STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
CONNECTICUT VALLEY HOSPITAL

Approved by SA
6/27/19
SHN

Connecticut Valley Hospital
1000 Silver Street
Middletown, CT 06457

June 27, 2019

Re: CMS Certification Number: 074003
Complaint Survey on June 16, 2019

Dear Sue,

Attached please find Connecticut Valley Hospital's Plan of Correction in response to the June 16, 2019 survey that was conducted by the Connecticut State Department of Public Health and The Center for Medicare & Medicaid Services (CMS).

I look forward to your response and any feedback. If you have any questions or concerns, please do not hesitate to contact Lakisha Hyatt 860-262-5884 or 860-214-8478 (cell).

Sincerely Yours,

Helene M. Vartelas

Helene M. Vartelas, MSN, RN
Chief Executive Officer

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

June 25, 2019

Helene Vartelas, CEO
Connecticut Valley Hosp
Silver St
Middletown, CT 06457

Dear Ms. Vartelas:

On **June 16, 2019** the Department of Public Health, Facility Licensing and Investigations Section of the Health Care Systems Branch, concluded a substantial allegation investigation at your facility. As a result of this investigation, substantial noncompliance remains. Please note that Connecticut Valley Hospital was previously identified with substantial noncompliance as identified in the Federal Deficiency Statement issued on **April 30, 2019.** As identified in the Federal Deficiency Statement issued on **April 30, 2019,** Connecticut Valley Hospital's 90-day termination date remains in effect and a new acceptable plan of correction is required.

Enclosed is the statement of deficiencies noted during this survey. Connecticut Valley Hosp must submit to the Department of Public Health a signed and dated plan of correction for all the deficiencies identified in the investigation that concluded **June 16, 2019.** The plan of correction must be written on the Statement of Deficiencies (Form CMS 2567), with identification of the staff member by title who has been designated the responsibility for monitoring the individual plan of correction submitted for each deficiency and shall be documented in the designated column.

Each deficiency needs to be addressed with a prospective plan of correction that include the following components:

- What corrective actions(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and
- How the facility will monitor its corrective action(s) to ensure the solutions are permanent. The facility must develop and implement a quality assurance tool to ensure that corrections is

achieved and sustained; and
- Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency; and
- Insert a Completion Date in appropriate column (X5).

The process provides the facility an opportunity to make corrections. A signed and dated (*column (X6)*) acceptable plan of correction must be submitted to the Facility Licensing & Investigations Section by **July 2, 2019**. If an acceptable POC is timely submitted, the Centers for Medicare and Medicaid Services (CMS) has granted permission for a second revisit. Your facility will be revisited to verify necessary corrections. As noted in the CMS letter to you dated **April 30, 2019**, the date on which the Medicare agreement terminates is **July 29, 2019**. Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction and susequent verification of compliance by the State Survey Agency.

Please return your response to Susan Newton, RN, Supervising Nurse Consultant, *State of Connecticut Department of Public Health, Facility Licensing and Investigations Section, 410 Capitol Avenue, MS#12HSR, P.O. Box 340308, Hartford, CT 06134-0308*. Please direct any questions to the Supervising Nurse Consultant at (860) 509-8018.

Sincerely,

SN/2

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

c. CMS
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	074003	A. BUILDING _____ B. WING	R-C 06/16/2019

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
{ADDO}	INITIAL COMMENTS A Revisit was concluded on 6/11/19. The Condition of Participation for Patient Rights was not met. During the Revisit, Immediate Jeopardy (IJ) was identified under Patient Rights for failure to properly supervise a patient with self-harm tendencies resulting in the patient swallowing 2 objects which required 2 medical procedures to remove the objects. The IJ Template was issued to the hospital on 6/11/19 at 4:45 PM. An immediate action plan was requested and received. An onsite survey was conducted on 6/16/19 and verified that Immediate Jeopardy was abated. Please refer to A 114, A 144	{A 000}	See Attached	
{A 115}	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: The Condition of Participation for Patient Rights was not be met. Based on clinical record review, observations, interviews with staff, review of hospital documentation and policy for 7 of 19 patients (Patients #17, 21, 22, 24, 25, 26, and 27)	{A 115}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Helene M. Yatlas MSN, CEO
TITLE: Chief Executive Officer
(X6) DATE: 6/26/19

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

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

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{A 115}	Continued From page 1 reviewed for self-harm, the hospital failed to: 1. Failed to ensure that the patient patients received care in a safe setting when staff failed to maintain continuous observations; 2. Failed to adequately supervise the patients; and 3. Failed to ensure the environment was free of accident hazards.	{A 115}		
{A 144}	Please refer to A144 PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, clinical record review, review of hospital policy, review of hospital documentation and staff interview for 7 of 19 sampled patients (Patients #17, 21, 22, 24, 25, 26, and 27) reviewed for self-harm behaviors, the hospital failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conductedand and/or failed to ensure that Patient # 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy. The findings	{A 144}		6/28/19

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{A 144}	Continued From page 2 include: 1. Patient # 17 was admitted to facility on 2/6/19. Diagnoses included Schizophrenia, PTSD, depression and PICA (eating items that are not food). Review of the readmission psychosocial history and assessment dated 2/7/19 identified diagnoses including impulsive behaviors, intermittent anger, depression, anxiety and symptoms of post-traumatic stress disorder (PTSD). The note identified a long history of suicidal ideation and PICA. The note further identified to develop a therapeutic relationship with patient, work with family towards discharge and stabilize psychiatric symptoms by improving medication adherence and active involvement in treatment. Review of the hospital discharge summaries dated 2/6/19, 3/24/19, 3/25/19, 3/26/19 and 3/31/19 identified the patient was admitted to the emergency department (ED) for acts of self-harm. The reports identified the patient ingested and/or inserted foreign objects into his/her body (a nail, part of a razor, top of a beer can, swallowed paper clips, and/or inserted pens into the urethra). The reports further identified that each time the patient had to have the items surgically removed. Review of the Treatment plan dated 4/25/19 identified a history of self-injurious behaviors and PICA. Interventions included the patient to be on a two to one monitoring (2 staff to one patient) at all times with male staff only for protection of self and others, patient to wear a jumpsuit in effort to prevent easier access to genital area,	{A 144}		

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{A 144}	Continued From page 3 medications as ordered, stress management groups, coping skills, rapport building, and tools to recognize and cope with anxiety. Special observation orders dated 5/1/19 at 4PM directed the patient may have wireless headphones during non TV times. Nurse's notes dated 5/1/19 at 8:30PM identified the patient was placed back on a two to one for 24 hours, male staff only at arm's length to prevent insertion and/or ingestion of objects. The note identified that staff reported that the patient stated "wait until its 11PM, its going down." The physician was notified and the directed to place the patient on CO (continuous observation) for 24 hours only. Physician orders dated 5/1/19 at 8:30PM directed the patient to be on CO (continuous observation) two males staff to patient for 24 hours at arm's length to prevent insertion and/or ingestion of objects. Nurse's notes dated 5/2/19 at 4:15AM noted that approximately 8:30PM on 5/1/19 the charge nurse reported that Patient # 17 refused his/her 8PM medications and threatened to do something when he/she will be switched from a two to one to a one to one special observations on the third shift. The note further identified that the RN requested to continue the patient on a two to one for the third shift. Physician progress note dated 5/2/19 at 4:15AM identified that due to the patient's non-compliance with medications and "threatening to do something" the patient was to stay on a two to one observation for 24 hours for risk of injury	{A 144}		

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{A 144}	Continued From page 4 and/or risk of ingestion of foreign objects. The note identified at 2:50AM the charge nurse notified that she gave the patient headphones. At 2:45AM, the patient told the charge nurse that he/she swallowed 2 AAA batteries. The note further identified that the special observation order did not specify that the patient was allowed to use headphones at night. The note further identified that the MD went to assess the patient, found the patient on the floor moaning and complaining of severe abdominal pain, the patient stated he/she swallowed the batteries of the headphones. Additionally the note identified the patient was transferred with 2 staff to the hospital for evaluation. Nurse's notes dated 5/2/19 at 4:45AM identified the patient was agitated, angry, pacing and refused PRN medications, and the patient verbalized he/she was upset over seeing two sitters with him/her. The note identified that at 1AM he/she asked for headphones to calm down. The note identified at 2:45Am the patient reported he/she swallowed 2 batteries. The patient was assessed complained of abdominal pain, the MD and RN Supervisor were made aware and the patient was transferred to the hospital for evaluation. Progress note dated 5/2/19 at 11:50PM (late entry for 5/2/19 at 3:45AM) identified the patient reported to MHA # 17 and # 16 that while speaking to the patient, MHA #17 asked the patient when he/she swallowed the batteries and the patient stated to him that "he/she swallowed the batteries while the other two staff (MHA # 15 and # 18) were on my sit (CO)." The patient further stated to MHA #17 "that one was sleeping and the other staff was sitting outside the room	{A 144}		

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(A 144)	Continued From page 5 out of his/her sight, and that's when he/she took the opportunity to take out the batteries of the headphones and swallow them." Facility documentation dated 5/2/19 at 2:45AM identified the patient reported that he/she swallowed 2 AAA batteries. The report identified the patient was very agitated, pacing in the blue room and refused PRN medications. The report identified that the patient asked for the headphones to calm down and he/she removed the batteries from the headset while on a two to one continuous observation. The documentation further identified the patient was able to remove the batteries from the headset while the patient was on a two to one male only continuous observation, and that both staff should have been within arm's length at all times. Although the patient was on two to one observations, the patient was able to obtain and ingest batteries from his/headphones. Review of the special observation sheet dated 5/2/19 at 2:45AM identified from 1AM (the time the patient was given the headphones) until 2:45AM when the patient reported he/she ingested the batteries, the patient was interacting appropriately with staff while in the blue room and was exhibiting no behaviors from 1AM until 2:30AM when the resident was noted to be pacing. Review of the clinical record at that time with the DON identified that although the nurse's notes reflect that the patient was agitated, angry, refusing medications and pacing the special observation sheet failed to accurately reflect the patient's behaviors between 1AM through 2:30AM. Review of the hospital discharge report dated	(A 144)		

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{A 144}	Continued From page 6 5/8/19 identified the patient was admitted after ingesting 2 batteries. The documentation identified the patient underwent an EGD (esophagogastroduodenoscopy) and removed one of the batteries and after an x-ray, the second battery was observed in the mid abdomen, likely the small bowel. The note further identified the pain as described by the patient was burning in the left abdomen. The patient was admitted to the hospital and had a colonoscopy on 5/7/19 for removal of the second battery. Interview with the Chief Operating officer (COO) on 6/11/19 at 1:35PM stated that when this incident occurred they looked at the corrective action plan that was in place and implemented new interventions. The COO stated that all data was reviewed related to the incident and that both staff members had received report/education at the start of the shift. The COO stated that after a thorough the investigation and speaking to the patient, it was identified that one staff was allegedly sleepy and the other staff was outside the room out of view of the patient when the patient swallowed the batteries. The COO further stated that the employees were removed from patient care and asked to write statements, but have not been able to interview staff and ask if they were sleeping and/or outside the room because the incident first goes to labor relations to investigate. Interview with RN # 11 on 6/12/19 at 7:05AM stated that Patient # 17 called her over and asked for the headphones to relax. RN # 11 stated that she checked the orders and saw new orders were written the shift before because the patient had threatening behaviors (two to one staff within arm's length of patient) when she went to the blue	{A 144}		

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{A 144}	Continued From page 7 room to give the patient the headphones she did not direct staff on monitoring or the headphones. RN # 11 stated that the 2 staff who were conducting observations on the patient were in the doorway and not within arm's reach as the order directed. RN # 11 stated that she did not speak to staff at that time regarding being an arms length away from the patient. RN # 11 stated that later on she was called over to talk to the patient and was told that the patient swallowed 2 batteries from the headphones. RN # 11 stated that she assessed the patient, notified the MD and RN Supervisor and removed the staff from patient care. RN # 11 stated that MHA #15 and MHA #18 told her they didn't see the patient ingest the batteries. Interview with MHA # 15 on 6/12/19 at 7:30AM stated that the patient was in the blue room pacing back and forth and he and MHA # 4 were sitting in the doorway to the room. MHA # 15 stated the nurse gave the patient headphones but did not give any direction to them regarding watching the patient with them. MHA # 15 stated that the patient asked us to call the nurse and the patient whispered to her that he/she swallowed the batteries. MHA # 15 further stated that he was not told by the nurse that he had to be an arm's length away from the patient at all times. Interview with MHA # 16 on 6/12/19 at 7:45AM stated that the patient was agitated and pacing and was given the headphones by the nurse during his 1:15AM to 2:15AM two to one CO. MHA # 16 stated that after the patient was given the headphones he/she calmed down, was still pacing and he could hear the music from the headphones. MHA # 16 stated that when they handed off the patient to MHA # 16 and # 18, the	{A 144}		

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{A 144}	Continued From page 8 patient was still pacing and listening to music. MHA # 16 stated that during his observation shift he was watching the patient's hands face and neck at all times. MHA # 16 further stated that when they took over the sit after the patient swallowed the batteries, the patient told him and MHA # 17 that he/she swallowed the batteries (after we finished the earlier CO when the patient got the headphones) when MHA # 15 and # 18 were doing the CO. MHA # 16 stated that the patient told him he/she went to the corner of the room and swallowed the batteries. Interview with MHA # 17 on 6/12/19 at 7:55AM stated that the RN gave the patient the headphones during their earlier CO (1:15AM-2:15AM) but was given no direction on the patient using the headphones. MHA # 17 stated that he was asked to take over the CO at approximately 2:30-2:45AM. MHA # 17 stated that when he approached the blue room where the patient was located, the patient was lying on the ground saying he/she was in pain and holding his/her stomach. MHA # 17 stated that he asked the patient why he swallowed the batteries and when did he/she do it and the patient told him he/she was tired of being there and that he/she swallowed them when MHA # 15 and # 18 were doing the CO. MHA # 17 stated that the patient stated that one of the staff was nodding off in the chair and the other was not in view of him/her. Interview with MHA # 18 on 6/12/19 at 8:40AM stated that when he did the CO the patient already had the headphones and was holding them in their hands pacing in the room. MHA # 18 stated that the patient asked us to call the nurse and when she came down she spoke to the patient and then said the patient swallowed the	{A 144}		

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{A 144}	Continued From page 9 batteries. MHA # 18 stated that the patient said that he/she swallowed the batteries before and that his/her chest was on fire and throat was burning. MHA # 18 stated that his job was to keep an eye on the patient at all times and that he was sitting in the doorway during his CO. 2a. Patient # 24 diagnoses included schizoaffective disorder, bipolar type and history if suicide ideation and self-harm behaviors. Special Observation orders dated 6/15/19 at 10am directed CO for 24 hours for risk of self-injury, hands, face, and neck visible at all times. Observation on 6/15/19 at approximately 5:45am with the Program Manager identified the patient sleeping in bed lying on side and LPN # 2 conducting the CO. The CO was sitting and facing the patient's back and was unable to visualize the patient's hands, face, and neck in accordance with physician orders to maintain the patient's safety. Although the Program Manager accompanied the surveyor and was present during the observation, the surveyor requested a verbal mitigation plan to address the LPN #2's noncompliance with the CO policy. Interview with the Program Manager at that time identified that the LPN should reposition his/her chair in order to visualize the patients hands, face, and neck at all times. b. Review of the Progress note dated 6/9/10 identified that while Patient # 24 was on 15 minute checks, another patient reported that Patient # 24 had cut self on the arm in the bathroom by rubbing arm against the ridge of the toilet paper roll. A Suicide Risk Re-Assessment was conducted but documentation of a physician assessment of current suicide risk was lacking or	{A 144}		

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{A 144}	Continued From page 10 that the form was signed by the physician. c. The Special Observation order dated 6/13/19 at 8:58pm directed CO for 24 hours for protection of self and protection of others and room search every shift while on CO. Review of the progress notes identified that the patient was in possession of a staple. Although the patient was on CO, the patient had access to an object that was potentially harmful. 3. Patient # 21 diagnoses included major depressive disorder, post-traumatic stress disorder, borderline personality disorder, and obstructive sleep apnea with a history of multiple suicide attempts. Special Observation orders dated 6/14/19 directed CO from 7:30pm to 7:15am, hands, neck and face must be visible at all time, continuous positive airway pressure (CPAP) while on CO. Observation on 6/15/19 at approximately 4am identified the patient sleeping in bed wearing a CPAP mask and was facing the window with back towards MHA # 14. Although the Program Manager accompanied the surveyor and was present during the observation, the surveyor requested a verbal mitigation plan to address the MHA's noncompliance with the CO policy. The Program Manager directed re-education of MHA to ensure staff was able to see the patient's hands, face and neck at all times. 4. Patient # 25 diagnoses included schizoaffective disorder and suicidality. Special Observation orders dated 6/14/19 at 9:20pm directed CO for suicidality all shift, hands, face, and neck visible at all times. Observation on 6/15/19 at approximately 4:30am identified the patient sleeping and MHA # 13 was conducting	{A 144}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 11 the CO. The MHA asked for the current time since he/she did not have a watch and needed to document the CO checks every fifteen minutes and had used the clock at the far end of the dorm prior to this time. MHA # 13 demonstrated that he/she got out of his/her chair, looked down in the hallway to see the clock, which failed to ensure MHA could see the patient's hands, face and neck at all times in accordance with physician's order to maintain patient safety. 5. Patient #27 was admitted to the hospital on 1/20/19. Patient #27 is known to the hospital who has an extensive history of self-injurious behavior, aggression toward others and ingesting items. Review of the treatment plan dated 1/30/19 identified that the patient had exhibited behaviors of hurting someone or having self-injurious behaviors and continued on CO and/or every 15 minute checks. Review of the special observation orders dated 5/1419 identified the patient was to be on every 15 minute checks for risk of aggression to self or others. Review of the treatment plan dated 1/30/19 identified that the patient had exhibited behaviors of hurting someone or having self-injurious behaviors and continued on CO and/or every 15 minute checks. Review of facility documentation on 5/18/19, Patient #27 reported to the nurse that during the day when he/she was on fresh air break with staff in attendance, the patient was able to pick up a rock and hide it into his/her undergarment. Patient #27 indicated that while he/she was taking a shower, he/she ingested the rock. Although Patient #27 was on every 15 minute checks, the facility failed to provide adequate supervision to Patient #27. Patient #27 was	{A 144}		

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 _____	R-C 06/16/2019

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 144}	Continued From page 12 known to the facility for ingesting items and the patient was able to pick up a rock and hide it until later where he/she ingested it during his/her shower time. Interview with the Program Director on 6/15/19 at 5:00am indicated that Patient #27 was on every 15 minute checks and the staff did not see him/her pick up a rock and put it in his/her undergarment. Review of facility policy identified that the fifteen minute observation is used when a patient's behavior, health, or mental health requires closer attention. The assigned staff member is responsible for checking on the patient's safety and well-being every 15 minutes. 6. Patient #26 was admitted to the hospital on 4/28/17. Patient #26 had a history of self-injurious behaviors, unpredictable and suicidal. Review of the special observation orders dated 6/7/19 identified that that the patient was on continuous observation from 7-3pm and 3-11pm shifts and every 15 minute checks on 11-7pm shifts. Review of the treatment plan dated 6/6/19 identified that Patient #26 has intermittent episodes of self-injurious and aggressive behaviors requiring constant observation and some restraint episodes. Review of hospital documentation dated 6/8/19 identified that at 5:20pm, Patient #26 was upset, went into his/her room for a while and was verbally redirected. Patient #26 ran in to the dining room, used a dining table to break a glass window, dropped to the floor and intentionally cut both hands and arms with the broken glass. Patient #26 sustained cuts to bilateral hands and was sent to the Emergency Department.	{A 144}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	074003	A. BUILDING _____ B. WING _____	R-C 06/16/2019

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{A 144}	Continued From page 13 Subsequently, Patient #26 sustained 7 stiches to the right hand and steri-strips to the left hand. Interview with the Program Director on 6/15/19 at 5:00am indicated that Patient #26 was on CO and need to be monitored closely. The facility policy for CO (continuous) identified that this was an observation in which the patient required ongoing monitoring to ensure his/her safety and/or the safety of others. The policy further noted that nursing staff assigned provided this by having a clear view of and unimpeded access to the patient at all times. The facility client and family handbook identified that a patient has the right to receive individualized treatment. 7. Observations during a tour of the Battell unit that commenced on 6/15/19 at 8:05 PM, identified the mental health workers assigned to conduct physician ordered constant observations for Patient #'s 21 and 22 did not have a clock and/or a watch to ensure that the required documentation was completed timely. Further observation identified that the mental health worker assigned to conduct a physician ordered constant observation for Patient #23 did not have a "panic alarm" in accordance with the policy and procedure. During an interview with Supervisor #2 on 6/15/19 at 8:30,s/he stated that the individuals conducting constant observations should have clocks and panic alarms in their possession. Review of the Special Observation Policy directed that the nursing staff assigned to Special Observation is responsible and accountable for ensuring patient safety. The patient's hands, face and neck must be in clear view at all times,	{A 144}		

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 _____	R-C 06/16/2019

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{A 144}	Continued From page 14 unless otherwise specified by the Physician's Special Observation order. 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. The staff may not read, socialize with other staff, use headsets/earphones or cell phones. The staff may not eat or drink. The hospital submitted an immediate action plan dated 6/11/19 to the State Agency immediately which identified that after the incident, the 2 MHA staff members were removed from patient care and an investigation was intitated. The following day (5/3/19), corrective actions were put in place including thirty (30) minute rotation of staff assigned to special observation on the unit where the patient resided, staff was educated to the change to the thirty minute rotation policy as they came on duty, and staff are to remain standing at all times when assigned to special observation. A memo was sent to all nursing staff informing them that the assignemnt of special observation was changed across the remainder of the hospital to 60 minute intervals. A focused treatment plan review was conducted upon the patients return from the hospital. The behavioral guidelines were revised and interventions added to ensure safety of the patient. All ptients were reviewed in the hospital who have a history of ingestion/insertion and all have behavioral guidlines in place. Accountability rounds are conducted by the charge nurse and supervisor to ensure the special observation are implemented to include the assignment of 30 minute rotations on the unit where the index patient resided, 60 minutes on all other units and that staff assigned	{A 144}		

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 144}	Continued From page 15 to observe the index patient remain standing at all times, and daily audits to be conducted and reviewed with the nursing executive committee on a monthly basis. An onsite review conducted on 6/16/19 identifed that the hospital implemented their immediate action plan and Immediate Jeopardy was abated.	{A 144}		

Tag	Plan of Correction	Completion Date
A115-1	Please see A-144	

Tag	Plan of Correction	Completion Date
A115-2	Please see A-144	

Tag	Plan of Correction	Completion Date
A115-3	Please see A-144	

Tag	Plan of Correction	Completion Date
A144-1	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient #27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following corrective actions. Immediately following report of the incident on 5/2/19, the patient was assessed and transferred to the Emergency Department of the local acute care medical facility and subsequently admitted for further medical assessment and treatment. The patient's Behavioral Guidelines were revised and a focus treatment plan review which added treatment interventions was conducted upon the patient's return to the facility. The patient was discharge to a more secure inpatient setting for further psychiatric care. The two staff assigned to observe the patient was immediately removed from patient care and an investigation into the incident was initiated. A Critical Incident Review (CIR), which included a root cause	5/2/2019 5/9/2019 5/9/2019 5/2/2019

	analysis, was conducted to identify causative factors related to the incident and the performing of special observations.	5/3/2019
	The special observation note written by the nurse describes the patient as agitated, angry, and pacing. The special observation sheet documented by the MHA for that same period of time indicates the patient was pacing, the patient was offered the blue room and there were no observed behaviors of concern such as assaults, posturing, aggressive statements, ingestion and/or insertion.	
	The MD orders allowed for the use of the headphones, therefore no additional instructions were given.	
	The following recommendations were based on the CIR: • more specific documentation of patient room searches and follow-up actions. • 30 minute rotation of special observation for the index unit. • 60 minute rotation of special observation on all other units. • staff assigned to observe the index patient remain standing at all times.	5/3/2019
	All other patients in the hospital with a history of ingestion/insertion were reviewed and 100% of those patients had behavioral guidelines in place.	5/3/2019
	Memos were sent to all Nursing staff informing them of the changes related to the rotation of assignment for Special Observation. Staff was educated to the change in practice as they came on duty beginning on third shift that same day.	5/3/2019
	A memo was distributed reinforcing the need to write a progress note specifying the results and follow up actions when a room search is conducted. Staff was educated as they came on duty beginning on third shift that same day. As of 6/25/19, 96% of staff was educated.	5/3/2019
	Education compliance rates for the Special Observation assignment rotation changes and the documentation of room searches are monitored weekly in Operations Council and reported out monthly in Governing Body.	5/8/2019
	The facility initiated a multidisciplinary Special Observation Task Force (SOTF) to ensure that the patients on special observation remain safe while receiving maximum therapeutic benefit through interactions with the staff. The task force is led by the Chief Operating Officer and facilitated by the Chief Quality Officer with the participation of the Chief of Professional Services. It also includes representation from	

	Medical Staff, Nurses, Mental Health Assistants (MHA), and psychology.	5/14/2019
	Accountability Rounds are conducted by the Charge Nurse and Nursing Supervisor to ensure that the Special Observations are properly implemented to include: • the assignment of 30 minute rotations on the unit where the index patient resided • the assignment of 60 minute rotations on all other units • the staff assigned to observe the index patient remain standing at all times. Any detected variation of practice is addressed immediately.	5/4/2019
	The following performance activities were implemented to monitor compliance:	
	Accountability Rounds forms are audited daily by the Director of Nursing. As of 6/25/2019, the audit data reflects 100% compliance.	5/4/2019
	Results of the Accountability Rounds will be reviewed in Nursing Executive Committee on a monthly basis.	5/23/2019
	The analysis is then presented monthly to Governing Body on an on-going basis or until the hospital determines that compliance has been maintained.	5/28/2019
	<u>Responsibility for Oversight</u> Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A144-2a	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following corrective actions.	
	LPN #2 was immediately removed from patient care on 6/15/2019.	6/15/2019
	The employee received reeducation and competency was	

	confirmed via: • Code of Conduct Training • Reeducation on the procedural expectations for special observations and Immediate Response after attempt of Self Injury • Special Observation competency was confirmed through direct observation.	6/15/2019 6/16/2019 6/17/2019
	The COO released an educational memo to all nursing staff, *RN Supervision of Special Observation*, clarifying the Head/Charge nurse is responsible for the supervision and the delivery of special observation. In addition, the shift report has been enhanced to include the procedural expectations of special observation and the expected immediate staff response if a patient attempts to self-injure.	6/14/2019
	The *CVH Cross Shift Report Sheet* was modified to include procedural expectations of special observation and the expected immediate staff response.	6/28/2019
	Additionally, clinical managers are performing On Site Leadership Reviews of special observations every shift. Managers are expected to: • Observe the delivery of the special observation. • Review the requirement to visualize a patient's hands, neck and face. • Immediately address any variation of practice consistent with facility procedure including the immediate removal and re-education of the staff involved. • Every shift a written report of the aggregate results from the On Site Leadership Review of Special Observation form will be shared with division and hospital executive leadership including all actions taken to address observed violations.	6/14/2019
	A Community Meeting was conducted on all inpatient units to review special observation safety precautions. Patients were reminded of staffs need to see hands, neck and face at all times.	6/15/2019
	The Behavioral Guidelines/Plans for all patients' on Special Observation for ingestion and self-injury were reviewed by the unit psychologist to ensure that the clinical interventions matched assessed patient needs.	6/17/2019
	The following performance activities were implemented to monitor compliance: • Results of On Site Leadership Review of Special Observation will be aggregated monthly by the Quality Department for presentation at Nurse Executive Committee.	

	Cumulative performance data will be presented monthly to Nursing Executive Committee, who will be responsible for identifying trends and implementing the necessary corrective actions. NEC will prepare and present a compliance monitoring summary report to Governing Body on an quarterly basis or until the hospital determines that compliance has been maintained at or above 90%. • The *CVH Cross Shift Report Sheet(s)* are reviewed daily by the DoN. Any deficiencies identified are addressed immediately through the supervision process. The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC). NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions. NEC will provide a monthly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. • Unit psychologist will review Behavioral Guidelines/Plans monthly to ensure that the plans; address the steps to prevent behaviors of concern, immediate response if someone attempts the behavior of concern, and that the guideline/plan is incorporated into the patient's treatment plan. The Director of Psychology will identify trends and implement the necessary corrective actions. The Director of Psychology will provide a monthly summary report to the Clinical Management Committee (CMC). CMC will provide a quarterly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief Nurse Executive	6/26/2019

Tag	Plan of Correction	Completion Date
A144-2b	In response to the finding that the facility failed to ensure patients	

	were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following corrective actions. A suicide assessment for Patient #24 was completed and documented on June 9, 2019. The Chief of Professional Services (COPS) reviewed all patients on Special Observations with the On-call Physician. The physician was re-educated by the Service Medical Director. The Chief of Professional Services issued a memo to the physicians reinforcing the requirements of Operational Procedure 2.8 Evaluating and Managing Suicide Risk. The UR/UM nurse will complete a weekly audit of 100% of the Reassessment of Suicide Risk (CVH-632) to assure proper completion of the re-assessment. UR/UM will provide a monthly report to the Clinical Management Committee (CMC). CMC will provide a quarterly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief of Professional Services	6/9/2019 6/15/2019 6/25/2019 6/25/2019

Tag	Plan of Correction	Completion Date
A144-2c	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following corrective actions. The patient was on 15 minute checks when he/she obtained the staple. He/she was on constant observation at the time they	

	presented the staple. Patient made no attempt to self-injure. The Behavioral Guidelines/Plans for all patients' on Special Observation for ingestion and self-injury were reviewed by the unit psychologist to ensure that the clinical interventions matched assessed patient needs. Unit psychologist will review Behavioral Guidelines/Plans monthly to ensure that the plans; address the steps to prevent behaviors of concern, immediate response if someone attempts the behavior of concern, and that the guideline/plan is incorporated into the patient's treatment plan. The Director of Psychology will identify trends and implement the necessary corrective actions. The Director of Psychology will provide a monthly summary report to the Clinical Management Committee (CMC). CMC will provide a quarterly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief Operating Officer	6/17/2019

Tag	Plan of Correction	Completion Date
A144-3	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following corrective actions. MHA #14 was immediately removed from patient care. The employee received reeducation and competency was confirmed via: • Code of Conduct Training • Reeducation on the procedural expectations for special observations and Immediate Response after attempt of Self Injury	6/15/2019 6/15/2019 6/16/2019

	• Special Observation competency was confirmed through direct observation.	6/17/2019
	The COO released an educational memo to all nursing staff, *RN Supervision of Special Observation*, clarifying the Head/Charge nurse is responsible for the supervision and the delivery of special observation. In addition, the shift report has been enhanced to include; the procedural expectations of special observation and the expected immediate staff response if a patient attempts to self-injure.	6/14/2019
	The *CVH Cross Shift Report Sheet* was modified to include procedural expectations of special observation and the expected immediate staff response.	6/28/2019
	Additionally, clinical managers are performing On Site Leadership Reviews of special observations every shift. Managers are expected to: • Observe the delivery of the special observation, • Review the requirement to visualize a patient's hands, neck and face. • Immediately address any variation of practice consistent with facility procedure including the immediate removal and re-education of the staff involved. • Every shift a written report of the aggregate results from the On Site Leadership Review of Special Observation form will be shared with division and hospital executive leadership including all actions taken to address observed violations.	6/14/2019
	A Community Meeting was conducted on all inpatient units to review special observation safety precautions. Patients were reminded of staffs need to see hands, neck and face at all times.	6/14/2019
	The Chief of Professional Services (COPS) reviewed all patients on Special Observations with the On-call Physician.	6/15/2019
	The Behavioral Guidelines/Plans for all patients' on Special Observation for ingestion and self-injury were reviewed by the unit psychologist to ensure that the clinical interventions matched assessed patient needs.	6/17/2019
	The following performance activities were implemented to monitor compliance. • Results of On Site Leadership Review of Special Observation will be aggregated weekly by the Quality Department for presentation at Nurse Executive Committee. Cumulative performance data will be presented weekly to	

	Nursing Executive Committee, who will be responsible for identifying trends and implementing the necessary corrective actions. NEC will prepare and present a compliance monitoring summary report to Governing Body on an on-going basis or until the hospital determines that compliance has been maintained at or above 90%. • The *CVH Cross Shift Report Sheet(s)* are reviewed daily by the DoN, Any deficiencies identified are addressed immediately through the supervision process. The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC). NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions. NEC will provide a monthly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. • Unit psychologist will review Behavioral Guidelines/Plans monthly to ensure that the plans; address the steps to prevent behaviors of concern, immediate response if someone attempts the behavior of concern, and that the guideline/plan is incorporated into the patient's treatment plan. The Director of Psychology will identify trends and implement the necessary corrective actions. The Director of Psychology will provide a monthly summary report to the Clinical Management Committee (CMC). CMC will provide a quarterly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief Nurse Executive	6/26/2019

Tag	Plan of Correction	Completion Date
A144-4	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety	

	and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following corrective actions.	6/15/2019
	MHA #13 was immediately removed from patient care and re-educated that he/she will ensure there is a clock upon taking over a constant observation.	6/15/2019
	The employee received reeducation and competency was confirmed via: • Code of Conduct Training • Reeducation on the procedural expectations for special observations and Immediate Response after attempt of Self Injury • Special Observation competency was confirmed through direct observation.	6/16/2019 6/17/2019 6/15/2019
	In response to staffs expressed need for clock access to support timely documentation clocks were purchased and attached to all folders deployed for special observation related documentation.	
	The COO released an educational memo to all nursing staff, *RN Supervision of Special Observation*, clarifying the Head/Charge nurse responsibility for the supervision and the delivery of special observation. In addition, the shift report has been enhanced to include; the procedural expectations of special observation and the expected immediate staff response if a patient attempts to self-injure.	6/14/19
	The *CVH Cross Shift Report Sheet* was modified to include procedural expectations of special observation and the expected immediate staff response.	
	Additionally, clinical managers are performing On Site Leadership Reviews of special observations every shift. Managers are expected to: • Observe the delivery of the special observation, • Review the requirement to visualize a patient's hands, neck and face. • Immediately address any variation of practice consistent with facility procedure including the immediate removal and re-education of the staff involved. • Every shift a written report of the aggregate results from the On Site Leadership Review of Special Observation form will be shared with division and hospital executive leadership including all actions taken to address observed violations.	6/14/2019

	The following performance activities were implemented to monitor compliance: • Results of On Site Leadership Review of Special Observation will be aggregated weekly by the Quality Department for presentation at Nurse Executive Committee. Cumulative performance data will be presented monthly to Nursing Executive Committee, who will be responsible for identifying trends and implementing the necessary corrective actions. NEC will prepare and present a compliance monitoring summary report to Governing Body quarterly until the hospital determines that compliance has been maintained at or above 90%. • The *CVH Cross Shift Report Sheet(s)* are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process. The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC). NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions. NEC will provide a monthly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief Nurse Executive	6/26/2019

Tag	Plan of Correction	Completion Date
A144-5	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting	

	in immediate jeopardy, the hospital implemented the following corrective actions. The MD assessed patient #27 on 5/16/2019 and placed patient on level 1 (30 minute checks). On 5/18/2019, the patient reportedly ingested a pebble taken from the courtyard. Patient # 27 was assessed by MD and RN, place on constant observation, jumpsuit ordered and a room search was conducted. A Focused Treatment Plan Review was completed addressing the ingestion of a pebble. The Chief of Professional Services (COPS) reviewed all patients on Special Observations with the On-call Physician. The Behavioral Guidelines/Plans for all patients' on Special Observation for ingestion and self-injury were reviewed by the unit psychologist to ensure that the clinical interventions matched assessed patient needs. Unit psychologist will review Behavioral Guidelines/Plans monthly to ensure that the plans; address the steps to prevent behaviors of concern, immediate response if someone attempts the behavior of concern, and that the guideline/plan is incorporated into the patient's treatment plan. The Director of Psychology will identify trends and implement the necessary corrective actions. The Director of Psychology will provide a monthly summary report to the Clinical Management Committee (CMC. CMC will provide a quarterly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief Operating Officer	5/20/2019 6/15/2019 6/17/2019

Tag	Plan of Correction	Completion Date
A144-6	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following	

	corrective actions. While on continuous observation, Patient #26 bolted away from staff in an attempt to self-injure. The staff providing the CO intervened appropriately per Collaborative Safety Strategies training by using verbal redirection, calling for assistance, and attempting to limit the self-injury. Patient #26 was immediately transported to an acute care hospital for treatment of the lacerations. The Chief of Professional Services (COPS) reviewed all patients on Special Observations with the On-call Physician. The Behavioral Guidelines/Plans for all patients' on Special Observation for ingestion and self-injury were reviewed by the unit psychologist to ensure that the clinical interventions matched assessed patient needs. Unit psychologist will review Behavioral Guidelines/Plans monthly to ensure that the plans; address the steps to prevent behaviors of concern, immediate response if someone attempts the behavior of concern, and that the guideline/plan is incorporated into the patient's treatment plan. The Director of Psychology will identify trends and implement the necessary corrective actions. The Director of Psychology will provide a monthly summary report to the Clinical Management Committee (CMC). CMC will provide a quarterly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief Operating Officer	6/7/2019 6/15/2019 6/17/2019

Tag	Plan of Correction	Completion Date
A144-7	In response to the finding that the facility failed to ensure patients were supervised and/or continuous observation was maintained and/or failed to follow physician orders to maintain patient safety and/or failed to ensure that a complete assessment was conducted and and/or failed to ensure that Patient# 27 did not have access to potentially harmful objects and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy, the hospital implemented the following corrective actions.	

	MHA was immediately removed from patient care and re-educated that he/she will ensure there is a safety alarm upon taking over a constant observation.	6/15/2019
	The employee received reeducation and competency was confirmed via: • Code of Conduct Training • Reeducation on the procedural expectations for special observations and Immediate Response after attempt of Self Injury • Special Observation competency was confirmed through direct observation.	6/15/2019 6/16/2019 6/17/2019
	The COO released an educational memo to all nursing staff, *RN Supervision of Special Observation*, clarifying the Head/Charge nurse responsibility for the supervision and the delivery of special observation. In addition, the shift report has been enhanced to include; the procedural expectations of special observation and the expected immediate staff response if a patient attempts to self-injure.	6/14/2019
	The *CVH Cross Shift Report Sheet* was modified to include procedural expectations of special observation and the expected immediate staff response.	
	Additionally, clinical managers are performing On Site Leadership Reviews of special observations every shift. Managers are expected to: • Observe the delivery of the special observation, • Review the requirement to visualize a patient's hands, neck and face. • Immediately address any variation of practice consistent with facility procedure including the immediate removal and re-education of the staff involved. • Every shift a written report of the aggregate results from the On Site Leadership Review of Special Observation form will be shared with division and hospital executive leadership including all actions taken to address observed violations.	6/14/2019
	In response to staffs expressed need for clock access to support timely documentation clocks were purchased and attached to all folders deployed for special observation related documentation.	6/15/2019
	The following performance activities were implemented to monitor compliance: • Results of On Site Leadership Review of Special Observation will be aggregated weekly by the Quality Department for	

	presentation at Nurse Executive Committee. Cumulative performance data will be presented weekly to Nursing Executive Committee, who will be responsible for identifying trends and implementing the necessary corrective actions. NEC will prepare and present a compliance monitoring summary report to Governing Body on an on-going basis or until the hospital determines that compliance has been maintained at or above 90%. • The *CVH Cross Shift Report Sheet(s)* are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process. The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC). NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions. 7/25/2019 NEC will provide a monthly summary report to Governing Body on an ongoing basis or until the hospital determines that compliance has been maintained at or above 90%. <u>Responsibility for Oversight</u> Chief Nurse Executive	6/26/2019