STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
CONNECTICUT VALLEY HOSPITAL

POC Approved 5/13/19 SHN

Connecticut Valley Hospital
1000 Silver Street
Middletown, CT 06457

May 10, 2019

CMS, Boston Regional Office
Division of Survey and Certification
JFK Federal Building, Room 2325
Boston, MA 02203

Re: CMS Certification Number: 074003
Survey ID: 1XTE11
Complaint Survey on April 12, 2019

Dear Dr. Reinertsen,

Attached please find Connecticut Valley Hospital's Plan of Correction in response to the April 12, 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 me at 860-262-6110 or Timothy Denier at 860-262-5996.

Sincerely Yours,

Helene M. Vartelas

Helene M. Vartelas, MSN, RN
Chief Executive Officer

HMV/sp
Attachments- Form CMS-2567 attached response

cc: Miriam E. Delphin-Rittmon, Ph.D., Commissioner, DMHAS
Barbara Bugella, MSN, Assistant to the Commissioner, DMHAS
Susan Newton, RN, Health Systems Regulation, Department of Public Health

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 04/12/2019

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A 000	INITIAL COMMENTS Two authorized substantial allegation surveys concluded on 4/12/19 at Connecticut Valley Hospital in response to CT 24871 and CT 25200. In addition, CT 25121 was reviewed in the same time frame as the hospital was under State jurisdiction when the complaint was received. For CT 25200: The Condition of Participation for Patient Rights was reviewed and was identified as not met. Immediate Jeopardy was identified under Patient Rights on 4/12/19. An onsite visit conducted on 4/12/19 verified that Immediate Jeopardy was corrected as of 4/4/19 when the hospital began educating staff regarding continuous observation (CO) and random nursing audits began to ensure staff were following the CO policy. For CT24871: The Condition of Participation for Nursing Services was reviewed. A standard level deficiency was identified. For CT25121: Standard level deficiencies were noted within the Condition of Participation for Nursing Services. Connecticut Valley Hospital Silver Street Middletown, CT 06457	A 000	See Attached Helene Vartelas, MSN, RN, CEO 5/10/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Helene M. Vartelas MSN, RN, CS | TITLE: CEO | (X6) DATE: 5/10/19

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.

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

Helene M. Vartelas MSN, R.N. C.S. | CEO | 5/10/19

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A 000	Continued From page 1 The total census is 349	A 000	See Attached 5/13/2019	
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 has not been met. A. Based on clinical record review, observations, interviews with staff, review of hospital documentation and policy review for 2 of 2 patients (Patient #11 and Patient #17) reviewed for self-harm and neglect, the hospital failed to: 1. Failed to ensure that the patient was free from neglect by failing to ensure the patient received care in a safe setting when staff failed to maintain continuous observations; 2. Failed to adequately supervise the patient; and 3. Failed to ensure the patient was free from neglect for failing to ensure the environment was free of hazards to avoid physical harm of the patient resulting in immediate jeopardy.	A 115	4/15/2019	
A 144	Please refer to A144, A145 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,	A 144	4/15/2019	

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A 144	Continued From page 2 review of hospital policy, review of hospital documentation and staff interview for 2 of 2 sampled patients (Patient #11 and #17) reviewed for self-harm behaviors, the facility failed to ensure the patient was supervised and/or continuous observation was maintained and/or failed to ensure the environment was free of hazards which resulted in harm of the patient resulting in immediate jeopardy. The findings include: 1. Patient # 17 was admitted to facility on 2/6/19. Review of the hospital discharge summary dated 2/6/19 identified the patient was admitted to the emergency department (ED) for acts of self-harm. The report identified the patient ingested a nail, part of a razor, top of a beer can and while waiting to be evaluated the patient inserted a piece of plastic fork into the genital area. The summary further identified that the patient had suicidal ideation. Review of the nursing admission assessment dated 2/6/19 identified recently the patient had thoughts of self-harm and/or self-mutilating behaviors. Review of the medical history dated 2/6/19 identified schizophrenia, history of bipolar disorder, anti-social disorder 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	A 144		

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A 144	Continued From page 3 and stabilize psychiatric symptoms by improving medication adherence and active involvement in treatment. Review of the Treatment plan dated 2/16/19 identified a history of self-harm behaviors and PICA. Interventions included medications as ordered, stress management groups, coping skills, rapport building, and tools to recognize and cope with anxiety. Review of nursing notes, social service notes and physician notes dated from time of admission (2/6/19) thru 3/23/19 identified the patient as medication compliant, a level 4 (unsupervised buildings and ground, meaning any psychiatric conditions present are considered either resolved or sufficiently stabilized that staff supervision is not always required) and attending groups and therapies. a. Review of incident report dated 3/24/19 at 11:50AM identified the patient reported he/she inserted a pen in the urethra and swallowed a paper clip. The physician was notified and assessed the patient and the patient was transferred to the ED for evaluation. The report further identified the patient had an increase in self-harming behaviors and that staff was to ensure they are viewing the resident from the front at all times, and a room search to be completed. Nurse's notes dated 3/24/19 at 11:50AM identified patient requested to speak to writer and the patient reported that he/she inserted a pen into the urethra and swallowed a paper clip. The note further identified that the pen was visible in the urethra area, the patient was assessed by the	A 144		

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A 144	Continued From page 4 physician and was transferred to the hospital. A Psychiatry note dated 3/24/19 at 12:10PM identified that he/she was asked to see the patient after the patient inserted a foreign object (pen) into the urethra area and swallowing a paper clip. The note identified after a phone call, the patient was upset and became involved in self-injurious behaviors and was transported to the ED. Review of the hospital ED report dated 3/24/19 identified the patient arrived complaining about a pen that was inserted into the urethra and a paper clip the patient swallowed. The report identified a pen was palpated at the base of the penis and scrotum and a chest x-ray confirmed an uncoiled paper clip in the stomach. The report further identified the patient was taken to the operating room for removal of the foreign objects. Nurse's notes dated 3/24/19 at 9:40PM identified the patient returned from the hospital, the physician was notified and the patient was placed on continuous observation status. Review of facility policy for Continuous Observation identified the patient requires ongoing monitoring to ensure his/her safety and/or safety of others. The nursing staff assigned provides that by maintaining unimpeded access and visualization of the patient at a distance determined by the level of risk and clinical need. Interview with the Program Director on 4/4/19 at 2:30PM stated that when a patient is on continuous observation the staff are to have an unobstructed view at all times and they must be able to see the patients hands, neck and face at	A 144		

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A 144	Continued From page 5 all times. Special observation orders dated 3/25/19 at 11AM directed to maintain the patient on continuous observation status for 24 hours. b. Review of incident report dated 3/25/19 at 10:30PM identified that the patient reported that when he/she went to take medications at 8AM, he/she grabbed a pen from the medication room door when the nurse wasn't looking. The report noted that when the patient needed to use the bathroom he/she inserted the pen into the urethra while the staff person performing the continuous observation was outside the bathroom stall. The MD was made aware and the patient was assessed and complained of pain and being unable to urinate. The patient was transferred to the ED for an evaluation. The Mental Health Associate (MHA) failed to maintain visual contact with the patient's hands, face, and neck at all times in accordance with hospital policy. Physician progress note dated 3/25/19 at 11:15PM noted assessed patient after patient stated that he/she inserted a pen into the urethra around noon because he/she was upset over a conversation. The note further identified that the patient was complaining of pain in the urethra and was unable to urinate. The note identified the patient was transferred to the ED for an evaluation. Nurse's notes dated 3/25/19 at 11:30PM identified the patient was maintained on CO (continuous observation) this shift for protection of self. The note identified at 10:30PM the patient reported that he/she inserted a pen into the urethra. The note further identified that the patient reported that he/she took the pen during the morning medication pass when the nurse turned her back	A 144		

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A 144	Continued From page 6 and inserted the pen while in the bathroom after he/she asked the MHA for privacy. The note further identified that he/she had been trying to remove the pen but was unable to and could not take the pain anymore. The physician was made aware of the event, the patient was assessed and sent to the ED for an evaluation. The Mental Health Associate (MHA) failed to maintain visual contact with the patient's hands, face, and neck at all times in accordance with hospital policy. Review of the hospital report dated 3/26/19 identified patient admitted to the ED after inserting a pen into the urethra, having difficulty urinating, is in severe pain and blood was noted at the tip of the meatus. The note identified that upon examination the patient appeared to be uncomfortable and having 400cc of urine in his/her bladder. The note further identified that the patient went to the operating room and had a cystoscopy and endoscopy with foreign body removal. Nurse's notes dated 3/26/19 at 6:35AM identified patient returned from hospital at 3:50AM and was on continuous observation related to protection of self. Interview on 4/9/19 at 9:50AM with MHA #5 who was assigned to care for the resident stated that she was assigned to do continuous observation on Patient # 17. MHA #5 stated that about 11:40M she assisted the patient to the bathroom and while the patient was urinating, she stood behind the patient and could not see the patient's hands. MHA# 5 stated that she did receive report from the nurse and was told not to leave the patient alone and to watch the patients hands at all times. MHA # 5 stated that she observed the patient as best as she could but the bathroom stalls are small and she could not fit in	A 144		

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A 144	Continued From page 7 the stall with the patient. MHA #5 failed to maintain continuous observation of the patient's hands, face and neck at all times in accordance with hospital policy. c. Review of incident report dated 3/26/19 at 11:31AM identified that the patient was on continuous observation and the patient reported that he/she inserted a pen into the urethra around 11:30AM. The report noted that the bathroom door was half open and staff had full sight of patient and saw the patient adjust self but did not think anything of it. Physician progress note dated 3/26/19 at 1:30PM identified the patient reported inserting a pen into the urethra when he/she went to the bathroom at 11:30AM. The patient was examined and the physician was able to palpate something at the base of the penis and the patient complained of pain and inability to urinate. The note further identified the patient stated he/she was inserting pens into his/her urethra out of anger and frustration. The patient was transferred to the ED for an evaluation. Nurse's notes dated 3/26/19 at 2:30PM identified that the patient remained on continuous observation for protection of self. The note identified the patient continued to make threats stating "I'm going back to the hospital", "I inserted a pen into my urethra and it hurts and I'm going back to the ED". Nurse's notes dated 3/26/19 at 3:30PM identified at approximately 3PM a unit search was conducted and 6 pens were found, 2 of the pens were found under the floor tile in the patient's room.	A 144		

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A 144	Continued From page 8 Review of the hospital discharge summary dated 3/26/19 identified the patient presented with foreign body in urethra and was sent to the OR for a cystoscopy. Additionally, the patient was started on Keflex 500mg 3 times a day for 7 days. Special observation orders dated 3/26/19 at 5:53PM directed the patient was to be on a one to one with 2 staff members at all times to prevent insertion of objects into the urethra, room search every shift for items patient can ingest and/or insert. Patient to use large toilet stall, patient to sit facing staff, no privacy, when finished going to bathroom may wipe self after showing staff hands, and when in bed hands are to be visible at all times. Nurse's notes dated 3/26/19 at 9PM identified patient returned from ED, refused to wear sweatpants as ordered and was on a one to one with 2 staff members. Interview with RN # 5 on 4/5/19 at 1:40PM stated that on 3/26/19 she overheard Patient # 17 say "it was already done." RN # 5 stated she spoke to the patient and asked what's going on and the patient stated that he/she inserted a pen into his/her urethra. RN # 5 stated that she assessed the patient and saw a pen sticking out from the patient's urethra, notified the MD and transported the patient to the ED. RN # 5 stated that a unit and room search were completed and found 6 pens, 4 on the unit and 2 pens under the tile floor in the patient's room. RN # 5 stated that she spoke to the MHA's prior to doing the CO and instructed them that the patients hands have to be visible at all times. RN # 5 further stated that during the investigation the MHA's reported that	A 144		

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A 144	Continued From page 9 while the patient was in the bathroom they stood behind the patient and his/her hands were not visible. Interview with MHA # 6 on 4/5/19 at 2:50PM stated she was doing the continuous observation on 3/26/19 between 11:15AM and 12:15PM. MHA # 6 stated that she took the patient to the bathroom and the patient squatted over the toilet and his/her hands were positioned on the inner thighs. MHA # 6 stated that she was standing at the doorway and MHA # 7 was behind her. MHA # 6 stated that she did not know why she told the nurse something different when asked but couldn't remember exactly how the patient was or where she stood while the patient in the bathroom. Although MHA #6 identified that she was standing at the doorway while the patient was in the bathroom, she also reported to RN #5 that she stood behind the patient and the patient's hands were not visible. Interview with MHA # 7 on 4/5/19 at 3:05PM stated that she did the environmental check prior to the patient going into the bathroom and observed the patient sit on the toilet. MHA # 7 stated that the patient was not visible to her because the door was half closed and when she questioned MHA # 6 about having the door open to watch the patient, MHA # 6 stated that "the patient needed privacy and couldn't go to the bathroom in front of us". MHA # 7 further stated that she told the nurse what happened and that she would not cover for MHA # 6. MHA #6 and MHA # 7 failed to maintain continuous observation of the patient's hands, face and neck at all times in accordance with hospital policy. Special observation orders dated 3/27/19 at	A 144		

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A 144	Continued From page 10 10:55AM directed one to one with 2 male staff, patient to have hands visible at all times, patient to wear sweatpants and if refuses check pockets before goes into bathroom and CO, room searoh room every shift for items patient can ingest/insert, while in bathroom patient is to sit on the toilet facing staff, no privacy and may wipe self after showing hands are empty, when in bed hands visible at all times and continue finger foods. Additionally at 2:40PM the order was updated to include when the patient was in blue room, one staff is to be at arm's length and one staff to sit in doorway, male staff only. Further review of the Special Observation orders from 3/27/19 through 3/30/19 at 11:30PM directed the orders continued as written. d. Review of incident report dated 3/31/19 at 8:10PM identified the nurse was called to evaluate the patient who was bleeding from the urethra. The note identified staff reported that the patient placed his/her hands in his/her pants for a moment and was immediately redirected by staff and when the patient's hands came out of his/her pants blood was observed on his/her hands and pants. The report stated that the patient identified placing a pen in the urethra. The area was assessed, pressure was applied to the site and the physician was notified and the patient was transferred to the ED. Physician progress noted dated 3/31/19 at 11:20PM identified patient inserted pen into the urethra and stated he/she got the pen from another patient who admitted to giving the patient the pen. Nursing notes dated 3/31/19 at 12:35AM identified patient reported he/she inserted a pen into the urethra area between 9:30PM-10:30PM while making a phone call. The patient was	A 144		

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A 144	Continued From page 11 assessed and the patient was trying to pull the pen out but was directed to stop and blood was noted in the patient's genital area. The physician was notified and the patient was transferred to the ED. Review of the hospital report dated 3/31/19 identified the patient presented after ingesting a cartridge of a pen and was spitting up blood and had inserted a pen into the urethra and was having pain. The patient was taken to the OR and a endoscopy and cystoscopy were performed with foreign body removal. Nurse's notes dated 3/31/19 at 10:15AM identified the patient returned from the ED, the unit and sleeping area were checked for any items. As a nursing intervention, the patient's bed was placed in the center of the room sp staff can be each side of the bed but the patient refused and pushed the bed against the wall. Special Observation orders dated 3/31/19 at 10:40AM directed the patient to be a two to one male staff to prevent insertion of objects into genital area, patient to have hands visible at all times. Patient to wear sweatpants, no underwear, if patient refuses, check pockets before the patient goes into bathroom and room search every shift for items the patient can ingest/insert. When the patient is in the bathroom use large toilet stall. Patient to sit facing staff when defecating or urinating, no privacy, patient may wipe self after showing hands are empty and hands to be visible at all times. Additional orders noted that patient is to eat away from peers and when in blue room one staff is to be at arm's length and the other to sit at doorway.	A 144		

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A 144	Continued From page 12 Interview with RN # 6 on 4/5/19 at 10:10AM stated that he was called to Patient # 17's room and upon entering the room saw the patient with blood on his/her hands and sweatpants. RN # 6 stated he assessed the patient and noted clood around the genital area and the physician was notified and the patient was transported to the ED. RN # 6 stated that they were not able to determine how the patient obtained a pen but identified that the patient had previously had an upsetting phone call and that when he/she was using the bathroom tried to close the stall door on staff. Interview with MHA # 8 on 4/8/19 at 3:05PM stated that he was doing CO with RN #7 and sitting an arm's length away from the patient when the patient put his/her hands down the pants and when he/she pulled his/her hands out, there was blood on his/her hands. MHA # 8 stated that the patient reported that he/she inserted it earlier and at that time was pushing the object in further. Interview with RN # 7 on 4/9/19 at 1:35PM stated he was providing CO and the patient was lying on the bed. RN # 7 stated that the patient had his/her fingers under the waistband of the pants and RN # 7 instructed the patient to take his/her hand out and when he/she finally did there was blood on his/her hand and at that time, he called the charge nurse. RN # 7 asked the patient how he/she obtained a pen and the patient would not divulge. MHA #8 and RN #7 failed to maintain continuous observation of the patient's hands, face and neck at all times in accordance with hospital policy which resulted in the patient being able to insert foreign objects into the urethra.	A 144		

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A 144	Continued From page 13 Observations on 4/4/19 at 9:45AM identified while entering B4 North unit Patient # 17 was observed in a observation room in front of the nursing station. The patient was noted standing on the side of the bed and 2 staff were observed seated in chairs on the other side of the bed with their heads down, not maintaining continuous observation. One staff member was observed holding a folder and the other staff had his hands folded on his lap and looking down. Observation with the Program Manager on 4/4/19 at 11:57 AM, Patient # 17 was observed noted standing at the bedside and 2 staff members were observed with their heads down not looking at the patient in accordance with the CO policy. Interview with the Program Director at that time stated that staff are to be looking at the patient's hands, face and neck at all times for safety. Interview with the Chief Nurse Executive on 4/5/19 at 9:30 AM stated that as of 4/4/19 on the second shift the hospital modified and/or implemented rounds to be completed by the charge nurse 4 times per shift at random times and 2 times by the RN Supervisor. The rounds are completed to ensure staff are adhering to hospital policy regarding observational status to ensure patient safety. The Chief Nursing Executive further stated that all staff are being re-educated on continuous observations prior to working their shift and all staff will receive report from the charge nurse at the start of their shift regarding specific patient needs. Nursing report, shift procedure, and accountability rounds were revised to ensure behavioral plans and guidelines and any MD orders for special observations are reviewed during each shift report. Interview with the Program Director of 4/5/19 at	A 144		

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A 144	Continued From page 14 2PM stated that as of 3/26/19, the hospital added a second staff member to do environmental rounds for Patient # 17, ensuring that staff would check the environment for hazards prior to the patient entering the area. The Program Director further stated that staff did not follow the hospital policy for CO regarding watching the patient's hands, face and neck at all times since he/she was able to obtain pens. Review of the clinical record with the Program Director on 4/5/19 at 2PM identified although there was on order for room searches every shift effective 3/26/19 at 4:20PM the clinical record noted the only documented room search was completed on 3/26/19 at 8PM. 2. Patient # 11's diagnoses included Paranoid Schizophrenia and self-harming behaviors. Review of the treatment plan dated 12/26/18 identified self-harming behaviors, interventions included RN to assess for warning signs of self-harming behaviors such as increased anxiety or agitation, assist with identifying situations that trigger self-harming thoughts/urges, and discuss positive coping skills. Physician orders dated 1/8/19 identified the patient as a Level 3 (does not constitute an imminent risk to self or others, not an elopement risk and has awareness of his/her circumstances of admission and has some working relationship with peers). a. Review of an incident report dated 1/14/19 at	A 144		

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A 144	Continued From page 15 12:45PM identified the patient reported that he/she inserted an earring into the genital area because the patient was upset. The report identified the physician was made aware and removed the earring from the patient. Additionally the report noted that the patient's jewelry was removed from the room. Physician orders dated 1/14/19 at 12:45PM directed to place patient on every 15 minute checks for unpredictable behaviors and room search to remove all jewelry items. Physician progress note dated 1/14/19 at 1:15PM identified the earring was extracted without pain or injury. Physician orders dated 1/21/19 at 1:45PM identified renew every 15 minute checks by 1 day and to be assessed by the treatment team. Physician orders dated 1/22/19 directed the patient to be a level 1 (Restricted to the unit, patient behaviors present management difficulties requiring close monitoring). Interview with MD #3 on 3/28/19 at 3:30 PM identified that the patient had unpredictable behaviors and needed to be supervised, which included 15 minute monitoring checks. Review of the annual treatment plan dated 1/23/19 identified self-harm. Nursing interventions included assess for warning signs of self-harming behaviors such as increased anxiety/agitation, help patient identify situations that trigger self-harming thoughts and discuss positive coping skills. Review of the treatment plan on 3/28/19 at 10:00	A 144		

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A 144	Continued From page 16 AM with the Chief of Patient Care Services identified although the treatment plan identified the behavior of placing an earring in the genital area, the treatment plan lacked documentation of new interventions regarding monitoring the patient to ensure he/she did not attempt it again. b. Review of an incident report dated 1/31/19 at 5:00 AM identified the patient reported inserting a sharp object in the genital area (screw from wheelchair). The report identified a genital exam was completed on the patient and 2 round sharp objects were removed. The patient admitted to also swallowing a metal disc from a necklace and inserting a third screw. Additionally, the report identified the patient was sent to the ED and 5 metal objects were found in the lower intestine. Review of nurse's notes dated 1/31/19 at 6:30AM identified that while staff was assisting the patient to the bathroom the patient identified that he/she inserted a sharp object (screw from wheelchair) into the genital area last evening during snack time because he/she thought they were being raped. The note further identified that a scant amount of blood was on the patient's brief and bed sheet and the nursing supervisor and MD were notified. Physician orders dated 1/31/19 at 8:25AM identified a level change to every 15 minute checks for safety and room search for contraband related to continuous self-destructive behaviors ie: inserting items in the genital orifice. Physician orders dated 1/31/19 3:50PM directed continuous observation all shifts for unpredictable behaviors/medical monitoring and room search	A 144		

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A 144	Continued From page 17 for harmful items. Review of the Focused treatment plan dated 2/1/19 identified the patient inserted and/or ingested foreign objects, was sent to the ED for an evaluation and when returned was placed on continuous observation. Review of special observation orders dated 2/1/19 through 2/5/19 identified continuous observations for unpredictable behaviors. Special observation orders dated 2/6/19 through 2/10/19 at 9:15AM identified continuous observation on 1st and 2nd shifts and every 15 minute checks on 3rd shift, and may not have small objects. Special observation orders dated between 2/10/19 and 3/25/19 identified special observation orders for a combination of continuous observation and every 15 minute checks due to the patient's unpredictable and fluctuating self-injurious/ self-destructive behaviors. Special instructions included: may not have small objects, fall risk, no personal belongings, and room search every shift. Review of the monthly psychiatry progress note dated 3/22/19 identified the patients psychiatric condition continues to fluctuate. Remains disorganized, paranoid, impulsive and unpredictable. Special observation orders dated 3/26/19 through 3/27/19 at 4PM identified continuous observation on 2nd shift, every 15 minute checks 1st and 3rd shifts, room search every shift and no personal belongings.	A 144		

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A 144	Continued From page 18 c. Review of an Incident Report dated 3/27/19 identified that at 2:55PM the patient reported he/she attempted self-harm by inserting tin foil into the urethra. The report further identified the patient was seen by the MD and the tin foil was removed and the patient was placed on continuous observation on all shifts. A Social Service note dated 3/27/19 at 3:46PM identified that while speaking with the patient, the patient was weepy and had a disorganized thought process. The note further identified that the patient reported that he/she inserted tin foil into the genital area in an act to harm self. Review of a medical progress note dated 3/27/19 at 3:30PM identified asked to see patient after admitting to placing a piece of foil (from a pudding cup) up in the urethra. The patient was assessed and noted to have a folded piece of foil in the urethra that was easily removed and no trauma was identified in the area. The note further identified the patient was placed on continuous observation. Special observation orders dated 3/27/19 at 4PM directed constant observation all shifts for self-injurious behaviors, room search every shift and no personal possessions. Interview with MD # 2 on 3/27/19 at 4:15PM identified that the patient had a history of ingesting and/or inserting items in the urethra. MD # 2 stated that it usually occurs when the patient is upset over something. MD # 2 stated that the patient was just taken off continuous observation and placed on every fifteen minute checks on the day shift the previous day. MD #2 stated that although the patient's checks were	A 144		

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A 144	Continued From page 19 decreased from continuous observation to every fifteen minute checks on days, staff still need to supervise the patient and ensure the environment is free from objects/hazards that the patient could obtain. Interview with MD # 3 on 3/27/19 at 4:15PM stated that Patient # 11 had improved behaviors and had recent medication adjustments. MD # 3 stated that although the patient was changed to every fifteen minute checks he/she still required monitoring and supervision due to the unpredictable behaviors. Interview with LPN # 1 on 3/27/19 at 4:30PM stated that she was aware of Patient # 11's history of swallowing and inserting foreign objects into him/her and not allowing the patient to have small objects. LPN # 1 stated that staff do not open food items for patients. LPN # 1 did not respond when asked why she would leave foreign objects/items and/or small objects with the patient who has a history of eating non edible items and/or inserting items in the urethra. Interview with the Program Director on 3/27/19 at 4:40PM stated that staff should not have left the (food) wrappers with the patient due to the patient's history and several orders of the patient not being able to have small objects. The Program Director further stated that staff are made aware from the nurse when receiving report of what a patient's status is while on CO. The hospital failed to ensure adequate supervision for Patient #11 who had fluctuating self-injurious/ self-destructive behaviors to prevent self-injurious behaviors. In addition, staff failed to ensure that small objects such a food	A 144		

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A 144	Continued From page 20 wrappers were removed from the patient's surroundings. Immediate Jeopardy was identified under Patient Rights on 4/12/19. An onsite visit conducted on 4/12/19 verified that Immediate Jeopardy was corrected as of 4/4/19 when the hospital began educating staff regarding continuous observation (CO) and random nursing audits began to ensure staff were following the CO policy.	A 144		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. 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 1 of 2 sampled patients (Patient #17) reviewed for neglect, the facility failed to ensure the patient was free from neglect for failing to supervise and/or maintain continuous observation and/or failed to ensure the environment was free of hazards to avoid physical harm of the patient resulting in immediate jeopardy. The findings include: Patient # 17 was admitted to facility on 2/6/19. Review of the hospital discharge summary dated 2/6/19 identified the patient was admitted to the emergency department (ED) for acts of self-harm. The report identified the patient ingested a nail, part of a razor, top of a beer can and while waiting to be evaluated the patient inserted a piece of plastic fork into the genital	A 145	4/15/2019	

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A 145	Continued From page 21 area. The summary further identified that the patient had suicidal ideation. Review of the nursing admission assessment dated 2/6/19 identified recently the patient had thoughts of self-harm and/or self-mutilating behaviors. Review of the medical history dated 2/6/19 identified schizophrenia, history of bipolar disorder, anti-social disorder 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 Treatment plan dated 2/16/19 identified a history of self-harm behaviors and PICA. Interventions included medications as ordered, stress management groups, coping skills, rapport building, and tools to recognize and cope with anxiety. Review of nursing notes, social service notes and physician notes dated from time of admission (2/6/19) thru 3/23/19 identified the patient as medication compliant, a level 4 (unsupervised buildings and ground, meaning any psychiatric conditions present are considered either resolved or sufficiently stabilized that staff supervision is not always required) and attending groups and	A 145		

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A 145	Continued From page 22 therapies, a. Review of an incident report dated 3/24/19 at 11:50AM identified the patient reported he/she inserted a pen in the urethra and swallowed a paper clip. The physician was notified and assessed the patient and the patient was transferred to the ED for evaluation. The report further identified the patient had an increase in self-harming behaviors and that staff was to ensure they are viewing the resident from the front at all times, and a room search to be completed. Nurse's notes dated 3/24/19 at 11:50AM identified patient requested to speak to writer and the patient reported that he/she inserted a pen into the urethra and swallowed a paper clip. The note further identified that the pen was visible in the urethra area, the patient was assessed by the physician and was transferred to the hospital. A Psychiatry note dated 3/24/19 at 12:10PM identified that he/she was asked to see the patient after the patient inserted a foreign object (pen) into the urethra area and swallowing a paper clip. The note identified after a phone call, the patient was upset and became involved in self-injurious behaviors and was transported to the ED. Review of the hospital ED report dated 3/24/19 identified the patient arrived complaining about a pen that was inserted into the urethra and a paper clip the patient swallowed. The report identified a pen was palpated and a chest x-ray confirmed an uncoiled paper clip in the stomach. The report further identified the patient was taken to the operating room for removal of the foreign	A 145		

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A 145	Continued From page 23 objects. Nurse's notes dated 3/24/19 at 9:40PM identified the patient returned from the hospital, the physician was notified and the patient was placed on continuous observation status. Review of facility policy for Continuous Observation identified the patient requires ongoing monitoring to ensure his/her safety and/or safety of others. The nursing staff assigned provides that by maintaining unimpeded access and visualization of the patient at a distance determined by the level of risk and clinical need. Interview with the Program Director on 4/4/19 at 2:30PM stated that when a patient is on continuous observation the staff are to have an unobstructed view at all times and they must be able to see the patients hands, neck and face at all times. Special observation orders dated 3/25/19 at 11:00AM directed to maintain the patient on continuous observation status for 24 hours. b. Review of an incident report dated 3/25/19 at 10:30PM identified that the patient reported that when he/she went to take medications at 8:00AM, he/she grabbed a pen from the medication room door when the nurse wasn't looking. The report noted that when the patient needed to use the bathroom he/she inserted the pen into the urethra while the staff person performing the continuous observation was outside the bathroom stall. The MD was made aware and the patient was assessed and complained of pain and being unable to urinate. The patient was transferred to the ED for an evaluation. The Mental Health Associate (MHA) assigned to Patient #17 failed to ensure the environment was free of	A 145		

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A 145	Continued From page 24 environmental hazards to avoid physical harm of the patient and/or failed to maintain visual contact with the patient's hands, face, and neck at all times in accordance with hospital policy. Physician progress note dated 3/25/19 at 11:15PM noted assessed patient after patient stated that he/she inserted a pen into the urethra around noon because he/she was upset over a conversation. The note further identified that the patient was complaining of pain in the urethra and was unable to urinate. The note identified the patient was transferred to the ED for an evaluation. Nurse's notes dated 3/25/19 at 11:30PM identified the patient was maintained on CO (continuous observation) this shift for protection of self. The note identified at 10:30PM the patient reported that he/she inserted a pen into the urethra. The note further identified that the patient reported that he/she took the pen during the morning medication pass when the nurse turned her back and inserted the pen while in the bathroom after he/she asked the MHA for privacy. The note further identified that he/she had been trying to remove the pen but was unable to and could not take the pain anymore. The physician was made aware of the event, the patient was assessed and sent to the ED for an evaluation. The Mental Health Associate (MHA) failed to ensure the environment was free of environmental hazards to avoid physical harm of the patient and/or failed to maintain visual contact with the patient's hands, face, and neck at all times in accordance with hospital policy. Review of the hospital report dated 3/25/19 identified patient admitted to the ED after	A 145		

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A 145	Continued From page 25 Inserting a pen into the urethra, having difficulty urinating, is in severe pain and blood was noted. The note identified that upon examination the patient appeared to be uncomfortable and having 400cc of urine in his/her bladder. The note further identified that the patient went to the operating room and had a cystoscopy and endoscopy with foreign body removal. Nurse's notes dated 3/26/19 at 6:35AM identified the patient returned from the hospital at 3:50AM and was on continuous observation related to protection of self. Interview on 4/9/19 at 9:50AM with MHA #5 who was assigned to care for the resident stated that she was assigned to do continuous observation on Patient # 17. MHA #5 stated that about 11:40AM she assisted the patient to the bathroom and while the patient was urinating, she stood behind the patient and could not see the patient's hands. MHA# 5 stated that she did receive report from the nurse and was told not to leave the patient alone and to watch the patients hands at all times. MHA # 5 stated that she observed the patient as best as she could but the bathroom stalls are small and she could not fit in the stall with the patient. MHA #5 failed to ensure the environment was free of environmental hazards to avoid physical harm of the patient and/or failed to maintain visual contact with the patient's hands, face, and neck at all times in accordance with hospital policy. c. Review of incident report dated 3/25/19 at 11:31AM identified that the patient was on continuous observation and the patient reported that he/she inserted a pen into the urethra around	A 145		

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A 145	Continued From page 26 11:30AM. The report noted that the bathroom door was half open and staff had full sight of patient and saw the patient adjust self but did not think anything of it. Physician progress note dated 3/26/19 at 1:30PM identified the patient reported inserting a pen into the urethra when he/she went to the bathroom at 11:30AM. The patient was examined and the physician was able to palpate something and the patient complained of pain and inability to urinate. The note further identified the patient stated he/she was inserting pens into his/her urethra out of anger and frustration. The patient was transferred to the ED for an evaluation. Nurse's notes dated 3/26/19 at 2:30PM identified that the patient remained on continuous observation for protection of self. The note identified the patient continued to make threats stating "I'm going back to the hospital", "I inserted a pen into my urethra and it hurts and I'm going back to the ED". Nurse's notes dated 3/26/19 at 3:30PM identified at approximately 3:00PM a unit search was conducted and 6 pens were found, 2 of the pens were found under the floor tile in the patient's room. Review of the hospital discharge summary dated 3/26/19 identified the patient presented with foreign body in urethra and was sent to the OR for a cystoscopy. Additionally, the patient was started on Keflex 500mg 3 times a day for 7 days. Special observation orders dated 3/26/19 at 5:53PM directed the patient was to be on a one to one with 2 staff members at all times to prevent	A 145		

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A 145	Continued From page 27 insertion of objects into the urethra, room search every shift for items patient can ingest and/or insert. Patient to use large toilet stall, patient to sit facing staff, no privacy, when finished going to bathroom may wipe self after showing staff hands, and when in bed hands are to be visible at all times. Nurse's notes dated 3/26/19 at 9PM identified patient returned from ED, refused to wear sweatpants as ordered and was on a one to one with 2 staff members. Interview with RN # 5 on 4/5/19 at 1:40PM stated that on 3/26/19 she overheard Patient # 17 say "it was already done." RN # 5 stated she spoke to the patient and asked what's going on and the patient stated that he/she inserted a pen into his/her urethra. RN # 5 stated that she assessed the patient and saw a pen sticking out from the patient's urethra, notified the MD and transported the patient to the ED. RN # 5 stated that a unit and room search were completed and found 6 pens, 4 on the unit and 2 pens under the tile floor in the patient's room. RN # 5 stated that she spoke to the MHA's prior to doing the CO and instructed them that the patients hands have to be visible at all times. RN # 5 further stated that during the investigation the MHA's reported that while the patient was in the bathroom they stood behind the patient and his/her hands were not visible. Interview with MHA # 6 on 4/5/19 at 2:50PM stated she was doing the continuous observation on 3/26/19 between 11:15AM and 12:15PM. MHA # 6 stated that she took the patient to the bathroom and the patient squatted over the toilet and his/her hands were positioned on the inner	A 145		

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A 145	Continued From page 28 thighs. MHA # 6 stated that she was standing at the doorway and MHA # 7 was behind her. MHA # 6 stated that she did not know why she told the nurse something different when asked but couldn't remember exactly how the patient was or where she stood while the patient was in the bathroom. Although MHA #6 identified that she was standing at the doorway while the patient was in the bathroom, she also reported to RN #5 that she stood behind the patient and the patient's hands were not visible. Interview with MHA # 7 on 4/5/19 at 3:05PM stated that she did the environmental check prior to the patient going into the bathroom and observed the patient sit on the toilet. MHA # 7 stated that the patient was not visible to her because the door was half closed and when she questioned MHA # 6 about having the door open to watch the patient, MHA # 6 stated that "the patient needed privacy and couldn't go to the bathroom in front of us", MHA # 7 further stated that she told the nurse what happened and that she would not cover for MHA # 6. MHA # 6 and MHA #7 failed to ensure the environment was free of environmental hazards to avoid physical harm of the patient and/or failed to maintain visual contact with the patient's hands, face, and neck at all times in accordance with hospital policy. Special observation orders dated 3/27/19 at 10:55AM directed one to one with 2 male staff, patient to have hands visible at all times, patient to wear sweatpants and if refuses check pockets before goes into bathroom and CO, room search room every shift for items patient can ingest/insert, while in bathroom patient is to sit on the toilet facing staff, no privacy and may wipe	A 145		

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A 145	Continued From page 29 self after showing hands are empty, when in bed hands visible at all times and continue finger foods. Additionally at 2:40PM the order was updated to include when the patient was in blue room, one staff is to be at arm's length and one staff to sit in doorway, male staff only. Further review of the Special Observation orders from 3/27/19 through 3/30/19 at 11:30PM directed the orders continued as written. d. Review of an incident report dated 3/31/19 at 8:10PM identified the nurse was called to evaluate the patient who was bleeding from the urethra. The note identified staff reported that the patient placed his/her hands in his/her pants for a moment and was immediately redirected by staff and when the patient's hands came out of his/her pants blood was observed on his/her hands and pants. The report stated that the patient identified placing a pen in the urethra. The area was assessed, pressure was applied to the site and the physician was notified and the patient was transferred to the ED. Physician progress noted dated 3/31/19 at 11:20PM identified patient inserted pen into the urethra and stated he/she got the pen from another patient who admitted to giving the patient the pen. Nursing notes dated 3/31/19 at 12:35AM identified patient reported he/she inserted a pen into the urethra area between 9:30PM-10:30PM while making a phone call. The patient was assessed and the patient was trying to pull the pen out but was directed to stop and blood was noted in the patient's genital area. The physician was notified and the patient was transferred to the ED.	A 145		

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A 145	Continued From page 30 Review of the hospital report dated 3/31/19 identified the patient presented after ingesting a cartridge of a pen and was spitting up blood and had inserted a pen into the urethra and was having pain. The patient was taken to the OR and a endoscopy and cystoscopy were performed with foreign body removal. Nurse's notes dated 3/31/19 at 10:15AM identified the patient returned from the ED and the unit and sleeping area were checked for any items. As a nursing intervention, the patient's bed was placed in the center of the room so staff could be on each side of the patient but the patient refused and pushed the bed against the wall. Special Observation orders dated 3/31/19 at 10:40AM directed the patient to be a two to one male staff to prevent insertion of objects into genital area, patient to have hands visible at all times. Patient to wear sweatpants, no underwear, If patient refuses to have pockets checked before patient goes into bathroom and room search every shift for items the patient can ingest/insert. When the patient is in the bathroom use large toilet stall. Patient to sit facing staff when defecating or urinating, no privacy, patient may wipe self after showing hands are empty and hands to be visible at all times. Additional orders noted that patient is to eat away from peers and when in blue room one staff is to be at arm's length and the other to sit at doorway. Interview with RN # 6 on 4/5/19 at 10:10AM stated that he was called to Patient # 17's room and upon entering the room saw the patient with blood on his/her hands and sweatpants. RN # 6 stated he assessed the patient and noted blood	A 145		

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A 145	Continued From page 31 around the genital area and the physician was notified and the patient was transported to the ED. RN # 6 stated that they were not able to determine how the patient obtained a pen but identified that the patient had previously had an upsetting phone call and that when he/she was using the bathroom tried to close the stall door on staff. Interview with MHA # 8 on 4/8/19 at 3:05PM stated that he was doing CO with RN #7 and sitting an arm's length away from the patient when the patient put his/her hands down the pants and when he/she pulled his/her hands out, there was blood on his/her hands. MHA # 8 stated that the patient reported that he/she inserted it earlier and at that time was pushing the object in further. Interview with RN # 7 on 4/9/19 at 1:35PM stated he was providing CO and the patient was lying on the bed. RN # 7 stated that the patient had his/her fingers under the waistband of the pants and RN # 7 instructed the patient to take his/her hand out and when he/she finally did there was blood on his/her hand and at that time, he called the charge nurse. RN # 7 asked the patient how he/she obtained a pen and the patient would not divulge. MHA #8 and RN #7 failed to ensure the environment was free of environmental hazards to avoid physical harm by being able to insert foreign objects into the urethra and/or failed to maintain visual contact with the patient's hands, face, and neck at all times in accordance with hospital policy. Observations on 4/4/19 at 9:45AM identified while entering Battell 4 North unit, Patient # 17 was observed in an observation room in front of the	A 145		

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A 145	Continued From page 32 nursing station. The patient was noted standing on the side of the bed and 2 staff were observed seated in chairs on the other side of the bed with their heads down, not maintaining continuous observation. One staff member was observed holding a folder and the other stafff had his hands folded on his lap and looking down. Observation with the Program Manager on 4/4/19 at 11:57 AM, identified Patient # 17 was observed standing at the bedside and 2 staff members were observed with their heads down not looking at the patient in accordance with the CO policy. Interview with the Program Director at that time stated that staff are to be looking at the patient's hands, face and neck at all times for safety. Interview with the Program Director of 4/5/19 at 2PM stated that as of 3/26/19, the hospital added a second staff member to do environmental rounds for Patient # 17, ensuring that staff would check the environment for hazards prior to the patient entering the area. The Program Director further stated that staff did not follow the hospital policy for CO regarding watching the patient's hands, face and neck at all times since he/she was able to obtain pens. Review of the clinical record with the Program Director on 4/5/19 at 2PM identified although there was on order for room searches every shift effective 3/26/19 at 4:20PM the clinical record noted the only documented room search was completed on 3/26/19 at 8PM. Interview with the Chief Nurse Executive on 4/5/19 at 9:30 AM stated that as of 4/4/19 on the second shift the hospital modified and/or	A 145		

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A 145	Continued From page 33 implemented rounds to be completed by the charge nurse 4 times per shift at random times and 2 times by the RN Supervisor. The rounds are completed to ensure staff are adhering to hospital policy regarding observational status to ensure patient safety. The Chief Nursing Executive further stated that all staff are being re-educated on continuous observations and all staff will receive report from the charge nurse at the start of their shift regarding specific patient needs. Immediate Jeopardy was identified under Patient Rights on 4/12/19. An onsite visit conducted on 4/12/19 verified that Immediate Jeopardy was corrected as of 4/4/19 when the hospital began educating staff regarding continuous observation (CO) and random nursing audits began to ensure staff were following the CO policy.	A 145		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on clinical record reviews, review of facility documentation, observations, interviews and policy review 1 of 3 patients reviewed for positioning (Patient # 12), the facility failed to ensure the patient was positioned appropriately while out of bed and/or for 1 of 3 patients reviewed for personal grooming (Patient #1), the facility failed to ensure grooming was performed by the appropriate licensed professional and/or for 1 of 2 patients reviewed for self-harm behaviors (Patient #17), the facility failed to ensure the patient's room was searched as	A 395	5/13/2019	

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A 395	Continued From page 34 directed by the physician. The findings include: 1. Patient #12's diagnoses included Schizophrenia and Dementia. Observation on 3/27/19 at 3:55PM identified that Patient #12 was in his/her room, with the lights off, the door closed and the patients back was to the door. Patient #12 was observed to be reclined back in a Broda chair and his/her head suspended in the air without the benefit of a pillow behind it. Further observation noted the patient was slouched down in the chair. Interview with Chief of Patient Care services at that time stated that the patient should have a pillow or something for head support and needs to be pulled up in the chair. Subsequent to surveyor inquiry, the patient was repositioned in the Broda chair and a pillow was placed behind the residents head. 2. Patient #1 was admitted on 1/26/17 with diagnoses that included schizophrenia and personality disorder. A Nurse's Note dated 1/25/19 at 6:00 PM identified Patient #1's hair was cut by the day shift nurse. The Patient was assessed and no injury was identified. An Incident report dated 1/25/19 at 6:00 PM identified Patient #1's hair was cut by a Medication Nurse. A Physician's Progress Noted dated 1/25/19 at 7:30 PM identified that Patient #1 asked for a haircut due to the length of the hair A Physician's Orders dated 1/28/19 at 12:00 PM identified that the nurse was instructed to cut a	A 395		

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A 395	Continued From page 35 matt out of the patient's hair per the patients request on the afternoon of 1/15/18. Interview with RN#1 on 3/5/19 at 10:30 AM stated that RN#3 came to her regarding Patient #1's matted hair. RN#1 directed RN #3 to attempt to comb the patient's hair and/or wash it. RN#1 further stated that she did not assess the patient's hair nor did she know that the patient's hair was cut until the end of the shift. Interview with MD #1 on 3/6/19 at 11:00 AM stated that RN#3 came to him regarding Patient #1's matted hair and the patient's request for a haircut. He directed the RN to cut the patients hair, not knowing that it was against facility policy. Interview with RN#3 on 3/7/19 at 11:45 AM stated that Patient #1 came to him twice during his medication pass asking if there was anything that could be done with his/her hair. RN#3 stated Patient #1's hair was very matted on one side and reported this to the head nurse (RN#1). RN #3 stated he was directed to try and comb the patient's hair out and/or provide a shower to wash his/her hair. RN#3 stated he was unable to comb out the matted hair and when MD #1 came to the unit, MD #1 directed him to cut the patient's hair. RN #3 further stated that he was not aware of the facility's policy not allowing nurses to cut patient's hair. Review of the facility's policy for Basic Needs identified only licensed hairdressers are permitted to cut patient's hair. 3. Patient #17 was admitted to facility on 2/6/19. Review of the hospital discharge summary dated	A 395		

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	074003	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 395	Continued From page 36 2/6/19 identified the patient was admitted to the emergency department (ED) for acts of self-harm. The report identified the patient ingested a nail, part of a razor, top of a beer can and while waiting to be evaluated the patient inserted a piece of plastic fork into the genital area. The summary further identified that the patient had suicidal ideation. Review of the nursing admission assessment dated 2/6/19 identified recently the patient had thoughts of self-harm and/or self-mutilating behaviors. Review of the medical history dated 2/6/19 identified schizophrenia, history of bipolar disorder, anti-social disorder 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 Treatment plan dated 2/16/19 identified a history of self-harm behaviors and PICA. Interventions included medications as ordered, stress management groups, coping skills, rapport building, and tools to recognize and cope with anxiety. Physician orders dated 3/21/19 directed the patient to be a Level 4 with unescorted grounds	A 395		

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A 395	Continued From page 37 passes daily betewwn 9:00 AM and 10:00 AM, 1:00 PM to 2:00 PM and 6:00 PM to 7:00 PM. May go to groups, activities and food carts on grounds. a. Review of an incident report dated 3/24/19 at 11:50AM identified the patient reported he/she inserted a pen in the urethra and swallowed a paper clip. The physician was notified and assessed the patient and the patient was transferred to the ED for evaluation. The report further identified the patient had an increase in self-harming behaviors and that staff was to ensure they are viewing the resident from the front at all times, and a room search was to be completed. A nurse's note dated 3/24/19 at 11:50AM identified patient requested to speak to writer and the patient reported that he/she inserted a pen into the urethra and swallowed a paper clip. The note further identified that the pen was visible in the urethra area, the patient was assessed by the physician and was transferred to the hospital. A Psychiatry note dated 3/24/19 at 12:10PM identified that he/she was asked to see the patient after the patient inserted a foreign object (pen) into the urethra area and swallowing a paper clip. The note identified after a phone call, the patient was upset and became involved in self-injurious behaviors and was transported to the ED. A Physician's order dated 3/24/19 at 5:20PM directed room searches for contraband including pens and items that can be swallowed. Review of the hospital ED report dated 3/24/19	A 395		

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A 395	Continued From page 38 identified the patient arrived complaining about a pen that was inserted into the urethra and a paper clip the patient swallowed. The report identified a pen was palpated at the base of the penis and scrotum and a chest x-ray confirmed an uncoiled paper clip in the stomach. The report further identified the patient was taken to the operating room for removal of the foreign objects. A nurse's note dated 3/24/19 at 9:40PM identified the patient returned from the hospital, the physician was notified and the patient was placed on continuous observation status. Review of the clinical record with the Program Director on 4/5/19 at 2PM identified although there was on order for room searches every shift effective 3/26/19 at 4:20PM the clinical record noted the only documented room search was completed on 3/26/19 at 8PM. The Program Director stated that room searches are to be completed and documented each shift to ensure the patient does not have any objects he/she may use to insert in the urethra. Review of the incident report dated 3/26/19 at 11:31AM identified that the patient was on continuous observation and the patient reported that he/she inserted a pen into the urethra around 11:30AM. The report noted that the bathroom door was half open and staff had full sight of patient and saw the patient adjust self but did not think anything of it. Physician progress note dated 3/26/19 at 1:30PM identified the patient reported inserting a pen into the urethra when he/she went to the bathroom at 11:30AM. The patient was examined and the physician was able to palpate something at the	A 395		

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A 395	Continued From page 39 base of the penis and the patient complained of pain and inability to urinate. The note further identified the patient stated he/she was inserting pens into his/her urethra out of anger and frustration. The patient was transferred to the ED for an evaluation. The nurse's note dated 3/26/19 at 2:30PM identified that the patient remained on continuous observation for protection of self. The note identified the patient continued to make threats stating "I'm going back to the hospital", "I inserted a pen into my urethra and it hurts and I'm going back to the ED". Nurse's notes dated 3/26/19 at 3:30PM identified at approximately 3PM a unit search was conducted and 6 pens were found, 2 of the pens were found under the floor tile in the patient's room. Review of the hospital discharge summary dated 3/26/19 identified the patient presented with foreign body in urethra and was sent to the OR for a cystoscopy. Additionally, the patient was started on Keflex 500mg 3 times a day for 7 days. Special observation orders dated 3/26/19 at 5:53PM directed the patient was to be on a one to one with 2 staff members at all times to prevent insertion of objects into the urethra, room search every shift for items patient can ingest and/or insert. Interview with RN # 5 on 4/5/19 at 1:40PM stated that on 3/26/19 she overheard Patient # 17 say "it was already done." RN # 5 stated she spoke to the patient and asked what's going on and the patient stated that he/she inserted a pen into	A 395		

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A 395	Continued From page 40 his/her urethra. RN # 5 stated that a unit and room search were completed after the patient was sent to the ED and found 6 pens, 4 on the unit and 2 pens under the tile floor in the patient's room. Special observation orders dated 3/27/19 at 10:55AM directed one to one with 2 male staff, patient to have hands visible at all times, patient to wear sweatpants and if refuses check pockets before goes into bathroom and CO, room search room every shift for items patient can ingest/insert. Further review of the Special Observation orders from 3/27/19 through 3/30/19 at 11:30PM directed the orders continued as written. b. Review of the incident report dated 3/31/19 at 8:10PM identified the nurse was called to evaluate the patient who was bleeding from the urethra. The note identified staff reported that the patient placed his/her hands in his/her pants for a moment and was immediately redirected by staff and when the patient's hands came out of his/her pants blood was observed on his/her hands and pants. The report stated that the patient identified placing a pen in the urethra. The area was assessed, pressure was applied to the site and the physician was notified and the patient was transferred to the ED. Physician progress noted dated 3/31/19 at 11:20PM identified the patient inserted pen into the urethra and stated he/she got the pen from another patient who admitted to giving the patient the pen. A nursing note dated 3/31/19 at 12:35AM identified patient reported he/she inserted a pen into the urethra area between 9:30PM-10:30PM	A 395		

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A 395	Continued From page 41 while making a phone call. The patient was assessed and the patient was trying to pull the pen out but was directed to stop and blood was noted in the patient's genital area. The physician was notified and the patient was transferred to the ED. Review of the hospital report dated 3/31/19 identified the patient presented after ingesting a cartridge of a pen and was spitting up blood and had inserted a pen into the urethra and was having pain. The patient was taken to the OR and a endoscopy and cystoscopy were performed with foreign body removal. A nurse's notes dated 3/31/19 at 10:15AM identified the patient returned from the ED, the unit and sleeping area were checked for any items. Special Observation orders dated 3/31/19 at 10:40AM directed two male staff were to observed the patient to prevent insertion of objects into genital area and the patient was to have hands visible at all times. additionally, the patient was to wear sweatpants, no underwear, if patient refuses, check pockets before the patient goes into bathroom and room search every shift for items the patient can ingest/insert. Interview with the Program Director of 4/5/19 at 2PM stated that as of 3/26/19, the hospital added a second staff member to do environmental rounds for Patient # 17, ensuring that staff would check the environment for hazards prior to the patient entering the area. The Program Director further stated that staff did not follow the hospital policy for CO regarding watching the patient's hands, face and neck at all times since he/she	A 395		

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A 395	Continued From page 42 was able to obtain pens. Review of the clinical record with the Program Director on 4/5/19 at 2PM identified although there was on order for room searches every shift effective 3/26/19 at 4:20PM the clinical record noted the only documented room search was completed on 3/26/19 at 8PM. The Program Director stated that room searches are to be completed and documented each shift to ensure the patient does not have any objects he/she may use to insert in the urethra.	A 395		

Response to CMS Survey ID: 1XTE11 of 4/12/2019

Tag	Plan of Correction	Completion Date
A 115-1	In response to the finding that the facility failed to ensure that the patient was free from neglect by failing to ensure the patient received care in a safe setting when staff failed to maintain continuous observation.	
	Individual Response Patient #11's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors such as the removal of small objects, food wrappers, etc. from the patient's surroundings. Patient #17's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors and ensure the environment is free of hazards.	3/28/2019 4/01/2019
	Systemic Response 1. Conducted a review of all constant observations and confirmed the presence of specific MD orders outlining the specific safety precautions as indicated. All patients with a history of insertion events were evaluated to ensure proper interventions are in place to ensure the patient's safety based on their current clinical condition. Treatment Plans were adjusted if necessary to include those interventions. 2. The facility investigation of the report of contraband being stored under floor tiles revealed the items had actually been hidden under the dormitory partition walls. In response the facility sealed the area where the contraband was hidden (between the walls and floor with Plexiglas) in all areas where this condition existed in the Battell Hall unit observation dorm rooms. 3. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 4. The Chief Nurse Executive issued a memorandum for the supervision and oversight of the performance of special observation. CVH has implemented changes in our supervision/oversight process of the performance of special observation. The registered nurse on each unit will supervise staff performing special observation on his/her shift. At a minimum of every two hours the RN will check every constant observation or higher level of observation	4/04/2019 4/01/2019 4/04/2019 4/04/2019

	randomly. The first check must be completed within 2 hours of the beginning of the shift. The RN Supervisor Accountability Rounds will continue twice per shift and will be recorded on the Registered Nurse/Nurse Supervisor, Accountability Rounds for carrying out assigned duties. Any identified performance issues will be immediately addressed by first maintaining patient safety and then reporting to the Nursing Supervisor for follow-up through the supervisory and progressive discipline process in accordance with Operational Policy & Procedure 5.9 Assessment & Reporting of Victims of Abuse, Neglect, or Exploitation, and Operational Policy and Procedure 8.27 Investigations of Alleged Violations of DMHAS Policies, Procedures, Regulations, and or Work Rules. 5. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above.	4/15/2019
	<u>Procedure Change</u> 1. Nursing ***P&P 7.6 Nursing Report and Change of Shift Procedure*** was revised and enhanced to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 2. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above. 3. CVH subsequently further enhanced Procedure ***2.11 Special Observation*** to reinforce the documentation requirements to occur every shift and incorporate the results of the searches conducted on that shift and any follow-up actions.	4/04/2019 4/04/2019 4/15/2019
	<u>Forms</u> 1. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** was modified to document the RN and RN Supervisors observations of competence in the performance of Special Observation for a total of six times per shift. 2. The ***CVH Cross Shift Report Sheet*** was modified to	4/06/2019

	document that all assigned staff had completed a review of all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation as part of the shift report process.	4/06/2019
	Education Plan 1. All facility nursing staff was educated on the revised performance expectations and supervisory oversight for special observation. This process began on the evening shift on 4/04/2019. All staff subsequently reporting for work will complete the education prior to beginning their assigned shift until 100% of staff has been trained. The completion of this review and acknowledgement of understanding the information will be documented on a CVH Form 288. 2. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 3. A memo to reiterate the expectation outlined in Procedure ***2.11 Special Observation*** was sent to all nursing staff. All staff subsequently reporting for work completed the education.	5/09/2019 5/09/2019 5/31/2019
	Compliance Monitoring 1. Staff Development will provide a weekly status report on the education for updated procedures on the performance and supervision of special observation, change of shift report process, and documentation of special observation related searches to the Operations Group. 2. Directors of Nursing will ensure that all of their assigned staff completed the education per the Plan of Correction timeline. 3. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** are reviewed daily by a Director of Nursing 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).	4/10/2019 4/10/2019 4/06/2019 5/09/2019

	NEC will compile and analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
	4. The ***CVH Cross Shift Report Sheet(s)*** are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
	The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
	NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
	5. Nursing Supervisors will review the patient record for all patients whom a search is ordered and conducted to minimize or eliminate the presence of dangerous objects in the environment.	5/06/2019
	The Nursing Supervisors will submit a weekly report to the DoN on the chart audit.	5/13/2019
	The DoN will analyze the reports and submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	6/13/2019
	NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	6/13/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	07/25/2019
	<u>Responsibility for Oversight</u> Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 115-2	In response to the finding that the facility failed to adequately supervise the patient.	
	Individual Response Patient #11's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors such as the removal of small objects, food wrappers, etc. from the patient's surroundings. Patient #17's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors and ensure the environment is free of hazards.	3/28/2019 4/01/2019
	Systemic Response 1. Conducted a review of all constant observations and confirmed the presence of specific MD orders outlining the specific safety precautions as indicated. All patients with a history of insertion events were evaluated to ensure proper interventions are in place to ensure the patient's safety based on their current clinical condition. Treatment Plans were adjusted if necessary to include those interventions. 2. The facility investigation of the report of contraband being stored under floor tiles revealed the items had actually been hidden under the dormitory partition walls. In response the facility sealed the area where the contraband was hidden (between the walls and floor with Plexiglas) in all areas where this condition existed in the Battell Hall unit observation dorm rooms. 3. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 4. The Chief Nurse Executive issued a memorandum for the supervision and oversight of the performance of special observation. CVH has implemented changes in our supervision/oversight process of the performance of special observation. The registered nurse on each unit will supervise staff performing special observation on his/her shift. At a minimum of every two hours the RN will check every constant observation or higher level of observation randomly. The first check must be completed within 2 hours of the beginning of the shift. The RN Supervisor	4/04/2019 4/01/2019 4/04/2019 4/04/2019

	Accountability Rounds will continue twice per shift and will be recorded on the Registered Nurse/Nurse Supervisor, Accountability Rounds for carrying out assigned duties. Any identified performance issues will be immediately addressed by first maintaining patient safety and then reporting to the Nursing Supervisor for follow-up through the supervisory and progressive discipline process in accordance with Operational Policy & Procedure 5.9 Assessment & Reporting of Victims of Abuse, Neglect, or Exploitation, and Operational Policy and Procedure 8.27 Investigations of Alleged Violations of DMHAS Policies, Procedures, Regulations, and or Work Rules. 5. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above.	4/15/2019
	<u>Procedure Change</u> 1. Nursing ***P&P 7.6 Nursing Report and Change of Shift Procedure*** was revised and enhanced to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 2. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above. 3. CVH subsequently further enhanced Procedure ***2.11 Special Observation*** to reinforce the documentation requirements to occur every shift and incorporate the results of the searches conducted on that shift and any follow-up actions.	4/04/2019 4/04/2019 4/15/2019
	<u>Forms</u> 1. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** was modified to document the RN and RN Supervisors observations of competence in the performance of Special Observation for a total of six times per shift. 2. The ***CVH Cross Shift Report Sheet*** was modified to document that all assigned staff had completed a review of all Behavioral Guidelines, Behavioral Plans and/or any	4/06/2019 4/06/2019

	associated MD/APRN orders for Special Observation as part of the shift report process.	
	Education Plan 1. All facility nursing staff was educated on the revised performance expectations and supervisory oversight for special observation. This process began on the evening shift on 4/04/2019. All staff subsequently reporting for work will complete the education prior to beginning their assigned shift until 100% of staff has been trained. The completion of this review and acknowledgement of understanding the information will be documented on a CVH Form 288. 2. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 3. A memo to reiterate the expectation outlined in Procedure ***2.11 Special Observation*** was sent to all nursing staff. All staff subsequently reporting for work completed the education.	5/09/2019 5/09/2019 5/31/2019
	Compliance Monitoring 1. Staff Development will provide a weekly status report on the education for updated procedures on the performance and supervision of special observation, change of shift report process, and documentation of special observation related searches to the Operations Group. 2. Directors of Nursing will ensure that all of their assigned staff completed the education per the Plan of Correction timeline. 3. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** are reviewed daily by a Director of Nursing 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 compile and analyze the two Division reports for	4/10/2019 4/10/2019 4/06/2019 5/09/2019 5/09/2019

	potential trends and patterns, and implement any necessary additional corrective actions.	
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
	4. The ***CVH Cross Shift Report Sheet(s)*** are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
	The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
	NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
	5. Nursing Supervisors will review the patient record for all patients whom a search is ordered and conducted to minimize or eliminate the presence of dangerous objects in the environment.	5/06/2019
	The Nursing Supervisors will submit a weekly report to the DoN on the chart audit.	5/13/2019
	The DoN will analyze the reports and submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	6/13/2019
	NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	6/13/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	07/25/2019
	<u>Responsibility for Oversight</u> Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 115-3	In response to the finding that the facility failed to ensure the patient was free from neglect for failing to ensure the environment was free from hazards to avoid physical harm of the patient resulting in immediate jeopardy.	
	Individual Response Patient #11's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors such as the removal of small objects, food wrappers, etc. from the patient's surroundings. Patient #17's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors and ensure the environment is free of hazards.	3/28/2019 4/01/2019
	Systemic Response 1. Conducted a review of all constant observations and confirmed the presence of specific MD orders outlining the specific safety precautions as indicated. All patients with a history of insertion events were evaluated to ensure proper interventions are in place to ensure the patient's safety based on their current clinical condition. Treatment Plans were adjusted if necessary to include those interventions. 2. The facility investigation of the report of contraband being stored under floor tiles revealed the items had actually been hidden under the dormitory partition walls. In response the facility sealed the area where the contraband was hidden (between the walls and floor with Plexiglas) in all areas where this condition existed in the Battell Hall unit observation dorm rooms. 3. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 4. The Chief Nurse Executive issued a memorandum for the supervision and oversight of the performance of special observation. CVH has implemented changes in our supervision/oversight process of the performance of special observation. The registered nurse on each unit will supervise staff performing special observation on his/her shift. At a minimum of every two hours the RN will check every constant observation or higher level of observation	4/04/2019 4/01/2019 4/04/2019 4/04/2019

	randomly. The first check must be completed within 2 hours of the beginning of the shift. The RN Supervisor Accountability Rounds will continue twice per shift and will be recorded on the Registered Nurse/Nurse Supervisor, Accountability Rounds for carrying out assigned duties. Any identified performance issues will be immediately addressed by first maintaining patient safety and then reporting to the Nursing Supervisor for follow-up through the supervisory and progressive discipline process in accordance with Operational Policy & Procedure 5.9 Assessment & Reporting of Victims of Abuse, Neglect, or Exploitation, and Operational Policy and Procedure 8.27 Investigations of Alleged Violations of DMHAS Policies, Procedures, Regulations, and or Work Rules. 5. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above.	4/15/2019
	<u>Procedure Change</u> 1. Nursing ***P&P 7.6 Nursing Report and Change of Shift Procedure*** was revised and enhanced to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 2. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above. 3. CVH subsequently further enhanced Procedure ***2.11 Special Observation*** to reinforce the documentation requirements to occur every shift and incorporate the results of the searches conducted on that shift and any follow-up actions.	4/04/2019 4/04/2019 4/15/2019
	<u>Forms</u> 1. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** was modified to document the RN and RN Supervisors observations of competence in the performance of Special Observation for a total of six times per shift. 2. The ***CVH Cross Shift Report Sheet*** was modified to	4/06/2019

	document that all assigned staff had completed a review of all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation as part of the shift report process.	4/06/2019
	Education Plan 1. All facility nursing staff was educated on the revised performance expectations and supervisory oversight for special observation. This process began on the evening shift on 4/04/2019. All staff subsequently reporting for work will complete the education prior to beginning their assigned shift until 100% of staff has been trained. The completion of this review and acknowledgement of understanding the information will be documented on a CVH Form 288. 2. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 3. A memo to reiterate the expectation outlined in Procedure ***2.11 Special Observation*** was sent to all nursing staff. All staff subsequently reporting for work completed the education.	5/09/2019 5/09/2019 5/31/2019
	Compliance Monitoring 1. Staff Development will provide a weekly status report on the education for updated procedures on the performance and supervision of special observation, change of shift report process, and documentation of special observation related searches to the Operations Group. 2. Directors of Nursing will ensure that all of their assigned staff completed the education per the Plan of Correction timeline. 3. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** are reviewed daily by a Director of Nursing 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).	4/10/2019 4/10/2019 4/06/2019 5/09/2019

	NEC will compile and analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
	4. The ***CVH Cross Shift Report Sheet(s)*** are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
	The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
	NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
	5. Nursing Supervisors will review the patient record for all patients whom a search is ordered and conducted to minimize or eliminate the presence of dangerous objects in the environment.	5/06/2019
	The Nursing Supervisors will submit a weekly report to the DoN on the chart audit.	5/13/2019
	The DoN will analyze the reports and submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	6/13/2019
	NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	6/13/2019
	The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	07/25/2019
	<u>Responsibility for Oversight</u> Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 144-1	In response to the finding that the facility failed to ensure the patient was supervised **and/or** continuous observation was maintained **and/or** failed to ensure the environment was free of hazards which resulted in immediate jeopardy.	
	Individual Response Patient #17's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors and ensure the environment is free of hazards.	4/01/2019
	Systemic Response 1. Conducted a review of all constant observations and confirmed the presence of specific MD orders outlining the specific safety precautions as indicated. All patients with a history of insertion events were evaluated to ensure proper interventions are in place to ensure the patient's safety based on their current clinical condition. Treatment Plans were adjusted if necessary to include those interventions.	4/04/2019
	2. The facility investigation of the report of contraband being stored under floor tiles revealed the items had actually been hidden under the dormitory partition walls. In response the facility sealed the area where the contraband was hidden (between the walls and floor with Plexiglas) in all areas where this condition existed in the Battell Hall unit observation dorm rooms.	4/01/2019
	3. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report.	4/04/2019
	4. The Chief Nurse Executive issued a memorandum for the supervision and oversight of the performance of special observation. CVH has implemented changes in our supervision/oversight process of the performance of special observation. The registered nurse on each unit will supervise staff performing special observation on his/her shift. At a minimum of every two hours the RN will check every constant observation or higher level of observation randomly. The first check must be completed within 2 hours of the beginning of the shift. The RN Supervisor Accountability Rounds will continue twice per shift and will be recorded on the Registered Nurse/Nurse Supervisor, Accountability Rounds for carrying out assigned duties.	4/04/2019

Any identified performance issues will be immediately addressed by first maintaining patient safety and then reporting to the Nursing Supervisor for follow-up through the supervisory and progressive discipline process in accordance with Operational Policy & Procedure 5.9 Assessment & Reporting of Victims of Abuse, Neglect, or Exploitation, and Operational Policy and Procedure 8.27 Investigations of Alleged Violations of DMHAS Policies, Procedures, Regulations, and or Work Rules. 5. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above.	4/15/2019
Procedure Change 1. Nursing ***P&P 7.6 Nursing Report and Change of Shift Procedure*** was revised and enhanced to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 2. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above. 3. CVH subsequently further enhanced Procedure ***2.11 Special Observation*** to reinforce the documentation requirements to occur every shift and incorporate the results of the searches conducted on that shift and any follow-up actions.	4/04/2019 4/04/2019 4/15/2019
Forms 1. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** was modified to document the RN and RN Supervisors observations of competence in the performance of Special Observation for a total of six times per shift. 2. The ***CVH Cross Shift Report Sheet*** was modified to document that all assigned staff had completed a review of all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation as part of the shift report process.	4/06/2019 4/06/2019

Education Plan 1. All facility nursing staff was educated on the revised performance expectations and supervisory oversight for special observation. This process began on the evening shift on 4/04/2019. All staff subsequently reporting for work will complete the education prior to beginning their assigned shift until 100% of staff has been trained. The completion of this review and acknowledgement of understanding the information will be documented on a CVH Form 288.	5/09/2019
2. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report.	5/09/2019
3. A memo to reiterate the expectation outlined in Procedure ***2.11 Special Observation*** was sent to all nursing staff. All staff subsequently reporting for work completed the education.	5/31/2019
Compliance Monitoring 1. Staff Development will provide a weekly status report on the education for updated procedures on the performance and supervision of special observation, change of shift report process, and documentation of special observation related searches to the Operations Group.	4/10/2019
2. Directors of Nursing will ensure that all of their assigned staff completed the education per the Plan of Correction timeline.	4/10/2019
3. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** are reviewed daily by a Director of Nursing DoN), any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
NEC will compile and analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019

The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
4. The ***CVH Cross Shift Report Sheet(s)*** are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
5. Nursing Supervisors will review the patient record for all patients whom a search is ordered and conducted to minimize or eliminate the presence of dangerous objects in the environment.	5/06/2019
The Nursing Supervisors will submit a weekly report to the DoN on the chart audit.	5/13/2019
The DoN will analyze the reports and submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	6/13/2019
NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	6/13/2019
The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	07/25/2019
<u>Responsibility for Oversight</u> Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 144-2	In response to the finding that the facility failed to adequate supervision for patient #11 who had fluctuating self-injurious / self-destructive behaviors.to prevent self-injurious behaviors and staff failed to ensure that small object such as food wrappers were removed from the patient's surroundings.	
	Individual Response Patient #11's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors such as the removal of small objects, food wrappers, etc. from the patient's surroundings.	4/01/2019
	Systemic Response 1. Conducted a review of all constant observations and confirmed the presence of specific MD orders outlining the specific safety precautions as indicated. All patients with a history of insertion events were evaluated to ensure proper interventions are in place to ensure the patient's safety based on their current clinical condition. Treatment Plans were adjusted if necessary to include those interventions.	4/04/2019
	2. The facility investigation of the report of contraband being stored under floor tiles revealed the items had actually been hidden under the dormitory partition walls. In response the facility sealed the area where the contraband was hidden (between the walls and floor with Plexiglas) in all areas where this condition existed in the Battell Hall unit observation dorm rooms.	4/01/2019
	3. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report.	4/04/2019
	4. The Chief Nurse Executive issued a memorandum for the supervision and oversight of the performance of special observation. CVH has implemented changes in our supervision/oversight process of the performance of special observation. The registered nurse on each unit will supervise staff performing special observation on his/her shift. At a minimum of every two hours the RN will check every constant observation or higher level of observation randomly. The first check must be completed within 2 hours of the beginning of the shift. The RN Supervisor Accountability Rounds will continue twice per shift and will	4/04/2019

be recorded on the Registered Nurse/Nurse Supervisor, Accountability Rounds for carrying out assigned duties. Any identified performance issues will be immediately addressed by first maintaining patient safety and then reporting to the Nursing Supervisor for follow-up through the supervisory and progressive discipline process in accordance with Operational Policy & Procedure 5.9 Assessment & Reporting of Victims of Abuse, Neglect, or Exploitation, and Operational Policy and Procedure 8.27 Investigations of Alleged Violations of DMHAS Policies, Procedures, Regulations, and or Work Rules. 5. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above.	4/15/2019
<u>Procedure Change</u> 1. Nursing ***P&P 7.6 Nursing Report and Change of Shift Procedure*** was revised and enhanced to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 2. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above. 3. CVH subsequently further enhanced Procedure ***2.11 Special Observation*** to reinforce the documentation requirements to occur every shift and incorporate the results of the searches conducted on that shift and any follow-up actions.	4/04/2019 4/04/2019 4/15/2019
<u>Forms</u> 1. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** was modified to document the RN and RN Supervisors observations of competence in the performance of Special Observation for a total of six times per shift. 2. The ***CVH Cross Shift Report Sheet*** was modified to document that all assigned staff had completed a review of all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation as part	4/06/2019 4/06/2019

of the shift report process.	
Education Plan 1. All facility nursing staff was educated on the revised performance expectations and supervisory oversight for special observation. This process began on the evening shift on 4/04/2019. All staff subsequently reporting for work will complete the education prior to beginning their assigned shift until 100% of staff has been trained. The completion of this review and acknowledgement of understanding the information will be documented on a CVH Form 288. 2. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 3. A memo to reiterate the expectation outlined in Procedure ***2.11 Special Observation*** was sent to all nursing staff. All staff subsequently reporting for work completed the education.	5/09/2019 5/09/2019 5/31/2019
Compliance Monitoring 1. Staff Development will provide a weekly status report on the education for updated procedures on the performance and supervision of special observation, change of shift report process, and documentation of special observation related searches to the Operations Group. 2. Directors of Nursing will ensure that all of their assigned staff completed the education per the Plan of Correction timeline. 3. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** are reviewed daily by a Director of Nursing 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 compile and analyze the two Division reports for potential trends and patterns, and implement any necessary	4/10/2019 4/10/2019 4/06/2019 5/09/2019 5/09/2019

additional corrective actions. The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
4. The ***CVH Cross Shift Report Sheet(s)*** are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
5. Nursing Supervisors will review the patient record for all patients whom a search is ordered and conducted to minimize or eliminate the presence of dangerous objects in the environment.	5/06/2019
The Nursing Supervisors will submit a weekly report to the DoN on the chart audit.	5/13/2019
The DoN will analyze the reports and submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	6/13/2019
NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	6/13/2019
The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	07/25/2019
<u>Responsibility for Oversight</u> Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 145	In response to the finding that the facility failed to ensure the patient was free from neglect for failing to supervise **and/or** maintain continuous observation **and/or** failed to ensure the environment was free from hazards to avoid physical harm of the patient resulting in immediate jeopardy.	
	Individual Response Patient #17's treatment plan was updated to include behavioral interventions to address the identified high risk behaviors and ensure the environment is free of hazards.	4/01/2019
	Systemic Response 1. Conducted a review of all constant observations and confirmed the presence of specific MD orders outlining the specific safety precautions as indicated. All patients with a history of insertion events were evaluated to ensure proper interventions are in place to ensure the patient's safety based on their current clinical condition. Treatment Plans were adjusted if necessary to include those interventions.	4/04/2019
	2. The facility investigation of the report of contraband being stored under floor tiles revealed the items had actually been hidden under the dormitory partition walls. In response the facility sealed the area where the contraband was hidden (between the walls and floor with Plexiglas) in all areas where this condition existed in the Battell Hall unit observation dorm rooms.	4/01/2019
	3. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report.	4/04/2019
	4. The Chief Nurse Executive issued a memorandum for the supervision and oversight of the performance of special observation. CVH has implemented changes in our supervision/oversight process of the performance of special observation. The registered nurse on each unit will supervise staff performing special observation on his/her shift. At a minimum of every two hours the RN will check every constant observation or higher level of observation randomly. The first check must be completed within 2 hours of the beginning of the shift. The RN Supervisor Accountability Rounds will continue twice per shift and will be recorded on the Registered Nurse/Nurse Supervisor,	4/04/2019

Accountability Rounds for carrying out assigned duties. Any identified performance issues will be immediately addressed by first maintaining patient safety and then reporting to the Nursing Supervisor for follow-up through the supervisory and progressive discipline process in accordance with Operational Policy & Procedure 5.9 Assessment & Reporting of Victims of Abuse, Neglect, or Exploitation, and Operational Policy and Procedure 8.27 Investigations of Alleged Violations of DMHAS Policies, Procedures, Regulations, and or Work Rules. 5. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above.	4/15/2019
Procedure Change 1. Nursing ***P&P 7.6 Nursing Report and Change of Shift Procedure*** was revised and enhanced to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report. 2. CVH enhanced Procedure ***2.11 Special Observation*** to clearly outline the accountability and responsibility of the charge nurse and the Nursing supervisor related to the safe delivery of special observation through direct observations as defined above. 3. CVH subsequently further enhanced Procedure ***2.11 Special Observation*** to reinforce the documentation requirements to occur every shift and incorporate the results of the searches conducted on that shift and any follow-up actions.	4/04/2019 4/04/2019 4/15/2019
Forms 1. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** was modified to document the RN and RN Supervisors observations of competence in the performance of Special Observation for a total of six times per shift. 2. The ***CVH Cross Shift Report Sheet*** was modified to document that all assigned staff had completed a review of all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation as part of the shift report process.	4/06/2019 4/06/2019

Education Plan 1. All facility nursing staff was educated on the revised performance expectations and supervisory oversight for special observation. This process began on the evening shift on 4/04/2019. All staff subsequently reporting for work will complete the education prior to beginning their assigned shift until 100% of staff has been trained. The completion of this review and acknowledgement of understanding the information will be documented on a CVH Form 288.	5/09/2019
2. The Chief Nurse Executive issued a memorandum detailing the revised and enhanced expectations related to Nursing Report and Change of Shift Procedure to ensure that all Behavioral Guidelines, Behavioral Plans and/or any associated MD/APRN orders for Special Observation are reviewed during each shift report. In those instances where staff arrives late to the unit they are expected to meet with the RN and receive the above shift report including the information specific to Special Observation behavior guidelines, behavioral plans, and MD/APRN orders. All staff will receive and sign the shift report.	5/09/2019
3. A memo to reiterate the expectation outlined in Procedure ***2.11 Special Observation*** was sent to all nursing staff. All staff subsequently reporting for work completed the education.	5/31/2019
Compliance Monitoring 1. Staff Development will provide a weekly status report on the education for updated procedures on the performance and supervision of special observation, change of shift report process, and documentation of special observation related searches to the Operations Group.	4/10/2019
2. Directors of Nursing will ensure that all of their assigned staff completed the education per the Plan of Correction timeline.	4/10/2019
3. The ***Registered Nurse/Nurse Supervisor, Accountability Rounds Form*** are reviewed daily by a Director of Nursing DoN), any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
NEC will compile and analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019

The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
4. The ***CVH Cross Shift Report Sheet(s)*** are reviewed daily by the DoN, any deficiencies identified are addressed immediately through the supervision process.	4/06/2019
The DoN will submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	5/09/2019
NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	5/09/2019
The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	5/23/2019
5. Nursing Supervisors will review the patient record for all patients whom a search is ordered and conducted to minimize or eliminate the presence of dangerous objects in the environment.	5/06/2019
The Nursing Supervisors will submit a weekly report to the DoN on the chart audit.	5/13/2019
The DoN will analyze the reports and submit a monthly summary report of the audit results to the Nurse Executive Committee (NEC).	6/13/2019
NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions.	6/13/2019
The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	07/25/2019
<u>Responsibility for Oversight</u> Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 395-1	In response to the finding that the facility failed to **ensure the patient was positioned appropriately while out of bed (A 395-1)** and/or ensure grooming was performed by the appropriate licensed professional (A 395-2) and/or the patient's room was searched as directed by a physician (A 395-3).	
	Individual Patient Response *Patient # 12* As noted in the CMS report the patient was immediately repositioned in his Broda chair by staff and re-education provided immediately by the Director of Nursing.	3/27/2019
	Systemic Response All other patients utilizing Broda chairs and adaptive medical equipment were assessed for repositioning needs. No other patients required additional interventions.	3/27/2019
	Education Plan Physical Therapy Supervisor provided multiple unit based trainings on proper positioning in the Broda chair. The Physical Therapy Supervisor initiated a train-the-trainer block of instruction on the proper placement and positioning of patient's in the Broda Chair training for Directors of Nursing. The Directors of Nursing will then provide education to all nursing staff on the proper placement and positioning of patients in the Broda chair, and observe nursing staff performance to verify competency for this device. An on-line class with video demonstration of how to effectively provide care to patients requiring a Broda chair has been developed and implemented for all nursing staff. On an on-going basis, the Physical Therapy department evaluates all requests for Broda chairs from a physician's medical order. When a Broda chair is implemented for a patient, the physical therapist (PT) provides training for all staff present. Instructions on the proper use of the Broda chair are also attached to the chair for staff reference. The Physical Therapists will provide training as needed.	3/29/2019 5/9/2019 6/01/2019 5/10/2019
	Compliance Monitoring Staff Development will be providing a weekly nursing training and competency compliance report to the Operations Council.	6/1/2019
	Responsibility for Oversight Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 395-2	In response to the finding that the facility failed to ensure the patient was positioned appropriately while out of bed (A 395-1) and/or **ensure grooming was performed by the appropriate licensed professional (A 395-2)** and/or the patient's room was searched as directed by a physician (A 395-3).	
	Individual Patient Response *Patient #1* Facility conducted a thorough review of the incident including a patient interview with Patient Advocate and independently confirmed that the client requested and approved of the hair cut both during and after. The analysis identified a violation of Nursing Policy and Procedure (NP&P) 13.7 Hair Care. This was an isolated event and limited to RN #3 and MD #1. RN #3 and MD #1 was provided re-education on Nursing Policy and Procedure 13.7 Hair Care and reminded that the facility employs licensed hairdressers to perform this task.	3/12/2019
	Systemic Response Facility conducted a thorough review of the unique incident. Nursing Executive Committee identified a knowledge deficit related to delivery and provision of ADL's for patients that are difficult to engage. In response, the ADL Skills Project Team, chaired by a Director of Nursing and participants including Unit based Registered Nurses, Mental Health Assistants, Occupational Therapist, Dental Hygienist, Speech Pathology and others have been tasked with implementation of a standardized method of engagement strategies for those clients who have been identified with a deficit in self-initiated grooming. Additionally, Licensed Hairdressers services have been increased to allow for scheduled on unit hair services in addition to the current centralized Page Hall Beauty Salon services.	5/13/2019
	Procedure Change The Nursing Executive Committee (NEC) reviewed and revised Nursing Policy and Procedure (NP&P) 13.7 Hair Care to clarify the schedule for patients receiving Hairdresser services, both unit based and brought to the hair salon in the treatment mall. The facility also provides this education at the time of hire emphasizing that the staff of the hospital are cognizant of the different hair care needs of all the patients.	4/6/2019
	Education Plan An on-line class was implemented for all nursing staff that included an excerpt of NP&P 13.7 Hair Care which emphasized that only licensed Hairdressers are permitted to cut, color, perm or relax patient hair along with the salon schedule A Licensed hairdresser is	3/27/2019

	located in the salon in the Page Hall Treatment Mall.	
	Compliance Monitoring The licensed hairdresser will begin keeping a log of patients who received hair styling services by location. Director of Rehab Therapies will monitor the log on a monthly schedule. The Director of Rehab Therapies will compile a report and submit a monthly summary of services to the Clinical Management Committee. Staff Development will be providing a weekly training compliance report to the Operations Council.	6/1/2019 7/26/2019 5/15/2019
	Responsibility for Oversight Chief Nurse Executive	

Tag	Plan of Correction	Completion Date
A 395-3	In response to the finding that the facility failed to ensure the patient was positioned appropriately while out of bed (A 395-1) and/or ensure grooming was performed by the appropriate licensed professional (A 395-2) and/or **the patient's room was searched as directed by a physician (A 395-3).**	
	Individual Response Patient #17's room is searched and documented as per physician order.	5/03/2019
	Systemic Response 1. The facility investigation of the report of contraband being stored under floor tiles revealed the items had actually been hidden under the dormitory partition walls. In response the facility sealed the area where the contraband was hidden (between the walls and floor with Plexiglas) in all areas where this condition existed in the Battell Hall unit observation dorm rooms. 2. CVH enhanced Procedure ***2.11 Special Observation*** to clarify the documentation requirements related to room searches for patients on Continuous Observation for Suicidal or Self-injurious behavior to ensure the results of searches and follow-up actions are properly documented.	4/01/2019 4/15/2019
	Procedure Change 1. CVH subsequently further enhanced Procedure ***2.11 Special Observation*** to reinforce the documentation requirements to occur every shift and incorporate the results of the searches conducted on that shift and any follow-up actions.	4/15/2019
	Education Plan 1. A memo to reiterate the expectation outlined in Procedure ***2.11 Special Observation*** was sent to all nursing staff. All staff subsequently reporting for work completed the education.	5/31/2019
	Compliance Monitoring 1. Nursing Supervisors will review the patient record for all patients whom a search is ordered and conducted to minimize or eliminate the presence of dangerous objects in the environment. The Nursing Supervisors will submit a weekly report to the DoN on the chart audit. The DoN will analyze the reports and submit a monthly summary report of the audit results to the Nurse Executive	5/06/2019 5/13/2019 6/13/2019

	Committee (NEC). NEC will analyze the two Division reports for potential trends and patterns, and implement any necessary additional corrective actions. The NEC will provide a monthly summary report to the Governing Body on an ongoing basis or until the hospital determines that 100% compliance has been maintained for a period of time.	6/13/2019 07/25/2019
	Responsibility for Oversight Chief Nurse Executive	

CVH Revisit

Date/Time IJ Template provided to entity: 6/11/19 @ 4:45 pm

IJ Component	Yes/No	Preliminary fact analysis which demonstrates whether key component exists.
Noncompliance: Has the entity failed to meet one or more federal health, safety, and/or quality regulations? If yes, in the blank space, identify the tag and briefly summarize the issues that lead to the determination that the entity is in noncompliance with the identified requirement. This includes the action(s), error(s), or lack of action, and the extent of the noncompliance (for example, number of cases). Use one IJ template for each tag being considered at IJ level.	(Yes)/No	A144 Failure to ensure a safe environment/care in a safe setting when a patient with a history of ingesting and inserting objects was able to ingest 2 batteries + required 2 medical procedures to remove the objects. Patient was on 2:1 staff observation at the time + neither staff noticed the patient remove batteries from head set + ingest them
AND		
Serious injury, serious harm, serious impairment or death: Is there evidence that a serious adverse outcome occurred, or a serious adverse outcome is likely as a result of the identified noncompliance? If Yes, in the blank space, briefly summarize the serious adverse outcome, or likely serious adverse outcome to the recipient.	(Yes)/No	Despite being on a 2:1 staff supervision, this intervention was ineffective as neither staff noticed/prevented the patient from swallowing harmful objects. The patient had to endure 2 medical procedures to remove the harmful objects.
AND		
Need for Immediate Action: Does the entity need to take immediate action to correct noncompliance that has caused or is likely to cause serious injury, serious harm, serious impairment, or death? If yes, in the blank space, briefly explain why.	(Yes)/No	This is the second time the facility is cited for lack of staff supervision to prevent a patient from self-harm. Plan of correction submitted on 5/10/19 not effective in remediating issue of ineffective staff supervision of patients with self harm tendencies

Disclaimer: The findings on this IJ Template are preliminary and do not represent an official finding against a Medicare provider or supplier. Form CMS-2567 is the only form that contains official survey findings.

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

CONNECTICUT VALLEY HOSPITAL

Connecticut Valley Hospital

Immediate Jeopardy Plan

June 11, 2019

1. Immediately following report of the incident on 5/2/19, the patient was assessed and transferred to the Emergency Department and admitted for further medical assessment and treatment.
2. The two staff assigned to observe the patient was immediately removed from patient care and an investigation into the incident was initiated.
3. The next day, the incident was reviewed and the following corrective actions were put in place:
    - 30 minute rotation of staff assigned to special observation on the unit where the client resided. Staff was educated to the change in practice as they came on duty beginning on third shift that same day. As of 6/11/19, 96% of staff was educated.
    - Staff to remain standing at all times when assigned to special observation for the index patient.
    - A memo was sent to all Nursing staff informing them that the assignment of Special Observation was changed across the remainder of the hospital to 60 minute intervals. Staff was educated to the change in practice as they came on duty beginning on third shift that same day. As of 6/11/19, 96% of staff was educated.
4. A focus treatment plan review was conducted upon the patient's return to CVH. The Behavioral Guidelines were revised and interventions were added to ensure the safety of the patient. Two days following return to CVH, the patient was discharged to a more secure inpatient setting for further psychiatric care.
5. All other patients in the hospital with a history of ingestion/insertion were reviewed and 100% of those patients had behavioral guidelines in place.
6. Accountability Rounds are conducted by the Charge Nurse and Nursing Supervisor to ensure that the Special Observations 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 to observe the index patient remain standing at all times. Accountability Rounds forms are audited daily by the Director of Nursing. The audit data reflects 100 % compliance with the change in practice.
7. Results of the Accountability Rounds will be reviewed in Nursing Executive Committee on a monthly basis. The analysis is then presented monthly to Governing Body. Education compliance rates are monitored weekly in Operations Council and monthly in Governing Body.

Helene Vartelas

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Chief Executive Officer

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