or all the abusive acts and did not to respond to, or come to Patient #40's aid and did not report the incidents of abuse to administration. d. Review of hospital Work Rule Violation Report dated 3/21/17 identified that, the Chief of Patient Care Services viewed video monitoring of care provided to Patient #40 on 3/12/17 (Day shift-no time indicated). It was identified that RN #24 and FTS #23 did not have a direct line of view of Patient #40 during the time they were assigned to provide CO. FTS #23 was observed placing a sheet over Patient #40's face while FTS #25 was behind the door using a cell phone. RN #24 and RN #26 were observed conversing with FTS #25	A 145		

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A 145	Continued From page 39 while using the cell phone and they failed to direct FTS #25 not to use the cell phone. FTS #25 was observed putting a drink to his/her lips in a sipping or spitting manner then gave the drink to Patient #40. FTS #25 was observed with his/her feet on Patient #40's bed. i. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes FTS #26, FTS #24 identified between 3:30 AM and 7:00 AM Patient #40 was identified as threatening staff, yelling, kicking, hitting, and spitting. No interventions were identified. At 9:15 AM, 9:30 AM, and 9:45 AM Patient #40 was in the bedroom identified as naked. Interventions included engagement. At 10:15 AM FTS #37 documented that Patient #40 had defecated in his/her clothing with a plan for engagement. At 10:30 AM Patient #40 was identified as sitting naked in his/her excrement. At 10:45 AM Patient #40 was showered. Between 1:00 PM and 1:30 PM Patient #40 was disrobing repeatedly. Interventions included engagement. ii. A nursing note dated 3/12/17 at 12:45 PM documented by RN #29 identified that Patient #40 engaged in ritualistic behavior, had a labile mood, was incontinent and was showered; ate well, and took medications as prescribed. The plan included to continue to monitor and provide a safe environment. iii. During this time frame on 3/12/17, RN #24, RN #26, FTS #23 and FTS #25 were identified as being present during these abusive acts, did not respond to, or come to Patient #40's aid, and did not report the incidents of abuse to administration. Adequate monitoring was not	A 145		

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A 145	Continued From page 40 provided to identify abuse and/or provide a safe environment. e. On 3/19/17 at 8:23 PM Patient #40 was in bed sleeping and FTS #30 was seated with his/her feet on Patient #40's bed. FTS #30 was holding a drink bottle, stood up, and began to shake Patient #40. FTS #30 then poured the liquid contents of the drink bottle on Patient #40. FTS #30 was observed pouring liquid on Patient #40 approximately 10 times, removing Patient #40's blanket during this time period. Patient #40 get out of bed and FTS #30 was observed to poke the patient who returned back to bed. FTS #30 again poured liquid on Patient #40's head, the patient rolled to the other side of the bed while FTS #30 continued to pour fluid on the patient. FTS #30 was observed going in and out of Patient #40's room several times and was observed with a gallon type container of liquid. FTS #30 took Patient #40's blanket and sheet away. Patient #30 sat up in bed with his/her hands covering his/her head while FTS #30 raised the liquid container over the patient's head and poured the liquid on the patient, intermittently, for a period of approximately 3 minutes. Patient #40 got out of bed and FTS #30 left the room. FTS #3 was observed to be present, behind the bedroom door during this incident. Patient #40 was standing in the corner of the room when FTS #30 returned with a clean shirt and bed linen. FTS #30 put dry sheets on the bed and the patient got back in the bed. FTS #30 motioned with his/her hands as if pouring liquid over the patient. FTS #30 was observed to leave the room again and return with additional bed linen. FTS #30 is observed, again, pouring liquid on Patient #40, who then got out of bed. FTS #30 and Patient #40 both walked behind the	A 145		

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A 145	Continued From page 41 bed and Patient #40 appeared to be falling backwards several times. FTS #30 continued to pour water on Patient #40 when he/she was out of the bed. i. At 8:59 PM, FTS #2 and FTS #38 were observed in Patient #40's room in the same time frame when FTS #30 was repeatedly pouring water on Patient #40. ii. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes by FTS #30 identified at 8:15 PM Patient #40 was asleep. At 8:30 and 8:45 PM Patient #30 is yelling and/or mumbling in bed, however, no behaviors of concern were documented and no interventions were identified 9:00 AM Patient was yelling and pacing, however no behaviors of concern were documented and no interventions were identified. iii. A nursing note dated 3/19/17 at 10:00 PM identified that Patient #40 had a good night overall with episodic yelling and racial slurs. The Patient engaged in ritualistic behaviors, napped, ate well, refused 8:00 PM medications but experienced no aggression or assaults. Will continue to monitor and provide a safe environment. iv. In this time frame of 3/19/17, FTS #2 and FTS #3 were identified as present during this abusive act and did not to respond to, or come to Patient #40's aid and did not report the incident of abuse to administration. Adequate monitoring was not provided to identify abuse and/or provide a safe environment. f. On 3/21/17 at 11:36 AM Patient #40 was in bed	A 145		

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A 145	Continued From page 42	A 145		

when RN #24 was observed attempting to put a pull-up incontinent brief on the patient over his/her pants while FTS #23 and FTS #25 held Patient #40's arms. Patient #40 resisted and struggled as the RN appeared to force the brief over the patient's legs. A fourth person, RN #28 entered the room during this incident. Patient #40 removed the brief, threw it to the floor and RN #24 picked itup and placed it on the door knob in the patient's room. FTS #25 was observed twice picking unidentified objects off the floor and throwing them at Patient #40. FTS #25 left the room and Patient #40 was observed rocking back and forth in the bed. FTS #25 returned to the room, took the brief from the door knob and repeatedly touched Patient #40 with the brief as Patient #40 paced in the room. FTS #25 directed Patient #40 back to bed and placed the brief on Patient #40's head (like a hat). The patient removed the brief. FTS #25 was observed repeatedly pointing his/her finger at Patient #40.

g. Observation of the hallway video during this same time period identified that RN #28 looked into Patient #40's room at the same time that the incident occurred.

i. Review of a Work Rule Violation Report dated 3/21/17 identified that, the Chief of Patient Care Services viewed video monitoring of care provided to Patient #40 on 3/21/17. It was identified that FTS #23 and FTS #25 held Patient #40's hands while RN #24 forced the (brief) onto the patient against his/her will. FTS #25 was observed to pick up cookies from the floor on a few occasions and throw them at Patient #40 or onto the patient's bed. FTS #25 was pacing around Patient #40's bed while pointing the brief

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A 145	Continued From page 43 at him/her and touching the brief against the patient. Patient #40 was observed to be "clearly upset," pulling his/her leg away, and was trying to cover him/herself with blankets. FTS #25 went behind Patient #40's bed and place a (brief) on the patient's head. RN #24 and FTS #23 sat in front of Patient #40's room and observed FTS #25's behavior. RN #28 looked into Patient #40's room and walked away. ii. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes by FTS #23 identified that on 03/21/17 at 11:30 AM and 11:45 AM Patient #40 was yelling, using racial slurs, was incontinent of stool and exhibited other psychotic symptoms. Interventions included re-orienting away from inappropriate behaviors and nursing interventions. iii. An RN Shift Note dated 03/21/17 at 2:00 PM by RN #24 identified that the patient was loud, racially hostile with episodes of yelling. The patient exhibited no aggression towards self or others but, periodically, was actively agitated. He/she required bathing due to fecal incontinence. Will continue to monitor and provide a safe environment. iv. In this time frame, FTS #23, FTS #25 and RN #24, RN #28 appeared not to respond to, or come to Patient #40's aid, and did not report the incidents to administration. Adequate monitoring was not provided to identify abuse and/or provide a safe environment. v. Interview with the CEO on 04/10/17 at 9:40 AM following a verbal description of his/her observations of some of the video surveillance in	A 145		

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A 145	Continued From page 44 Patient #40's room, identified that the staff assigned to close observation failed to report multiple incidents of disrespectful behaviors, abuse, neglect, and patient exploitation because, the staff, themselves, were complicit with the acts. h. Review of the video log (of Patient #40) provided by the hospital identified the following: i. On 2/27/17, evening staff used their cellphones while performing constant observation (CO) that included FTS #22. On 2/27/17 FTS #41 and FTS #42 threw clothing and a cup at the patient while RN #24 was seen in the doorway. There were two staff in room who left and closed the door. RN #24 closes the door and leaves. FTS #31 had his feet on the patient's bed. FTS #31 and FTS #35 were on sit (performing constant obervations). FTS #32, (working on another unit at this time) sits on bed and hits/taunts patient, contact made 34 times. The 13th and 34th are blows to the patients head. The patient tries to get away by getting off the bed, FTS #32 follows to the side of the bed, and the patient sits back on bed, again retreating. The patient becomes clearly agitated, engaging in repetitive behaviors, rocking. The patient begins to defend by kicking FTS #32 to get away from him after prolonged tormenting by FTS #32. ii. On 2/28/17 day and evening staff used their cellphones while performing CO that included RN #24, FTS #22, and FTS #43. On 2/28/17, FTS #27 and FTS #24 on sit. FTS #24 throws sheets at the patient. FTS #24 is	A 145		

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A 145	Continued From page 45 sleeping. FTS #26 and FTS #24 have their feet on the patient's bed. FTS #25 is sleeping, reclined with feet on the patient's bed. Staff have to wake up FTS #25 when the patient leaves his/her room, RN #24 is texting on the phone, and FTS #22 comes in to the patient's room and uses cell phone. iii. On 3/1/17 night, day and evening staff used their cellphones while performing CO that included FTS #25, FTS #21, FTS #30, FTS #27. On 3/1/17, FTS #25 leaves room with phone in hand nearly the entire sit on the phone. FTS #25 appears to hit patient in the head, the patient holds head and appears upset. Staff leaves and turns off light. Patient sits up on bed yelling out door, another staffer (unknown) closes door. FTS #25 throws a cookie and food at the patient instead of handing it to the patient. FTS #25 again throws food at patient. While FTS #25 is on the phone behind the door, he is unable to react when the patient jumps up from bed and leaves the room with one shoe on, seems agitated. The patient is agitated returns to room and leaves again. The patient gets into altercation with FTS #25 and others. Staff restrain the patient up in the air to land on restraint bed while the patient struggles. FTS #25 is seen eating a plate of food in front of the patient for him/herself and throws the food at the patient a number of times. The food lands on the bed and the patient eats it from the sheets. FTS #25 gets another plate of food and gives it to the patient. FTS #25 feeds the patient remaining food from his plate with the utensil that he has been using. FTS #24 places his feet on the patient's bed then jumps up with raised fists in front of the patient and blocks the doorway. The patient	A 145		

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A 145	Continued From page 46 swings a sheet at the sitter and FTS #27 makes threatening gestures to the patient. FTS #30 comes on duty and begins kicking patient repeatedly, kicks the patient off the bed while FTS #26 watches and does nothing. iv. On 3/2/17 night, day and evening staff used their cellphones while performing CO that included FTS #24, FTS #30, FTS #26, FTS #25, and FTS #42. On 3/2/17, as the patient exits the room, FTS #42 pushes patient onto bed three times and finally uses a chair to push the patient back onto bed. At one point, the patient's door was closed leaving no sitters with the patient. FTS #30 is on his cellphone, puts his feet on the patient's bed, and starts poking and uncovering the patient's sheets multiple times. FTS #24 is talking on his cell phone. FTS #25 is using his cellphone most of the time while performing constant observation. When the patient leaves the room, FTS #28 does not stay with the patient, therefore 2:1 is not maintained. FTS #28 leaves again to check TV in an empty patient room. Staff performing the CO had their feet on the bed while the patient was in the bed. FTS #28 and FTS #38 eat sunflower seeds in the room while FTS #28 put his feet on the patient's bed next to the patient's head. v. On 3/3/17 day and evening staff used their cellphones while performing CO that included FTS #25, FTS #59, FTS #30, and FTS #29. On 3/3/17, FTS #31, one of the FTS's assigned to perform 2:1 constant observations of the patient was sleepings in the chair until staff relieved him. FTS #31 raises his hand and appears to be	A 145		

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A 145	Continued From page 47 striking the patient in the back, FTS #29 witnessed this incident but doesn't do anything. FTS #26 leans over the patient's bed, repeatedly kicks the patient and the final blow results in the patient retreating while FTS #27 and FTS #29 perform CO and watch the entire episode. FTS #31 arrives to perform CO and immediately goes to the patient's bed while seated in chair and repeatedly kicks the patient while RN #25 RN is watching. RN #25 then starts kicking the patient from near the head of the bed with FTS #31 joining in kicking the patient. RN #25 again starts kicking the patient. FTS #31 changes potion with RN #25. FTS #31 now watching from near head of bed. RN #25 had the patient's head in a leg lock on the bed. RN #25 leans forward and appears to punch or push the patient. RN #25 starts pulling on the patient's sheets and struggling with the patient. RN #25 pulls on sheets while kicking the patient and restrains the patient to the bed by holding the patient down with both his legs on top of the patient. FTS #26 shines a flashlight on the patient in bed, the patient appears in distress. RN #25 has feet on the bed, the patient gets off the bed. RN #25 shoves the patient's mattress off the bed with force. The patient is seen standing in the corner of the room with both sitters with their feet on the bedframe. FTS #26 enters the room kicks the patient and then leaves while RN #25 and FTS #31 watch. The patient is seen moving on the floor in a dark corner of the room, RN #25 goes over to the corner two times and activity is noticed and appears to be contact with the patient. FTS #27 appears in the doorway and observes what is going on in the corner between RN #25 and the patient. FTS #27 and FTS #24 are now the sitters, drink coffee while their feet are on the bedframe. The patient moves between the floor	A 145		

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and the corner of the room while mattress is still on the floor on the other side of the bed. FTS #29 enters and touches the patient on the head three times while circling the bed causing the patient to be extremely agitated then leaves. RN #25 enters and FTS #27 enters behind and appears to yell with hand gestures at the patient causing agitation. RN #25 repeatedly touches the patient causing extreme agitation. RN #25 also circles the bed numerous times and reaching out to touch the patient with the patient visible upset. The Patient get out of bed to get away from RN #25 and RN #25 pursues the patient, arms outreached. The Patient goes back to bed and tries to dodge being touched by RN #25, but RN #25 continues. FTS #24 and FTS #27, the assigned sitters were out in the hall talking and not watching. The patient enters the hallway and is stopped by FTS #24. RN #25 starts touching the patient again with the patient visibly agitated and retreating. FTS #26 enters the room, RN #25 comes out from behind the bed, touches the patient to agitate him/her while FTS #26 kicks the patient three times. FTS #25 comes in for sitter change is on his cellphone. FTS #59 and FTS #45 are now the sitters on their cellphone. FTS #59 follows the patient to the bathroom while still using his cellphone. FTS #25 throws food at the patient, repeatedly and shares a snack with the patient. FTS #25 spits food onto the patient's shirt, bed, and pants and the patient eats it. FTS #23 and RN #28 watch from the doorway. FTS #30 puts feet on sheets next to the patient, the patient gets agitated. FTS #30 puts foot against the patient's arm. FTS #30 uses his feet to tug at patient's sheets four times. FTS #41 is looking at FTS #30's phone in the doorway. FTS #30 and FTS #29 are seen using their cellphone while performing CO. Staff performing the CO had their

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A 145	Continued From page 49 feet on the bed while the patient was in the bed. A different patient, Patient # 80 strikes FTS #22 about the belt, FTS #22 executes a single person takedown, not in compliance with Collaborative Safety Strategies (CSS, approved restraint methods) while FTS #46 and FTS #2watch in close proximity. vi. On 3/4/17 during the night, day and evening shifts, staff used their cellphones while performing CO that included FTS #47, FTS #48, FTS #29, and FTS #30. On 3/4/17, during the night, day and evening shifts, FTS #26 repeatedly kicks the patient while FTS #47 is witnessing this incident. FTS #26 again starts kicking the patient and kicks the patient off the bed. FTS #47 is using his cellphone while performing CO duty. FTS #30 comes in and starts kicking the patient, FTS #26 enters the room and kicks the patient and then leaves. FTS #26 retuned for the first sit on the day shift and threatens to swing a towel at the patient. FTS #26 pokes the patient with his shoe twice while FTS #39 watches. When the patient tries to leave the room, FTS #26 raises his foot to stop the patient. FTS #26 kicks the mattress partially off the bed at the patient. The patient repeatedly put the mattress back on the bed and FTS #26 kicks it back at the patient. FTS #26 eventually kick the mattress off the bed as FTS #39 watches. vii. On 3/5/17 during the day and evening shifts, staff used their cellphones while performing CO that included FTS #2, FTS #36, and FTS #24. On 3/5/17, during the night, day and evening shifts, FTS #30 and FTS #49 using cell phones	A 145		

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A 145	Continued From page 50 while performing CO. RN #24 puts both feet on the patient's newly changed sheets to tie shoes. The patient begins picking things up off the floor and eating them, spitting some back out. FTS #2 and FTS #50 engage in a conversation and pay no attention to this behavior. RN #24 stands and torments the patient by continuing to administer to whatever he can touch, arms, head and legs. The patient attempts to kick and swing to stop. RN #24 goes around the bed and takes gloves off then appears to take a fighting stance and starts touching the patient. RN #24s blocks the patient's swings with his forearm while FTS #2 and FTS #35 watch. FTS #2, FTS #36 and FTS #24 rotate through and use their cellphones while in the room. FTS #24 is asleep in the chair and was inattentive on duty for a long period of time while leaned back with head tilted towards the wall, with little or no movement seen. viii. On 3/6/17, during the evening shift, staff used their cellphones while performing CO that included FTS #24 and FTS #43. On 3/6/17, RN #25 tries to wake FTS #24 relieved by FTS #29. FTS #24 barely moves and continues to sleep, RN #25 leaves. FTS #26 appears to be sleeping in the chair reclining while feet were on the head of the patient's bed. FTS #30 has his feet on the bed and the patient objects. FTS #30 drops his entire leg across the patient's body, then as soon as the patient settles, FTS #30 kicks the patient in the shoulder. RN #25 enters the room and torments the patient by touching the patient while circling the bed while the patient is facing RN #25 trying to defend self. Sitters FTS #42 and FTS #26 observe this incident and don't do anything. RN #25 enters	A 145		

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A 145	Continued From page 51 the room again and starts hitting the patient, leans over the bed. FTS #26 comes out from behind the door and starts kicking the patient from the foot of the bed. Both FTS #26 and RN #25 moves their chairs closer to the patient in bed and start kicking the patient and then both pin the patient to the bed by putting their legs across his the patient's body. FTS #26 is kicking and holding the patient down with his legs from a seated position, RN #25 is seated next to the patient as has the patient in a leg lock around his/her neck. FTS #30 enters and approaches the head of the immobilized patient. FTS #29 enters the room and goes to the far side of the room and torments the patient in the dark room. The patient is trying to defend self while FTS #29 moves back and forth causing the patient to move to face him. FTS #26 again returns and leans over the bed and the patient is motionless. The patient gets up and walks around the room, FTS #30 stands and appears to demand that the patient get back to bed, the patient complies. FTS #30 moves in and hits and/pokes the patient in the head three times. FTS #30 is seen sleeping on duty while performing CO. FTS #48 closes the patient door while FTS #45 and FTS #51 do nothing and without apparent reason. Door remains closed for approximately 12 minutes. FTS #51 is observed across the hall while the patient's door is closed and at an angle that does not provide a line of sight. FTS #45 walks away twice for long periods of time while performing CO including to get a snack and eat in an adjacent room and in the hallway, far from the patient's room. FTS #24 on his cellphone for extended periods of time behind the door and leaves sit twice for bowls of food that he eats in the patient's room. FTS #24 walks off sit two more times. FTS #43 on cell phone behind door.	A 145		

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A 145	Continued From page 52 FTS #31 performing CO while feet are on the patient's bed within inches of the patient's head. ix. On 3/7/17, during the day shift, staff used their cellphones while performing CO that included FTS #52, FTS #25, FTS #62, and FTS #23. On 3/7/17, FTS #26 and FTS #31 are performing CO and are reclined with feet on bed next to the patient, the patient sits up and appears agitated. FTS #24 relieves RN #25 on sit and appears to have to wake RN #25. FTS #26 arrives to relieve FTS #52 and FTS #26 starts kicking the patient in front of FTS #24 who watches and does nothing. FTS #26 sits in chair and begins kicking patient with both feet. FTS #24 leaves the room momentarily and RN #25 returns with a cup in hand, leans over patient, the patient is seen flinching and retreating to the far side of the bed. RN #25 leaves and FTS #24 is seen in the hall by another camera, and re-enters passing RN #25 exiting the room with a cup in hand. Patient is seen wiping his/her face. FTS #24 gets up and picks up sheet off the floor and gives it to the patient. RN #25 and FTS #31 appear to be sleeping. The patient appears to be sleeping until RN #25 gets up and grabs the patient. The patient was swinging at RN #25, RN #25 goes around the bed back and forth spearing to make contact and agitating the patient. The patient was seen trying to get away from RN #25 while remaining on the bed. FTS #27 and FTS #31 do nothing. RN #25s hand was visible holding/pressing sheet over the patients head. FTS #26 comes in and appears to take a swing at the patient who is trying to get away from RN #25. RN #25 enters with a cup of water and appears to pour water over the patient's head. The patient jumps up and knocks the cup from RN #25's	A 145		

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A 145	Continued From page 53 hand to the floor. RN #25 rips the sheets from under the patient and off the bead to clean up the liquid off the floor. While cleaning, RN #25 leans over the bed and the patient is reeling from RN #25's contact. RN #25 returns to the room with a mop and wheeled bucket. RN #25 mops the patients head while the patient sits on the bed. RN #25 mops the floor and then returns mopping the patient's head. RN #25 wrings out the mop in the bucket press and returns to mopping the patients head. RN #25 mops the entire room. RN #25 returns and throws a sheet at the patient. FTS #26 pushes the mattress of the bed while the patient stands on the other side. FTS #25 gets up to leave the room and picks up the bed sheet and hits the patient in the face with it. RN #24 provides lotion to the patient who is touching self for sefl-gratification. FTS #25 was kicking the mattress in close proximity to the patient's leg causing the patient to jolt three times. RN #24 was standing next to FTS #25 while FTS #25 uses cellphone. FTS #53 was reading a magazine/catalogue while performing CO. x. On 3/8/17, during the day and evening shifts, staff used their cellphones while performing CO that included FTS #25, FTS #23, FTS #45, and FTS #24. On 3/8/17, FTS #45 and RN #28 leave the patient unattended in room multiple times, as the patient walks unescorted down the hall, and close the door and leave the patient unattended in the patient's bedroom. RN #24 is in the patient's bedroom against wall with eyes shut. FTS #26 places feet on the patient's head while the patient was in bed. FTS #24 puts his feet on the patient's bed while the patient is sleeping. FTS #25 appears to taunt the patient while in bed.	A 145		

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A 145	Continued From page 54 The patient ate a piece of paper while FTS #25 and RN #24 were performing CO. FTS #25 grabs the patient's arm while the patient in bed. FTS #25 kicks the patient's left leg while the patient in bed. FTS #25 taunts the patient while the patient in bed and strikes at the patient. Housekeeper #1 was in the patient's room and raises a large dry mop at the patient in a threatening gesture while the patient was in bed. FTS #25 enters the patient's room with a cup and throws the contents at the patient while the patient is on the bed. FTS #25 reenters the patient's bedroom and throws the remaining contents inside the cup at the patient while patient is on bed. FTS #23 appears to taunt the patient with a utensil while the patient is on the bed and continues this behavior while RN #28 observes this behavior. FTS #25 enters the patient's bedroom with a cup and spoon and drops food from a cup onto the patient. The patient consumed a paper envelope that the patient had torn into pieces. FTS #25 reenters the patient's bedroom while the patient is in bed and pulls off the sheet exposing the patient who is without pants on. RN #24 enters the patient's bedroom while the patient is in bed and pulls off the sheet two times exposing the patient who is without pants on. FTS #29 enters the patient's bedroom and appears to taunt the patient while the patient is in bed and pulls off the sheet exposing the patient who is without pants on and then throws the sheet at the patient. FTS #29 raises his feet and makes contact with the patient while the patient is on bed and then kicks the patient twice. FTS #24 and FTS #29 pulls at the patient's sheets numerous times until the patient enters into a struggle with staff to retain the sheet then staff pull the sheet off the patient's bed onto the floor. FTS #29 taunts the patient by swatting at	A 145		

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the patient with a folded paper towel three times. FTS #46 and FTS #28 leave the patient to go on break and a trip to the break room multiple times. FTS #29 also left the patient's bedroom while on sit and returns one minute later on two occasions. Either FTS #29 or FTS #2 leave the patient with one sitter for one minute.

xi. On 3/9/17, during the night shift, FTS #29 used his cellphone while performing CO. On 3/9/17 staff left the patient with one sit which included FTS #49, FTS #27, FTS #42, and FTS #26.

On 3/9/17, during the night, day and evening shifts, one of the sits either FTS #49 or FTS #26 leaves for five minutes and retuned. FTS #29 kicks the patient repeatedly in the patient's bedroom unprovoked by the patient while the patient is sitting on bed. FTS #27 raises foot and makes contact with patient's head while the patient is lying down in bed. FTS #42 pulls sheet and appears to taunt the patient while the patient was lying on bed. FTS #26 appears to taunt the patient while the patient was lying in bed. RN #25 appears to kick the patient in the head and other areas numerous times while the patient is in bedroom lying down in bed and FTS #27 watches. FTS #27 kicks the patient twice while the patient is lying down in bed. RN #25 stands up and appears to slap the patient's head while the patient is in the bedroom on the bed. RN #25 was not assigned to sit but enters the patient's room and taunt the patient as he provided medication to the patient. FTS #49 on sit in the patient's doorway reading the paper. FTS #26 lifts his legs up and places his feet on the patient's head while the patient is lying down in bed. FTS #26 enters the patient's room and rolls

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up paper and sticks it in the patient's ear. FTS #27 kicks the patient while the patient is sitting up in bed. FTS #26 taps the patient on top of the head before leaving the patient's bedroom. FTS #53 on sit with patient and is reading a newspaper while patient is in bed. RN #25 lifts feet up and kicks at the patient and appears to taunt him while the patient is on his/her bed then rests his foot on the patient multiple times. RN #25 pulls the sheet from the patient and then throws it as the patient while the patient is sitting on bed. RN #25 appears to taunt the patient while the patient is sitting up on his bed.

xii. On 3/10/17, during the day shift, staff used their cellphones while performing CO that included FTS #54, FTS #42, FTS #25, and FTS #22. On 3/10/17 during the day shifts, staff left the patient with one sit that included FTS #39, RN #25 (21 minutes), RN #28 (1 minute).

On 3/10/17, RN #25 lunges towards the patient with an open hand and appears to make contact with the patient's head while the patient is lying in bed. FTS #29 raises his hand at the patient to taunt the patient while the patient was sitting up in bed. FTS #25 appears to be taunting the patient while sitting on a chair in the patient's bedroom with the patient sitting on the bed and then slams back of chair repeatedly into the patient's bed. FTS #25 throws content of soda can at the patient while the patient is on bed. FTS #25 places his left hand on the patient's right shoulder while the patient is sitting on bed and then pushes the patient. RN #24 enters the patient's room, restrains the patient's arm while the patient is sitting on bed then sprays the patient in the face with aerosol can. FTS #23 enters the patient's bedroom while the patient is lying in bed, takes

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A 145	Continued From page 57 the sheet and pulls it over the patient's head then ticks it in around the patient's head and body then leaves the room. The patient finds a sports drink left by staff behind the patient's bedroom door and proceeds to drink the contents. xiii. On 3/11/17, during the night, day and evening shifts, staff used their cellphones while performing CO that included FTS #22, FTS #45, FTS #25, FTS #27, FTS #31, and FTS #26. On 3/11/17, during the night, day and evening shifts, an unidentified staff member (on 5/11/17, the revised log identifed the staff as FTS #29) put a towel and sheet around the neck of the patient lying in bed, then placed over the patient's face. FTS #29 wheels his chair up to the patient and kicks the patient. FTS #29 moves to the far side of the room and touches the patient multiple times to agitate the patient. RN #25 enters the room with a drink for the patient and moves next to the patient to agitate the patient every time the patient tries to drink, then touches the patient before he leaves. FTS #29 reaches out and taps the patient from behind and continues to repeatedly touch the patient while FTS #45 watches. RN #25 enters and touches, hugs and agitates the patient. The patient is reacting and appears to be in pain. As soon as the patient stops reacting, RN #25 starts again as the FTS #29 and #59. FTS #25 strikes the patient in the head with the TV remote, the patient "reels" forward while FTS #23 is watching. The Patient sits up abruptly, FTS #25 grabs the patient, FTS #25 and FTS #23 kick the patient. FTS #23 twice pushes the patient back to lie down from a sitting position. FTS #25 throws food and hit the patient in the head, it bounces off and lands on the floor. FTS #25 picks it up off the floor and throws it on	A 145		

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A 145	Continued From page 58 the patient's bed. FTS #25 attempts to feed the patient by touching food to patient's face. FTS #25 throws more food on the patient's sheets as FTS #23 watches. When the patient was agitated and approached FTS #23 who was sitting in the doorway, FTS #23 holds up foot and fists to block the patient's movement. The patient becomes visibly agitated and FTS #23 continues to move to the bed with foot up, even after the patient returned to his bed. FTS #31 with feet on bed within inches of the patient's head. RN #25 enters and begins hitting/touching the patient repeatedly. FTS #63 leaves FTS #26 alone on sit (approximately 28 minutes) and doesn't return. FTS #32 who was assigned to another unit, enters room and disturbs the patient who is resting. FTS #32 touches and pulls the sheet off the patient. The patient was up and rocking after the incident and was observed by FTS #23 and FTS #46. RN #25 starts tormenting the patient from the far side of the bed and forces the patient down to the bed, patient seen struggling. The patient's shirt was pulled down off shoulders appeared ripped. This incident occurred while FTS #31 and FTS #23 were on CO. An unknown RN arrives, the room light is put on and the patient is seen with a ripped shirt. RN #25 arrives and puts his "rear end" in the patient's face. RN #25 straddles the patient and "puts crotch in patient's face and makes humping motion" as FTS #23 and FTS #31 watch and FTS #23 appears to laugh. RN #25 again puts "rear end" in patient's face. Before RN #25 leaves the patient's room, he pushes the patient's head with his foot, then gets up and stands over resting patient. FTS #23 touches the patient's head with his foot then touches the patient's head. The patient jumps up to a sitting position and is agitated. FTS #23	A 145		

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A 145	Continued From page 59 touches the patient's head which is covered with a sheet. FTS #27 rolls out from behind the door and starts touching/hitting the patient's head. The patient is visibly agitated. FTS #27 reaches out and pulls the patient's ripped shirt. FTS #26 enters the room and bothers the patient by repeatedly touching the patient and the patient is rocking in bed. FTS #27 takes position at the head of the bed and makes contact with the patient head and face four times and the patient reels back and is agitated. xiv. On 3/12/17, FTS #26 puts his feet on the patient's bed. FTS #24 appears to be sleeping and starts moving after 45 minutes. FTS #24 appears to kick the patient with right foot to the patient's left leg. FTS #27 wheels chair towards the patient's bed and kicks the patient with his right leg. The patient gets behind the bed and FTS #27 kicks the mattress three times while FTS #24 keeps the patient trapped behind the bed, the mattress is hanging off the back of the bed. FTS #26 appears in the doorway and none of the three staff attempt to assist the patient with placing the mattress back on the bed. FTS #26 and RN #25 enter the patient's room. FTS #26 shines a flashlight in the patient's face repeatedly. A total of five staff are in the patient's room with the patient visibly upset and sitting on bed. RN #25 jumps from his chair and forces sitting patient down flat on the bed and then re-approaches a second time. RN #25 and FTS #27 alternate approaching the bed and appear to make contact. RN #25 was kicking the patient's mattress. Both CO leave the room and FTS #25 closes the door. The patient opens the door and FTS #25 closes the door. FTS #23 is texting with his watch. FTS #27 reaches into pocket and removes what appears to be an E-Cigarette and	A 145		

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A 145	Continued From page 60 places it in his mouth three times. FTS #27 walks off sit for approximately 6 minutes and returns with a salad in a plastic container. FTS #31 appears to leave the CO without any relief. xv. On 3/13/17, during the day and evening shifts, staff used their cellphones while performing CO that included FTS #30, FTS #27, and FTS #22. On 3/13/17, FTS #30 motions his "rear end" towards the patient's head and then proceeds to kick the patient while the patient attempted to drink. FTS #30 kicks the patient's left arm. FTS #30 places right leg on the patient and begins kicking the patient observed by RN #24. RN #24 enters the patient's room, walks to the backside of the bed and grabs the patient around the neck for a few seconds and then leaves the room. FTS #30 rips the sheet of the patient while the patient was touching self for self-gratification and FTS #25 was in doorway laughing while FTS #35 in the hallway performing CO. The patient picked up paper off the floor and placed it in his/her mouth. FTS #30 was texting and did not notice. FTS #3 flings folded paper at the patient who is sitting on bed. FTS #32 who was assigned to another unit, enters the patient's room and point's finger at the patient. FTS #29 then grabs the patients' left arm and tugging on arm. xvi. On 3/14/17, day staff used their cellphones while performing CO that included FTS #45. On 3/14/17, FTS #27 reaches into his hoodie and pulls out to what appears to be an E-Cigarette and smokes. As staff walk by, FTS #27 is seen placing this device down near his leg. FTS #29, was assigned to perform census checks and not	A 145		

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A 145	Continued From page 61 CO, enters the patient's room and shines a flashlight into the patient's eyes as he/she sleeps causing the patient to wake up. FTS #29 repeatedly pushes the patient down on the bed. FTS #29 leaves and returns to the patient's room pointing the flashlight at the patient and pushes the patient repeatedly back on the bed. There was no reaction from FTS #26 and FTS #27, the assigned CO staff. FTS #29 and FTS #26 simultaneously kick the patient and goes on for seven minutes. A snack is given to FTS #29 who then appears to tease the patient with the snack. Not sure who the snack is intended for but FTS #29 eats the entire snack. FTS #29 taunts/disrupts the patient while the patient is touching for self-gratification. FTS #45 throws a used napkin at the patient on the bed. FTS #48 pulls the patient's room door closed completely. FTS #29 who was not assigned to perform CO, begins to taunt/poke/pull at the patient. FTS #32, who was assigned to another unit, enters the room and pulls the sheet off the patient while the patient is sleeping. FTS #25 enters the room and pulls a sheet of the patient. FTS #25 makes contact with the patient's neck/back and the patient reels back. xvii. On 3/15/17, night, day and evening staff used their cellphones while performing CO that included FTS #3, FTS #25, FTS #48, and FTS #23. On 3/15/17, FTS #25 pulls a sheet of the patient, FTS #25 puts a towel over the patient's head and then puts leg and foot on top of the patient while FTS #25 is behind the door and on cell phone. The patient was moving leg up and down with a large bruise on the right leg/shin of the patient. FTS #48 walks into the patient's room with a bag	A 145		

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of chips. He repeatedly throws a chip at the patient onto the bed. FTS #48 hugs and puts arm around the patient as the patient is trying to leave the room. FTS #48 raises both fists to the patient as the patient approached the doorway. RN #24 eats two bites of a cookie and then gives the rest to the patient. FTS #48 throws cookies onto the bed for the patient. FTS #28 kicks the patient two different times in the bottom half of the patient's body while FTS #23 is watching.

xviii. On 3/16/17, night staff used their cellphones while performing CO that included FTS #29 and FTS #27.

On 3/16/17, FTS #30 disturbs the patient with fluid, the patient jolts up in bed and is frantically moving about the bed and sits up and appears to be crying in the sheets. FTS #26 is behind the door and is kicking the patient repeatedly With FTS #29 on sit. FTS #26 starts pulling at sheet of the patient who appears to be sleeping. FTS #26 hits the patient in the head. FTS #26 kicks the patient repeatedly while the patient tries to defend self. FTS #27 goes over to the patient's bed and agitates the patient trying to sleep. The patient starts to throw sheets at FTS #27, FTS #26 sits in a chair and puts legs and feet on the patient to hold the patient down. RN #25 watches from a far corner of the room. RN #25 pushes the patient up and down on the bed. FTS #29 rolls over to the patient and hits the patient on the face/head with a rolled up folder while RN #40 is on sit. FTS #29 taps the patient on the shoulder twice while the patient is taking pants on and off. FTS #29 rolls over to the patient again taking pants on and off and starts to pull at the pant leg of the patient, then pushed the patient and then pulls the patent's shirt. FTS #25 is not on sit and

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is taunting the patient as he walks the patient back from the dayroom. FTS #25 pushes the patient in the chest with both RN #40 and FTS #29 in the room. FTS #25 continuously to constantly touch the patient's right shoulder and back, the patient seems very agitated. FTS #29 repeatedly taps/hits the patient. The patient falls beck in bed and covers self with arms. FTS #23 repeatedly touches the patient in the head with a sneaker as FTS #59 watches. FTS #23 puts both feet on the bed on each side of the patient's head and pushes down on the patient's head and cheeks as FTS #59 watches. FTS #28 swings his leg and foot in a motion that appears to kick the patient and makes contact.

xix. On 3/17/17, evening staff used their cellphones while performing CO that included FTS #3 and FTS #32.

On 3/17/17, RN #25 comes in and throws the patient's sheets onto the floor. RN #25 sits in the chair and puts his feet on the bed and kicks the patient repeatedly, appears to be kicking the patient in the head. RN #25 kicks the patient off the bed, kicks the mattress off the bed. FTS #26 kicks the mattress off the bed as the patient tries to put it back on the bed. RN #25 kicks the mattress onto the patient as the patient is trying to put the mattress back, RN #25 kicks the mattress again as the patient is still trying to put the mattress back on the bed. FTS #26 kicks up the mattress near the head of the bed. FTS #48 stands in the door of the patient's room and reads the paper. FTS #32 enters as a CO, FTS #32 pokes the patient as the patient tries to leave the room. FTS #32 is sitting in chair in doorway and kicks the patient's foot. FTS #32 is constantly aggravating the patient, grabs the patient's pant

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leg/knee, pulls at his/her shirt and continuously taps the patient. FTS #32 slides chair over to the patient while the patient in lying down and grabs onto arm. FTS #32 grabs arm of the patient again and moves arm back and forth. During the sit, FTS #32 is continuously putting a hat onto the patient's head. The patient does not want the hat on his/her head and will immediately throw it onto the floor. FTS #32 puts patient's hat onto the patient's face. FTS #32 grabs arm of patient again. FTS #32 continuously grabs/taps/pulls at the patient's arm, body, shirt. FTS #32 comes in with a plate of food and eats while continuously taunting the patient and poking him/her with a stick/toothpick/pencil like object. FTS #32 pulls the sheet of the patient. FTS #30 comes in with a towel and puts it on the back of the patient's neck and pushes down. FTS #32 pulls on the patient's shirt to get him/her back into the room. FTS #32 is next to the patient in the chair with his leg on the patient's bed and starts hitting/tapping/pulling at patient. FTS #28 gets out of chair and hits the patient. FTS #28 kicks the patient repeatedly while sitting in chair. A flashlight from the hall into the patient's room clearly shoes a ripped shirt on the patient. FTS #32 puts legs on the patient's head. FTS #32 pulls at the patient's shirt. FTS #32 kicks the patient in the head. FTS #31 kicks the patient while the patient is in bed. FTS #32 enters the patient's room, sits down, and puts legs on top of the patient.

xx. On 3/18/17, the night and evening staff used their cellphones while performing CO that included FTS #3.

On 3/18/17, FTS #30 comes from behind the patient, rips the patient's shirt, exposing the patient's whole back. FTS #30 pulls the shirt off,

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leaves the room and returns with a new shirt. FTS #3 waving towel over the patient's head while the patient was lying down. FTS #3 wheels self behind the door and along the way, he touches the patient a few times and the patient becomes agitated. FTS #3 snaps the towel at the patient's face. FTS #30 shines a flashlight in the patient's face. FTS #30 comes in the patient's room, bends down towards the patient's face, flips the mattress and the patient off the bed, FTS #3 and FTS #2 do nothing. FTS #3 picks up the towels on the floor and begins to snap in the patient's face. FTS #2 wheels his chair over to the patient and kicks the patient.

xxi. On 3/19/17, day and evening staff used their cellphones while performing CO that included FTS #43, FTS #30, FTS #3, and FTS #2. FTS #38 was reading a book hidden in a folder in the doorway.

On 3/19/17, RN #1, who was assigned to another unit, is talking for 18 minutes with FTS #2 up the hall (from the revised log dated 5/12/17). FTS #33 performed a single person takedown and restraint and not in accordance with Collaborative Safety Strategies (CSS) technique. FTS #30 wakes patient up touching the patient's face, ear and begins to pour liquid towards the patient's face as the patient is lying down. FTS #30 leaves the room for more liquid and continues to pour water on the patient. FTS #30 leaves the room to a get a jug of water. FTS #30 gets the gallon jug from the floor under the head of the bed. He immediately starts to pour liquid at the patient. FTS #30 gets up and pours liquid from the far side of the bed. FTS #30 pulls the patients sheets off, covers head and pours water on the sheet while FTS #3 is present. RN #1, was not

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A 145	Continued From page 66 assigned to this unit but is visiting and speaking to FTS #2 and doesn't notice that the patient is wet from FTS #30 pouring liquid on the patient and doesn't act regarding FTS #30's feet on the bed. FTS #41 and FTS #52 change the patient's soaked sheets and clothes and FTS #30 assists. FTS #3 exits the room to view assignments sheets posted outside the patients's room. FTS #30 is then off CO but returns and touches the patient. FTS #38 is reading a book hidden in a red folder in the doorway. FTS #30 enters the patient's room and lifts the mattress and flips the patient onto the floor. FTS #2 was sitting right next to the bed when this occurs. FTS #30 comes back into room and harasses the patient. FTS #38 was reading his book and FTS #2 watches. FTS #30 comes in and harasses the patient. FTS #2 is seen twice blocking FTS #30's access to the patient before FTS #2 gets up and leaves the room. FTS #30 continues to harass the patient who had been resting/still/asleep. FTS #38 watches the entire incident from the door with a book in hand. On 3/20/17, RN #25 kicks the patient's mattress to the floor twice as the patient was walking around room/bed. The patient sits on the floor and not until twenty six minutes later, FTS #26 moves his legs and feet to allow the patient to put mattress back on the bed. FTS #25 throws food from the doorway at the patient. FTS #25 swats the patient with rolled up paper. FTS #25 throws food on the ground at the patient. FTS #23 consistently touched the patient with his foot. While FTS #22 stands in doorway and holds up his hand as the patient approaches the doorway. It is unclear if contact is made with the patient's ear/side of head. The patient retreats to room and appears to be crying, standing and then while seated, appears to cry in sheets.	A 145		

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A 145	Continued From page 67 xxii. On 3/21/17, night, day, and evening staff used their cellphones while performing CO that included FTS #52, FTS #27, FTS #25, FTS #22, FTS #24, and FTS #2. On 3/21/17, FTS #27 and FTS #42 take turns on sit and are not performing 2:1. FTS #24 walks off sit for a prolonged period of time. FTS #52 appears to be sleeping in the corner. FTS #24 is reclined in chair, feet on bed near head, facing ceiling, asleep. FTS #25 leaves the room and FTS #23 is away from the door talking to a sit down the hall and no one was watching the patient. FTS #25 kicks the patient's mattress crooked on the frame. FTS #23 scolds the patient with rolled up sheets of paper, hits the patient in the head with it three times while RN #28 watches from a seat in the hall. FTS #25 and RN #24 try to convince the patient to use a diaper, the patient refuses. FTS #25 with a black object in hand, flicks the side of the patient's face. FTS #25 and RN #24 enter and FTS #25 pulls the patient down in bed. RN #24 attempts to put the diaper on the patient. FTS #23 enters and helps FTS #25 hold down by arms while RN #24 puts diaper on over the patient's sweatpants. The Patient takes the diaper off and throws it on the ground. RN #24 picks it up and hangs it on the door handle. FTS #25 enters and pick up items off floor and throws them at the patient. FTS #25 attempts to convince the patient to use the diaper and the patient refuses. FTS #25 circles the bed annoying the patient. FTS #25 put the diaper over the patients head from behind, picks up more items from the floor and again throws them at the patient. FTS #23, RN #28, and RN #24 are eating in doorway, all watch and all four staff are	A 145		

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A 145	Continued From page 68 seen laughing. RN #24 and FTS #25 return and taunt the patient with the diaper. The floor is cleaned with a buffer and spray. Debris is seen flying as the buffer runs. The floor is not swept. The patient circles the room picking things up off the floor and eats them. The sitters are outside the room. FTS #25 pulls the patient by the back of the shirt off the bed and escorts to the bathroom, seen again in the hallway grabbing the back of the patient's shirt. FTS #22 takes a sip of his soda and gives the rest to the patient. xxiii. On 3/22/17, night staff used their cellphones while performing CO that included FTS #24 and FTS #29. On 3/22/17, FTS #27 pulls the patients sheets with foot, kicks top sheet under and the bed and starts kicking the patient. FTS #27 attempts to put a cowboy hat on the patient. FTS #27 is seen kicking the patient occasionally then kicks the top sheet to the corner of the room. FTS #27 starts kicking the patient repeatedly, very fast, then a few isolated blows, totally unprovoked as FTS #29 watches. FTS #29 attempts to put a cowboy hat on the patient, the patient throws it off. FTS #27 leaves sit without being relieved and gets coffee and returns six minutes later. Attempts to interview FTS #'s 3, 24, 26, 27, 28, 30, and 42, RN #24 on 6/21/17 and/or 6/27/17 were unsucessful or the staff declined to respond to interview questions. Interview with FTS #29 on 6/27/17 identified that he/she did not ever hit or mistreat Patient #40. FTS #29 could not recal if he/she ever witnessed any coworkers mistreat or treat Patient #40 in a rough manner.	A 145		

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A 145	Continued From page 69 i. Although interview with the CEO on 4/10/17 identified that any staff who was involved with abuse, neglect or exploitation of a patient or witnessed the same, was placed on administrative leave (AL)(leave from work), review of the list of staff on AL received on 4/20/17 only identified 21 staff and not the 40 staff identified in the video log as being abusive or witnessing abuse, restraint and/or seclusion and not reporting abuse, neglect, or exploitation. The updated staff on the AL list received on 4/25/17 only identified 25 staff on AL and not the 40 staff identified in the video log. The updated AL list received on 4/28/17 only identified only 28 staff on AL and not the 40 staff identified in the video log. The staff who were using their cellphones while performing constant observations with the patient and/or within the patient care area or left the patient area while assigned to perform constant observations were also not identified as on the AL list, which was identified as 8 additional staff. The updated AL list recevied on 5/12/17 identifed 31 staff on Administrative Leave. Interview with the CEO on 4/10/17 identified that an allegation of abuse was reported on 3/21/17 regarding Patient #40 and no staff had previously reported any allegations of abuse. Further review identified that staff and patients are not allowed to eat in the patient's room. Staff are not allowed to eat/drink in front of the patients and cellphones were not allowed on the patient units unless the staff have been authorized by the police. j. Patient #80 was admitted to the hospital on 12/23/14 following a lengthy hospitalization at	A 145		

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A 145	Continued From page 70 another acute care hospital. Diagnoses included paranoid schizophrenia, continuous. Review of an Annual Present Status/Treatment Plan Review (TPR) dated 8/5/16 by MD #6 identified that Patient #80 had a history of persistent mental illness, multiple long-term hospitalizations due to psychotic thinking and severe assaultive behaviors. The Patient had demonstrated a decrease in physical aggression and required one episode of physical restraints on 6/27/16. The Patient's insight was poor with limited judgement. i. An Annual Nursing Re-Assessment dated 8/13/16 identified personal preferences that included lying down with a cold face cloth, additional/extra medication, exercise, going for a walk, having a warm or cool drink, watching TV, talking with another patient, eating something, talking to staff, or listening to music. Things that made it more difficult when the patient was upset included being touched, not having input/choices, noise in general, bedroom door being opened, and yelling. ii. An Integrated Treatment Plan (ITP) dated 02/14/17 identified objectives that included refraining from physical aggression including touching, hitting, and/or kicking or sexual inappropriateness for four consecutive months by utilizing his/her personal preferences of engaging in social and leisure activities, utilizing quiet time in room, practicing skills taught in groups, and taking prescribed medications. iii. Review of a nursing progress note dated 3/3/2017 at 9:30 PM by identified that Patient #80 was maintained on Constant Observation for protection of others. At approximately 3:20 PM, and without warning or provocation, the patient hit	A 145		

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A 145	Continued From page 71 a staff member. A code was called, the patient was placed in four point restraints and Thorazine 100mg and Benadryl 100 mg was administered by mouth for acute aggression per physician order at 3:40 PM. No injury was noted and the patient was in four point restraints for 1 hour and 55 minutes. iv. Review of Restraint documentation identified that a takedown occurred at 3:20 PM, with a physical hold at 3:21 PM, and a secure guide escort at 3:23 PM. 4 Point restraints were applied at 3:24 PM and removed at 5:15 PM. v. Review of the video surveillance tapes on 4/18/17 identified that on 3/3/17 at 3:18 PM, FTS #22 is identified standing in the hallway. FTS #46 and FTS #2 are observed sitting in the hallway. Patient #80 approached FTS #22 and punched him/her in the abdomen. FTS #22 held Patient #80's arm, pushing the patient against the wall as he/she slid the patient down the wall to the floor. One of the other FTS's stood up and eight other staff came on the scene. RN #20, MD #6, and a Police Officer were also present. The Patient was assisted to a standing position and escorted to the seclusion room utilizing a secure guide escort. vi. FTS #22 failed to perform the take down and physical hold in accordance with hospital policies and procedures. Additionally, the Staff Debriefing Form identified that non-physical intervention techniques were not utilized due to the immediacy of patient's behavior that necessitated immediate physical response by staff and, furthermore, the technique was done correctly. vii. Documentation failed to identify interventions	A 145		

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A 145	Continued From page 72 attempted following the secure guide escort, take down, and physical hold that necessitated the utilization of four point restraint and/or why medications were not administered prior to the utilization of four point restraint. viii. Interview with the Chief Operating Officer (COO) on 04/10/17 at 10:00 AM identified that the hospital's review of the video surveillance of the restraint episode involving Patient #80 and FTS #22 identified that the single person take down was not in accordance with CSS training and represented an inappropriate use of restraint. ix. Interview with multiple staff members on 05/02/17 at 2:13 PM identified that although all staff received Collaborative Safety Strategies (CSS) training upon hire and annually, the training did not include strategies on how to safely deal with an unanticipated direct assault by a patient when other staff is not readily available. At this time, staff identified that the CSS training is only available on-line and they did not have sufficient time to thoroughly complete the training. Additionally, hands on, supervised, training with practice sessions is lacking. k. Patient #81's diagnoses included schizoaffective disorder, antisocial personality disorder, polysubstance dependence, and asthma. Review of the Integrated Treatment Plan dated 3/30/17 identified the patient was at risk for assaults and sexually inappropriate behavior for which he/she cannot be taken off constant observation. Review of facility documentation dated 4/4//17 and interview with MD #6 and Unit Supervisor #1 on 4/27/17 and 5/2/17, respectively	A 145		

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A 145	Continued From page 73 identified that there were concerns regarding Patient #81's assigned social worker (SW #1). It was reported that Social Worker #1 made a threatening statement on 10/13/16 about Patient #81 that "I will take him/her out if the patient comes towards me". Over the next several weeks Social Worker #1 reportedly stated to a number of staff members that would do "whatever she needed to do" or that she "would take him/her out" if the patient approached her in an aggressive manner. Social Worker #1 reported that the patient was smiling at her which she interpreted as a threat. Social Worker #1 became increasing irritable and suspicious while on the unit. The Supervising Social Worker and Forensic Admission Director (Social Worker #1's Supervisors) were advised of the situation in December 2016. Unit Supervisor #1 identified that he had been in contact with Supervising Social Worker regularly due to Social Worker #1's threats and difficulty managing her emotions and behavior on the unit. These concerns were shared with Forensic Admission Director. In December 2016, meetings with MD #6, Supervising Social Worker, Forensic Admission Director, the Acting Division Director, and others, discussed the concerns regarding SW #1. MD #6 and Unit Supervisor #1 recommended that a MHAS-20 (work rule violation report) be submitted and that Social Worker #1 be assigned to another unit due to safety concerns. The supervisors did not agree and instead chose to have Supervising Social Worker provide Social Worker #1 with weekly supervision. MD #6 and Unit Supervisor #1 requested a follow up meeting with Supervising Social Worker and Forensic Admission Director requesting that a MHAS-20 be submitted and that Social Worker #1 be assigned to another unit. Again, continued	A 145		

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A 145	Continued From page 74 supervision was recommended by Supervising Social Worker, Forensic Admission Director, and the Acting Division Director. Another meeting was conducted on 3/28/17 because of continued concerns regarding Social Worker #1's behavior. i. A safety plan was developed that included Social Worker #1 calling the Patient #81's unit before coming onto the unit to ensure that the patient wasn't in the area. Although Social Worker #1 agreed with the plan, she did not call the unit prior to arriving in accordance with the safety plan. ii. An incident report and MHAS-20 were submitted on 4/4/17, almost 4 months after the initial allegation. Further interview with Unit Supervisor #1 identified that although he agreed that the MHAS-20 should have been completed in December 2016, the Activing Division Director and Supervising Social Worker instead wanted a supervision plan. Although interview with Supervising Social Worker identified that as part of his supervision plan, he met weekly with Social Worker #1 for the first month and then periodically thereafter, he did not receive any reports of concern from Unit Supervisor iii. Interview with Unit Supervisor #1 on 5/2/17 identified that he continued to report to Supervising Social Worker that Social Worker #1s behaviors were concerning. The MHAS-20 report was completed by Forensic Admission Director on 4/11/17, seven days after the allegation was submitted which was not in accordance with hospital policy. The work rule violations report fails to identify that the critical incident reporting was initiated by Forensic Admission Director or the Assistant Division	A 145		

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A 145	Continued From page 75 Director, in accordance with hospital policy which includes notification of agency police, Chief of Professional Services, Division Medical Director, Facility Human Resource Director, CEO, and Office of Healthcare Systems. iv. Social Worker #1 was not immediately removed from the patient care area pending the outcome of the preliminary investigation or a temporary reassignment in accordance with hospital policy until 4/28/17, when the State Agency requested the facility to follow their abuse policy to protect the patients on the unit. v. On 4/28/17, the hospital temporarily reassigned Social Worker #1 offsite to another building. The Patient Safety Event and Incident Management Policy directs the Incident Report Form (CVH-494) be completed prior to the end of the shift by the person who observes and/or has initial knowledge of the incident, the supervisor will submit the MHAS-20 and other relevant documents to the Division Director by the end of the shift when the alleged violation occurred or was discovered. Although the policy further identified that the hospital will take immediate and appropriate action to protect patients involved in allegations of abuse, neglect or exploitation, including removing alleged perpetrators from direct contact with patient pending the outcome of the facility's investigation as indicated, the policy has conflicting information which directed a temporary reassignment of patient care responsibilities within the assigned unit or reassignment to another patient care unit when there is an allegation of verbal abuse.	A 145		

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A 145	Continued From page 76 l. Patient #90 was admitted to the hospital (Unit 6) on 4/5/17 on a PEC with diagnoses that included schizoaffective disorder and cannabis use disorder. Initial admission orders dated 4/5/17 directed to initiate constant observation for protection of others (POO). Home psychotropic medications were continued until 4/12/17 when medication dosage and form was adjusted. Review of an incident report dated 4/11/17 at 2:00 PM by Unit Supervisor #1, identified that an incident of verbal abuse was alleged on 4/11/17 at 2:00 PM by Patient #90. A summary of the incident included that Patient #90 reported to MD #6 that FTS #39 made a threatening statement when in the nursing station earlier that morning. According to Unit Supervisor #1, FTS #39 was not working the unit on first shift. i. On 4/12/17, Patient #90 again spoke with Director of Client Rights and stated that he/she had misunderstood FTS #39's statement. Section 8, Investigation by Unit Director/Supervisor of the incident report form identified that Patient #90 reported overhearing FTS #39 make a threatening statement in the nursing station while waiting to use the phone. The Director of Client Rights was contacted at approximately 2:00 PM. Addendum B, the First Level Review, again, identified the incident date as 4/11/17. With the date of the investigation as 4/11/17. Precipitating patient events were identified as none. Unit Acuity/Staff Issues were identified as none. Milieu/Environmental Issues were identified as none. Actions taken to protect the victim were described as NA (not applicable). The Section of the form identified as Direct Care Staff Actions Related to the Incident included a repetition of the original description of the allegation.	A 145		

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A 145	Continued From page 77 Recommendations/Further Actions: included to investigate for possible Work Rule Violation. Addendum C of the Investigation Section completed by the Assistant Division Director on 04/18/17 identified an incident date of 4/11/17 related to Patient #90 with a date of investigation of 4/11/17. The Assistant Division Director identified that Patient #90 misinterpreted the staff's response and has since been transferred out of the maximum security unit. Review of a written statement by the Director of Client Rights dated 4/10/17 identified that on 4/10/17 he/she was asked by Unit Supervisor #1 to speak with Patient #90 about the allegation following the Unit 6 Community Meeting which began at 10:00 AM that day. Following the meeting, The Director of Client's Rights spoke privately with Patient #90. The Director identified him/herself and explained his/her role. Patient #90 identified that he/she was aware of the director's role, and, furthermore, he/she had been mistaken about what he/she had heard and strongly denied that anything had occurred adding that he/she believed that he/she was not thinking right at that time. The Director continued to encourage free discussion without fear of retribution/retaliation, however, the Patient continued to assure the Director that he/she had no concerns. A copy of the written statement was forwarded to the Acting Division Director, the Chief of Patient Care Services, MD #6, and Unit Supervisor #1. ii. An RN Shift Note dated 4/10/17 at 6:00 AM identified that Patient #90 was hyper-verbal with sitters but exhibited no aggressive or assaultive behaviors. A nursing note dated 4/10/17 at 6:15 AM identified that there were no concerns. A Treatment Plan review dated 4/10/17 at 3:30 PM by SW #1 identified that the patient was friendly	A 145		

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A 145	Continued From page 78	A 145		

and cooperative but displayed pressured speech that was hard to follow. Thought process was described as disorganized and tangential. Review of Integrated Progress Notes from 4/8/17 through 4/12/17 failed to identify any Patient/staff conflict and/or concern.

iii. Review of a Positive Behavioral Support Plan and/or Special Observation sheet with documentation every 15 minutes from 4/10/17 at 7:00 AM through 4/11/17 at 7:00 PM failed to identify that FTS #39 performed Special Observations documentation and/or that any behaviors of concern were identified. Review of Nursing Staff Assignment/Supervisor's reports for 4/9/2017, 2:45 PM through 11:15 PM shift through 4/11/17 2:45 PM through 10:45 PM shift identified that FTS #39 worked one shift in that period on 4/9/17 at 10:45 PM through 4/10/17 at 7:15 AM which was consistent with the time of the allegation.

iv. Interview with the Director of Client Relations on 5/02/17 at 9:00 AM identified that although he had been informed of the allegation on 4/10/17, he/she was uncertain when the incident had allegedly occurred. The Director of Client Relations did not ask the patient anything about what he/she was alleging and/or request the name of the staff allegedly involved. According to the Director, the hospital policy directed that it was the responsibility of the staff member's direct supervisor to conduct an interview in the case of an allegation of abuse.

v. Although the incident report identified that the incident occurred on 4/11/17 at 2:00 PM of the Director of Patient Relations' written statement and interview identified that the incident occurred

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A 145	Continued From page 79 on or before the morning of 4/10/17. Additionally, although FTS #39 was scheduled to work during the time period in question, the investigation lacked evidence that he/she had been interviewed and/or removed from the patient care area until the investigation was completed. vi. The Assistant Division Director was unavailable for interview. m. WH4-1's diagnoses included exhibitionism, drug abuse, major depressive disorder, and antisocial personality disorder. Review of the integrated progress notes dated 3/20/17 at 9:15pm identified that at 5:30pm the patient reported being "harassed" by a nurse after having a verbal interaction, the patient felt unsafe on the unit and the nurse supervisor was notified. The note further identified that the nurse worked on another unit the rest of the shift. Review of the facility documentation identified that the alleged patient abuse incident occurred on 3/20/17 at 5:30pm but the nurse supervisor failed to immediately complete a an incident report (CVH-494) report in accordance with facility policy and was not completed until the next day, 3/21/17 at 12:25pm. (Verbal notifications were made on 3/20/17). Interview with the Chief of Patient Care Services on 4/11/17 at 4pm identified that she was not sure why the form was not completed on 3/20/17. i. The first level review (Addendum B) by the Unit Director was completed by Unit Supervisor #2 on 3/27/17 but not within three working days of the incident. The MHAS-20 form (work rule violation form) was submitted to the Division Director on 3/23/17 and not by the end of the shift in	A 145		

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A 145	Continued From page 80 accordance with the hospital policy. Interview with the Supervisor of Labor Relations on 4/18/17 identified that she did not initially view the initial report as an allegation as abuse, therefore waited until all the required documentation was received, then assigned the investigation to an investigator. As of 4/18/17, the investigation is still in progress since the hospital policy directs 30 workdays to complete their investigation. ii. Another incident report (CVH-494) was completed by MD #1 on 3/23/17 regarding the same incident. The patient identified the interaction between the Acting Division Director and RN #20 occurred on 3/16/17. The incident report form and the work rule violation report (MHAS-20) identified the date as 3/16/17 but was crossed out by unknown staff and written over as 3/20/17. Interview statement reflected dates including 3/20/17 and crossed out to reflect 3/15/17. The Division Director was notified of the incident on 3/22/17 and not by the end of the shift in accordance with facility policy. There is no documentation to reflect that the Facility Human Resource Director or the Division Director of Public Safety were notified in accordance with facility policy. iii. The second level review was completed by the Division Director on 3/29/17, and not within seven days in accordance with policy and there was no analysis documented. The forms did not identify that advocacy staff was notified in order to interview the patient within seven days after the case was reported. The Unit Supervisor/Supervisor Checklist was not completed as of 4/19/17. Interview with RN #20 on 4/17/17 at 4:25pm identified that he submitted a complaint to administration about the patient's	A 145		

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A 145	Continued From page 81 access to violent video games on the unit. RN #20 further stated that he did not yell or threaten the patient but every time he submits a complaints, he feels retaliated against and that Chief of Patient Care Services buries the complaints and that there is a fear of reporting anything at the hospital. iv. Review of the facility's Patient Safety Event and Incident Management policy identified in part, that any occurrence meeting the definition of an incident as listed in the policy will be documented on the Incident Report Form (CVH-494) prior to the end of the shift by the person who observes and/or has initial knowledge of the incident. Although the policy further identified that the hospital will take immediate and appropriate action to protect patients involved in allegations of abuse, neglect or exploitation, including removing alleged perpetrators from direct contact with patient pending the outcome of the facility's investigation as indicated, the policy has conflicting information which directed a temporary reassignment of patient care responsibilities within the assigned unit or reassignment to another patient care unit when there is an allegation of verbal abuse. v. Review of the Authorization List failed to identify any of the staff noted in the log as being authorized to carry/use a cellphone in the patient care areas. Review of the Assessment and Reporting of Victims of Abuse, Neglect or Exploitation policy identified in part, that all hospital staff with reasonable cause to suspect or believe abuse,	A 145		

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A 145	Continued From page 82 neglect, or exploitation is occurring, are required to report same to a supervisor. Staff intervention to assure the safety and treatment of the identified patient. The patient should be moved to a physically safe location. The initiation of the incident reporting and investigation process includes the employee who observes abuse, neglect or exploitation, or has initial knowledge of an allegation is responsible for completing the incident report form (Form 494) by the end of the shift when the alleged violation occurred or was discovered. Whenever a supervisor or manager becomes aware of an allegation of abuse, neglect, or exploitation they must complete the MHAS-20 work rule violations form, and orally notify the Department Division Director and Public Safety immediately. The report should include witness statements from each employee involved and each witness. The completed MHAS-20 must be submitted to the appropriate Division Director by the end of the shift when the alleged violation occurred or was discovered. The report must be faxed to Labor Relations Division within 24 hours of completion. If the alleged abuser is a staff member at the hospital, the Public Safety Officers and staff should follow the hospital Operational Procedure 8.27 Reporting Alleged Violations of Policies, Procedures, Regulations or Work Rules. The Nurse Supervisor must also ensure that an incident report is completed and submitted. A copy is submitted to the Division Director by the end of the shift in which the abuse occurred, was alleged, or discovered. An allegation of abuse is considered to be a "critical incident" and will activate the critical incident procedure (Operational Procedure 5.8 Patient Safety Event and Incident Management).	A 145		

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A 145	Continued From page 83 For some of the patient populations, the hospital has an obligation to report to other state agencies. The groups include, in part, Department of Social Service for suspected elderly abuse and Office of Protection and Advocacy for alleged abuse of clients of the Department of Developmental Disabilities. The Social Work staff member is assigned to the team is the hospital designated reporter within 5 calendar days of learning of the alleged incident. The Patient Safety Event and Incident Management policy identified that critical incident reporting and notification includes the staff person who observes, is involved in, or becomes aware of any critical incident immediately notifies the supervisor on duty. The supervisor on duty notifies the attending psychiatrist/on-call physician and initiates the verbal and written notification process. The unit director/ registered nurse supervisor, or other Department Supervisor as appropriate, immediately notifies the Division/Department Director or designee. The Unit Director/Registered Nurse Supervisor, or other Departmental Supervisor as appropriate, notifies the following individuals as soon as possible, no later than the end of the shift in which the incident occurred, Chief of Professional Services, Division Medial Director, F and Facility Human Resources Director (if staff involved). The Division/Department Director verbally notifies other key hospital leadership staff including at a minimum, the CEO/designee. The Division/Department Director reviews all potential sentinel and critical incidents in the safety huddle. The CEO/designee notifies the agency Office of Health Care Systems, the Director of the Psychiatric Security Review Board (PSRB) for all	A 145		

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A 145	Continued From page 84 patients under the jurisdiction of the PSRB, Public Safety and the Department of Corrections, as appropriate, The Unit Director/Registered Nurse Supervisor consults with the attending psychiatrist/on-call physician to determine the need for any external patient related notifications that may be needed such as next of kin, and conservator, probation or parole officer, Tarasoff warnings, significant others, other agencies, etc. Written notification/reporting includes the Unit Director/Registered Nurse Supervisor completes the Critical Incident Verbal and Written notice form and forThe Activing Division Directors copies as soon as possible, and no later than the end of the shift in which the incident occurred to CEO, Chief of Professional Services, Division/Department Director, Division Medical Director, Director of Compliance and Performance Improvement, and the Director of Human Resources, if staff involved. The CEO forThe Activing Division Directors a copy of the Incident Report Form and the Critical Incident Verbal and Written Notices form to the Director of Health Care Systems at the Office of the Commissioner within one business day. The first level review is to be completed by the Unit Director and documented on the Incident Report Form (Addendum B) within three working days. A second level review is to be completed by the Division Director and documented on the Incident Report form (Addendum C) within seven working days. The third level review is to be completed by the Critical Incident Review Action Plan subcommittee of the Quality Risk and Safety Committee and documented in the committee minutes within 60 days for all adverse events determined to be critical incidents. This committee will review, analyze and identify a	A 145		

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corrective action plan.

Incidents that involve allegations of abuse, neglect, or exploitation. All employees must report any evidence of the abuse, neglect or exploitation of patients to their supervisor immediately. This obligation extends to any employee who is directly involved, witnesses, or is made aware of an alleged incident of abuse, neglect or exploitation.

The employee who observes abuse, neglect or exploitation or has initial knowledge of an allegation is responsible for completing the Incident Report Form (CVH-494) by the end of the shift when the alleged violation occurred or was discovered in accordance with this procedure.
The supervisor or manager on duty who is made aware of an allegation of abuse, neglect or exploitation must ensure the completion of the MHAS-20 Work Rule Violation Form, and orally notify the Department or Division Director Public Safety (assigned Police Lieutenant or designee) is notified immediately or allegations of physical or sexual abuse.
The RN Supervisor (for allegations against nursing staff) or the Unit Director and Discipline Chair for allegations against other staff initiate the preliminary investigation under the direction of the Division Director or designee.

The alleged perpetrator(s) is immediately removed from patient care pending the outcome of the preliminary investigation. The RN supervisor or Unit Director collects witness statements from all staff on duty that may have information relevant to the alleged violation prior to the end of the shift. The supervisor reviews

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A 145	Continued From page 86 documented witness statements and ensures they are complete and signed by the witness/involved person as required by DMHAS Policy AC 230 D19). The supervisor will document as much as possible chain of events, by studying physical features and objects, as well as the names and placement of all involved persons, witnesses, victim, etc. at the time of the incident on the Incident Report. The supervisor will submit the MHAS-20 and other relevant documents (witness statements, staffing sheet, routine or special observation forms, incident report form), to the Division Director by the end of the shift when the alleged violation occurred or was discovered. The hospital will take immediate and appropriate action to protect patients involved in allegations of abuse, neglect or exploitation, including removing alleged perpetrators from direct contact with patients pending the outcome of the facility's investigation as indicated. The DMHAS Human Resources Office of Labor Relations and the Division/Department Director may determine that it if necessary for the alleged perpetrator to be place on administrative leave with pay or temporarily reassigned to another unit, division or department in order to ensure an optimum level of patient care, safety and welfare and to protect the employee from further allegations. The Facility Human Resources Office will immediately notify the CEO and the affected employee in writing. Temporary reassignment is utilized when circumstances do not warrant placing the alleged perpetrator on administrative leave with pay, but there reassigning the employee to a non-direct care area, or removing the employee from direct contact with the patient alleging abuse, is determined to be in the best	A 145		

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A 145	Continued From page 87 interest of both the patient(s) and staff. Criteria for the use of temporary reassignment of a non-direct care area includes, but is not limited to the following: Allegations of verbal abuse. Allegations of physical where there is no preliminary evidence to support the allegation but there are no specific facts, evidence or witness statements that disprove the allegation. The Division/Department Director is responsible for removing alleged perpetrators from direct contact with patients as indicated as soon as the perpetrators are identified as such and communicating this to the Facility Human Resources Office. The Facility Human Resources Office will immediately notify the CEO and the affected employee in writing. The temporary reassignment will continue until the investigation is completed, additional factual information deems temporary reassignment no longer necessary or as allowed by the collective bargaining agreement. If the patient has a history of two or more false allegations, the Treatment Team shall document this in the Integrated Treatment Plan with objectives and interventions to address the behavior. The Division Director will notify Labor Relations of all incidents involving allegations of abuse, neglect or exploitation as specified in Commissioner's Policy AC230/D19 Reporting Alleged Violations of DMHAS Policies, Procedures, Regulations or Work Rules. Labor Relations is responsible for conducting an investigation to determine the validity of the allegation. Investigation will commence within 24 hours of the incident being reported, whereby the supervisor collects and submits witness statements to Labor Relations, and be completed within 30 business days, except when material	A 145		

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A 145	Continued From page 88 evidence is unavailable. In those cases, the investigation will be completed within 5 business days of its availability. Advocacy staff will attempt to interview a reported victim within 7 days after the case is reported. All patients are to be offered the opportunity to speak with advocacy staff. Patient interviews may be conducted jointly by Advocacy staff and DMHAS Labor Relations staff wherever appropriate. The client rights officer will document interviews with involved patient(s) and any patient witnesses, and submit patient interview statements to Labor Relations. Labor Relations Investigators will use appropriate hospital resources, including Division Clinical Management staff involved in investigatory interviews, to address clinical implications and other risk management issues that are not in their area of expertise. The Labor Relations investigator will maintain a written record of the investigatory interview, including the interviewed person's responses to questions and any additional statements provided. Investigations must result in a written summary report that clarifies and/or reconciles information submitted a the time of the initial report (i.e. Incident Report Form, MHAS-20 Form, Witness Statements, etc.) with additional information gathered throughout the course of the investigation. The Investigation Summary Report includes a summary of the investigation and findings. The clinical manager documents his/her analysis and conclusions of administrative and/or clinical issues identified for further review as a result of participation in the investigatory interviews. The clinical manager ensures the recommended follow-up action occurs and documented	A 145		

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A 145	Continued From page 89 verification is sent to Labor Relations for inclusion in the investigation file. Investigation Review Committee (IRC), The Investigation Review Committee will oversee investigations of incidents of abuse, neglect and exploitation that allegedly involve staff misconduct. Sentinel Event/Critical Incident Review Process and Methodology- Sentinel events and other adverse events deemed to be critical incidents are investigated and examined through a comprehensive systematic analysis. The comprehensive systematic analysis results in the development of a corrective action plan to reduce the potential recurrence of a similar event. A comprehensive systematic analysis is the methodology by which an in-depth investigation is conducted focusing on systems and process to identify causal and contributing factors that underlie the event (any incidental findings may be noted for action). The comprehensive systematic analysis is documented and maintained in the sentinel event/critical incident file. A Corrective Action Plan is developed to eliminate or control system hazards or vulnerabilities that have been identified by the comprehensive systematic analysis. The plan must identify corrective actions directly related to causal and contributory factors, assign responsibility for implementation, include time lines for completion and identify strategies for evaluating the effectiveness of the actions and strategies for sustaining the changes. The Chief of Professional Services and the Director of Compliance & Performance Improvement will direct all aspects of sentinel	A 145		

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event reviews. An interdisciplinary review team, to include the Director of Nursing Quality & Patient Safety, will be charged by the CEO.

The Chief of Professional Services and the Director of Compliance & Performance Improvement are responsible for ensuring the following in relation to the sentinel event review. The Division Medical Director serves as the incident review (CIR) Manager for all other critical incidents involving patients or having a significant impact on the clinical care of patients. A Performance Improvement facilitator assigned by the Director of Compliance and Performance Improvement assists the Medical Director in a facilitative role. The CIR manager is responsible for ensuring in part, a meeting convened within 7 days of the incident and a review session is convened no later than 30 days after the incident to gather additional information and validate findings of the investigation. The assigned performance Improvement facilitator is responsible for in part, ensuring the critical incident file is complete prior to submission to the CEO for closure. The Department Director is responsible for in part, required documentation including a corrective action plan (CAP), comprehensive systemic analysis, ongoing monitoring of the CAP, and ensuring the critical incident file is completed and accurate prior to submission to the CEO for closure.

The hospital training materials on Recognizing and Reporting Abuse and Neglect identified, in part, that a healthcare culture that accepts indignity directed toward hospital patients and hospital staff will go on to accept abuse and neglect of patients. The hospital has a Zero

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A 145	Continued From page 91 Tolerance for abuse and neglect. Abuse is the intentional maltreatment of an individual that may cause injury and can be physical, psychological, sexual, and/or verbal. Neglect is defined as a failure to provide care for individuals who are unable to care for themselves. Types of care include physical needs, nutritional needs, medical needs, emotional needs, and safety needs. Exploitation includes taking unjust advantage of another person or their property for one's own gain. Overt signs of physical abuse include hitting, punching, choking, tripping, shoving, pulling, restraining unnecessarily, and using excessive force resulting in pain or injury, withdrawing food or other basic needs, controlling behavior through punishment. Overt signs of psychological abuse include treating a person in ways that cause emotional pain or distress, humiliation and ridicule, harassment, threatening with punishment, threatening with deprivation, intimidating through yelling or threats, habitual blaming or scapegoating. Overt signs of Verbal Abuse include oral, written, or gestured language that is swearing, disparaging, derogatory, insulting, demeaning, or vulgar. Overt signs of sexual abuse include sexual contact, sexual harassment, sexual assault, showing pornographic material, and/or eliciting sex. Overt signs of neglect include failing to assist in personal hygiene, being left in soiled bedding or clothing, unsuitable clothing or covering for the weather, failing to toilet the patient when required. All employees have an absolute obligation to report allegations of abuse, neglect, or exploitation both verbally and in writing at the time of the incident. As an employee, you have an unambiguous obligation to intervene if possible. You have an obligation to protect the patient and extends to all who are directly involved, witness,	A 145		

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A 145	Continued From page 92 or are made aware of the alleged incident. You must report immediately to your supervisor. The condition of the patient must be assessed by a licensed provider, medical care must be provided, and the alleged perpetrator must be removed from contact with the patient. Failure to report incidents may result in disciplinary action against you. The hospital Code of Ethics identified that all staff act with integrity, respect, and courtesy and ensure the worth of all persons at all times and the hospital staff will expose, without fear or favor, illegal or unethical conduct of others who are providing patient care or services. Review of the Collaborative Safety Strategies Inpatient Program FY17 identified, in part, the risk factors for staff burnout in mental health providers include emotional exhaustion, compassion fatigue, vicarious traumatization, depersonalization/cynicism, negative and cynical attitude towards patients, co-workers, and management, reduces personal accomplishment, negative self-evaluation of job effectiveness and self-worth. Two or more staff are required for physical restraint when there is immediate risk of injury to self/others, never physically intervene alone. General Work Rule #19 identified that physical violence, verbal abuse, inappropriate or indecent conduct and behaviors that endanger the safety and welfare of persons or property is prohibited.	A 145		
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by	A 154		

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A 154	Continued From page 93 staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: 1. Based on observation, review of clinical records, hospital policy and procedure and interviews for 2 of 2 patients reviewed for restraint utilization, Patients #40 and #80 the hospital failed to ensure that physical and/or mechanical restraints were not imposed as a means of coercion, discipline, convenience, or retaliation by staff. The findings include: a. Patient #40 was admitted to the hospital on 08/31/1995 with diagnoses that included schizoaffective disorder, autism spectrum disorder, osteoporosis, seizure disorder, recurrent aspiration pneumonia, psychogenic polydipsia, and a history of multiple fractures. i. A Treatment Plan Review (TPR) dated 3/22/17 for February 2017 through March 2017 identified that Patient #40 continued to demonstrate problems with explosive affect, physical aggression, sexualized behaviors, impulsivity, and poor self-care. He/she had required intensive staff support to maintain safety and to ensure his/her ADLs were appropriately maintained. He/she required a physical intervention on 3/1/17 after becoming assaultive to staff. Objectives included that the Patient would use or attempt to use his/her personal preferences to better manage his/her frustrations and remain free of aggression to self and others as evidenced by a gradual reduction of acts of aggression and restraints.	A 154		

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A 154	Continued From page 94 ii. Physician Orders dated 3/2/17 through 3/22/17 directed that Patient #40 have constant observation (CO) with two (gender specific) staff members for protection of self and others, water intoxication, activities of daily living (ADL), and targeting staff of the opposite sex (verbal and physical assaults). iii. A Physician Order for restraints dated 03/01/17 at 10: 40 AM by MD #6 and RN #27 directed to place Patient #40 in Physical Restraint not to exceed 20 minutes, and mechanical restraint not to exceed 2 hours (4 point) due to imminent risk of assaultive aggression as evidenced by hitting, kicking, spitting. Physical and/or psychological risk considerations included, osteopenia and history of aspiration pneumonia. Discontinuation criteria included, calm, cooperative, and non-aggressive behavior. iv. Review of restraint documentation dated 03/01/17 at 11:00 AM by RN #24 identified that Patient #40 was punching at staff, swinging, lunging, chasing, and spitting. The Patient was offered and refused a quiet area (refused and stormed out). Staff offered to talk with the Patient and he/she screamed and attempted to strike at the staff member. A Secure Guide Escort and Third Person Assist was implemented at 10:40 AM followed by a Physical Hold at 10:45 AM. Four Point Restraints were applied at 10:45 AM and discontinued at 12:25 AM. v. Review of video surveillance of the restraint episode from 10:30 AM through 10:42 AM identified that Patient #40 was on the bed in his/her room. FTS #25 (involved in an incident of physical and psychological abuse of Patient #40 that AM) was visible behind the door. A lighted	A 154		

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screen consistent with a cellular phone was visible. FTS #25 and Patient #40 exited the room and entered the hallway at 10:35 AM. At 10:36 AM, Patient #40 returned to his/her room followed by FTS #25 and FTS #36. FTS #36 exited the bedroom at 10:37 followed shortly by FTS #25 and Patient #40 who was moving rapidly with arms extended. Patient #40 attempted to strike FTS #37, and FTS #25 placed his/her hands on the Patient's upper arm and wrist in what appeared to be a Secure Guide Escort Hold. The Patient pulled away and five other staff approached. Within one minute the patient sat on the floor. Immediately, the patient attempted to lie down on the floor and was curled up on the floor with approximately 5 staff surrounding him/her. At 10:39 AM a restraint bed was wheeled into the hallway and the Patient was lifted onto the bed. Four point restraints were applied. The Patient did not appear to resist. At 10:41 AM the patient was wheeled into the restraint room and out of view.

vi. Review of the every fifteen minute documentation of the Positive Behavioral Support Plan and/or Special Observations failed to validate the Behaviors of Concern documented prior to the initiation of restraints. The behaviors documented included repetitive ritualistic behaviors and, although the Patient required re-orientation away from ritualistic behaviors; aggressive, assaultive, or in-appropriate behaviors directed towards staff were not documented. Further review of restraint documentation identified that Patient #40 yelled, spit, and pulled at the restraints from 10:55 AM through 11:55 AM and then was lying down, quietly and asked to be released at 12:25 PM. Trazadone 100 mg and Valium 10 mg were

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A 154	Continued From page 96 ordered by MD #6 and administered by mouth at 11:30 AM. Patient #40 sustained ½ inch abrasion at the back of his/her head during the restraint episode. vii. Review of a list of things that made it more difficult for the patient when he was already upset included being touched, people staring at him/her, yelling, and the time of year including the anniversary of the crime he/she committed (02/26/1995). viii. The Patient had been subjected to physical and psychological abuse at 7:00 AM and the alleged perpetrator approached him/her later potentially causing the patient further mental anguish as evidenced by his/her aggressive response to the staff. A physical interaction involving touching by staff ensued resulting in four point restraint. Oral medications were not offered and/or administered until 11:30 AM, delaying the possible calming effect and prolonging the need for restraints. Documentation lacked evidence that the time of year in relation to the crime committed and/or other issues were considered prior to implementing or discontinuing physical and mechanical restraints. ix. Review of the Seclusion/Restraint Patient Debriefing form dated 3/1/17 at 11:00 AM by RN #27 identified that Patient #40 refused to answer the 10 questions on the form, however, the form was signed and dated prior to the discontinuation of restraints at 12:25 PM, additionally, the Staff Debriefing form was completed at 11:15 AM prior to the discontinuation of restraints at 12:25 PM. 2. Review of an incident report on Patient #40	A 154		

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A 154	Continued From page 97 initially dated 4/17/17 identified that the date of the incident was crossed out and replaced with 3/19/17. The report, documented by the Assistant Division Director, identified alleged physical patient abuse towards Patient #40 with FTS #33 identified as the aggressor. Other staff involved included FTS #34, FTS #60, RN #34, and RN #26. PT #40 attempted to strike FTS #34 and was immediately grabbed from behind in a bear hug type of hold and taken down to his/her bed in a rough manner. FTS #40 went into the Patient's room held his/her legs. Other staff responded and entered the room. FTS #60, put his/her hand on the Patient's forehead while RN #26 and RN #34 entered the room. i. According to the Assistant Division Director, Patient #40 was held briefly on the bed for less than one minute. No medications were administered. No restraints were ordered, and no paperwork was generated. Review of nursing documentation including the integrated progress notes dated 3/19/17 at 1:45 PM by RN #26 and Positive Behavioral Support Plan/Special Observation identified that the Patient was aggressive and yelling, but failed to identify that the Patient required a take-down and/or type of physical restraint. ii. The physical restraint episode lacked physician notification, a physician order, and/or restraint documentation and/or an RN Assessment prior to or after the episode. Additionally, the one person take-down was not in accordance with Collaborative Safety Strategies (CSS) training. The time of the occurrence was unclear with the investigation dated 4/17/17. iii. A hospital restraint policy identified that all	A 154		

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A 154	Continued From page 98 patients have the right to be free from restraint, of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff and directed that the RN assesses and documents the situation and obtains and documents physician's order. The physician describes the patient's specific behaviors which are observable and measurable necessitating immediate risk and the behavioral criteria necessary for release/discontinuation. j. Patient #80 was admitted to the hospital on 12/23/14 following a lengthy hospitalization at another acute care hospital. Diagnoses included paranoid schizophrenia, continuous. Review of an Annual Present Status/Treatment Plan Review (TPR) dated 8/5/16 by MD #6 identified that Patient #80 had a history of persistent mental illness, multiple long-term hospitalizations due to psychotic thinking and severe assaultive behaviors. The Patient had demonstrated a decrease in physical aggression and required one episode of physical restraints on 6/27/16. The Patient's insight was poor with limited judgement. i. An Annual Nursing Re-Assessment dated 8/13/16 identified personal preferences that included lying down with a cold face cloth, additional/extra medication, exercise, going for a walk, having a warm or cool drink, watching TV, talking with another patient, eating something, talking to staff, or listening to music. Things that made it more difficult when the patient was upset included being touched, not having input/choices, noise in general, bedroom door being opened, and yelling. ii. An Integrated Treatment Plan (ITP) dated	A 154		

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A 154	Continued From page 99 02/14/17 identified objectives that included refraining from physical aggression including touching, hitting, and/or kicking or sexual inappropriateness for four consecutive months by utilizing his/her personal preferences of engaging in social and leisure activities, utilizing quiet time in room, practicing skills taught in groups, and taking prescribed medications. iii. Review of a nursing progress note dated 3/3/2017 at 9:30 PM by identified that Patient #80 was maintained on Constant Observation for protection of others. At approximately 3:20 PM, and without warning or provocation, the patient hit a staff member. A code was called, the patient was placed in four point restraints and Thorazine 100mg and Benadryl 100 mg was administered by mouth for acute aggression per physician order at 3:40 PM. No injury was noted and the patient was in four point restraints for 1 hour and 55 minutes. iv. Review of Restraint documentation identified that a takedown occurred at 3:20 PM, with a physical hold at 3:21 PM, and a secure guide escort at 3:23 PM. 4 Point restraints were applied at 3:24 PM and removed at 5:15 PM. v. Review of the video surveillance tapes on 4/18/17 identified that on 3/3/17 at 3:18 PM, FTS #22 is identified standing in the hallway. FTS #46 and FTS #2 are observed sitting in the hallway. Patient #80 approached FTS #22 and punched him/her in the abdomen. FTS #22 held Patient #80's arm, pushing the patient against the wall as he/she slid the patient down the wall to the floor. One of the other FTS's stood up and eight other staff came on the scene. RN #20, MD #6, and a Police Officer were also present. The Patient was	A 154		

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	074003	A. BUILDING _____ B. WING _____	C 07/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONNECTICUT VALLEY HOSP	SILVER ST MIDDLETOWN, CT 06457

(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 154	Continued From page 100 assisted to a standing position and escorted to the seclusion room utilizing a secure guide escort. vi. FTS #22 failed to perform the take down and physical hold in accordance with hospital policies and procedures. Additionally, the Staff Debriefing Form identified that non-physical intervention techniques were not utilized due to the immediacy of patient's behavior that necessitated immediate physical response by staff and, furthermore, the technique was done correctly. vii. Documentation failed to identify interventions attempted following the secure guide escort, take down, and physical hold that necessitated the utilization of four point restraint and/or why medications were not administered prior to the utilization of four point restraint. viii. Interview with the Chief Executive Officer (CeO) on 04/10/17 at 10:00 AM identified that the hospital's review of the video surveillance of the restraint episode involving Patient #80 and FTS #22 identified that the single person take down was not in accordance with CSS training and represented an inappropriate use of restraint. ix. Interview with multiple staff members on 05/02/17 at 2:13 PM identified that although all staff received Collaborative Safety Strategies (CSS) training upon hire and annually, the training did not include strategies on how to safely deal with an unanticipated direct assault by a patient when other staff is not readily available. At this time, staff identified that the CSS training is only available on-line and they did not have sufficient time to thoroughly complete the training. Additionally, hands on, supervised, training with	A 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 154	Continued From page 101 practice sessions is lacking.	A 154		
A 165	482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based on review of facility policy and interview, the hospital failed to implement a restraint policy with least restrictive interventions. The findings include: Review of the restraint log dated dated 2/1/17 to 4/10/17 identified that restraint types included take down, physical hold, secure guide escort, and 4 point restraints. Interview with the Chief of Patient Care Services on 4/13/17 identified that the hospital does not use 2 point restraints. Review of the Restraint Use for the Management of Violent or Self Destructive Behavior policy identifies that the approved mechanical restraints approved for use at the hospital include in part, four-point restraints. Prior to the initiation of restraint, therapeutic interventions are employed considering patient-specific triggers as a means to help the patient regain control of his/her behavior, use of secure guide escort or a third person assist. The policy does not identify the use of 2 point restraints, a least restrictive restraint.	A 165		