# STATE OF CONNECTICUT

## Department of Public Health

## LICENSE

## License No. 0074

## Hospital for Mentally Ill Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

State of CT, Department of Mental Health and Addiction Services of Hartford, CT d/b/a Whiting Forensic Hospital is hereby licensed to maintain and operate a Hospital for Mentally Ill Persons.

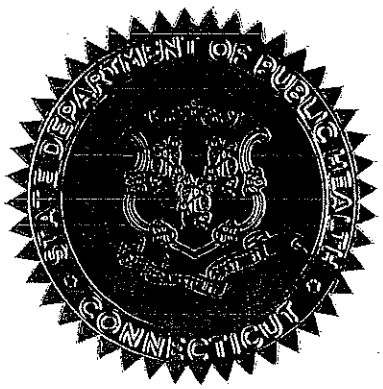
**Whiting Forensic Hospital** is located at 70 O'Brien Drive, Middletown, CT 06457-3945.

The maximum number of beds shall not exceed at any time:

229 General Hospital Beds

This license expires **June 30, 2020** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, August 21, 2018. INITIAL.




Raul Pino, MD, MPH
Commissioner

# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

May 7, 2019

Hal Smith, CEO
Whiting Forensic Hospital
70 O'Brien Drive
Middletown, CT 06457

Dear Mr. Smith:

Unannounced visits were made to Whiting Forensic Hospital on May 2, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

**The plan of correction is to be submitted to the Department by May 17, 2019.**

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **May 17, 2019** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

An office conference has been scheduled for **June 4, 2019** at **9:00 AM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain

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legal representation, your attorney may accompany you to this meeting.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan H. Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SN/DS:jf

Complaints #24725, #25037, #25323 and #24336

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The following is a violation of the Regulation of Connecticut State Agencies Section 17-227-14g Nursing (D)(1).

1. *Based on video review, review of job descriptions and staff interviews for 4 of 4 patients reviewed for incidents on unit 6, nursing staff failed to ensure the patients were supervised in the milieu when 5 incidents of patient to patient physical aggression and/or inappropriate touching occurred and/or based on direct observations, review of job descriptions and staff interviews, the facility failed to ensure nursing staff were present in the milieu supervising, interacting, and/or assisting patients. The findings include:

Review of video interactions between Patient #11 and Patient #15 identified the following:

a. Review of video (time stamped 12/11/18 at 3:46PM) identified Patient's # 11 and # 15 sitting in the dayroom without staff present. Patient # 15 was noted to stand up and walk up to Pt# 11 and taps his/her hand. PT # 11 was observed making a kicking motion towards Pt# 15 then stood up and pushed PT# 15 away. Further review of the video identified 3 staff members were in the enclosed nursing station at the time of this incident and left the nursing station in response to the incident.
b. Review of video (time stamped 12/19/18 at 11:45AM) identified Pt# 11 was sitting in a chair in the dayroom when Pt #15 entered the room, walked up to Pt# 11 and kicked his/her foot. Pt #11 was observed to jump up from the chair and both patients made fists and started swinging at each other and hitting each other. Pt# 15 was observed to fall/sit into a chair while Pt #11 continued to swing at and punch Pt #15, then leave the room. Further video observation noted that 3 staff members were in the enclosed nursing station at the time of this incident and left the nursing station in response to the incident.
c. Review of video (time stamped 12/22/18 3:25PM) identified Pt # 11 sitting in the dayroom when Pt #15 entered the dayroom and sat down near Pt # 11. Pt # 15 was observed to reach over and tap Pt #11 on the foot. Pt # 11 was observed to stand up, take off his/her coat, walk over to Pt# 15 and start hitting Pt # 15 while Pt # 15 is sitting in the chair. Video observation of the nursing station identified 4 staff members were in the enclosed nursing station at the time of this incident and left the nursing station in response to the incident.
d. Review of video (time stamped 1/7/19 at 1:58PM) noted the DON and a staff person walking towards the nursing station on unit 6, stop and speak to staff. Further observation noted that when the DON and staff member continue walking down hallway they pass the bathroom and stopped and saw Pt# 15 strike Pt# 11 and called to staff to call "a code". A code is a process to notify staff of a psychiatric emergency that requires all available clinical staff to respond. Review of the incident report dated 1/7/19 at 2:05PM identified Pt# 15 struck Pt #11 in the right check. The patients were separated and brought to each of their rooms without further incident.
e. Review of video (time stamped 12/27/18 at 12:38PM) identified Patient #12 in the unit 6 hallway talking to staff who were in the nursing station. Patient #12's pants were noted to be worn lower than his/her hips with an undergarment showing. No staff were visible in the

hallway. Patient #16 is observed to approach Patient #12, reach out, and appear to touch the waist band of Patient #12's pants. Patient #12 quickly turned around and exchanged words with Patient #12. Video observation of the nursing station identified 3 staff members were in the enclosed nursing station at the time of this incident and left the nursing station in response to the incident.

f. Observation on 1/16/19 at 1:10PM during a tour of unit 6 with the Director of Quality, noted 2 patients pacing up and down the hallways and no staff visible. Further observation noted upon reaching the glass encased nursing station identified the door closed with 6 staff members sitting inside the nursing station in a circle drinking coffee, talking and laughing. Observations of both hallways noted no staff present.

g. Observations on 1/22/19 at 10:10AM during a tour of unit 6 with the Director of Quality identified 4 patients walking in the hallways and 1 patient sitting in the dayroom. Upon approach to the nursing station, it was identified that 5 staff members were sitting in the nursing station talking, drinking coffee and 1 staff member reading the newspaper. Observations of both hallways noted no staff present.

The Whiting Service Nurse competency-based job description identified that the nurse demonstrates knowledge of duties and levels of responsibilities for team members, and demonstrates responsiveness to the needs and priorities of patients.

The Forensic Treatment Specialist (FTS) competency-based job description identified that the FTS participates as an active member of the treatment team and demonstrates the ability to collaborate with unit staff and follow a unit schedule which is responsive to patient care needs.

Interview with the Chief Nursing Officer (CNO) on 1/17/19 at 2:30PM stated that staff not be in the nursing station all at the same time. Staff should be out in the hallways and dayrooms monitoring, engaging with patients and providing activities. The CNO stated that unless there is a reason for them to be in the nursing station they should be out on the floor with patients.

Interview with the 7 AM to 3 PM Director of Nursing (DON) on 1/22/19 at 10:46AM stated that staff staying inside the nursing bubble had previously been identified and she had spoken to the RN Supervisors that staff should not be in the nursing station. The DON identified that she was aware that it is still happening. The DON stated that they are working on changing things and the expectation should be for staff to be out on the unit engaging/ monitoring the patients and conducting programs.

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The following is a violation of the Regulation of Connecticut State Agencies Section 17-227-14g Nursing (D)(1).

2. *Based on clinical record reviews, video review, review of hospital documentation and staff interviews for 2 of 7 patients reviewed for incidents (Patients #13 and 17) the hospital failed to ensure staff were present on the unit supervising patients during the period of time of alleged sexual contact. The findings include:
   a. Patient #13 was admitted on 12/21/18 for competency restoration, had a diagnosis of bipolar disorder and no documented history of sexual inappropriateness.
   Patient #17 was admitted on 10/30/18 for competency restoration, had a diagnosis of bipolar disorder and no documented history of sexual inappropriateness.
   Review of Patient #17's clinical record identified that between 11/23/18 and 12/1/18 identified that he/she had "created minor issues" on the unit by standing in the doorways of opposite sex peers (including Patient #13), hugging opposite sex peers (including Patient #13) and required redirection and review of appropriate boundaries.
   Review of a hospital incident report dated 12/1/18 identified that at approximately 7:35 PM another patient was observed looking into Patient #17's room. Then Patient #13 was observed coming out of Patient #17's room. The incident report identified that a review of hallway cameras found that at 6:01 PM Patient #17 entered Patient #13's room and exited at 6:08 PM (7 minutes later). Then Patient #13 observed entering Patient #17's room at 7:35 PM and exited about 10 seconds later. At the time of the event, Patient #13 reported having consensual sexual contact with Patient #17. Patient #13 was seen by a physician, alleged that he/she had consensual intercourse with Patient #17 and denied any coercion. Patient #13 agreed to have an evaluation at an acute care hospital for sexually transmitted diseases, counseling and other examinations as appropriate.
   Review of Patient #13's clinical record identified a nursing note on 12/1/18 at 9:00 PM that identified staff saw Patient #17 come out of Patient #13's room between 7:30 and 7:40 PM. It was documented that agency police viewed the (hallway) video and identified that Patient #17 was in Patient #13's room for 2 minutes. Patient #13 identified to nursing staff that the sexual encounter was consensual. On return from the hospital, Patient #13 retracted his/her statement and stated the sexual contact was not consensual. Patient #13 declined further hospital evaluation and was placed on constant observation with staff of the same sex.
   Review of a video time stamped 12/1/18 at 5:59 PM a census check was done. At 6:01 PM Patient #17 entered Patient #13's room and remained there for 7 minutes when he/she was seen standing in the hallway, then walked away. Although a hospital investigation identified that census checks were completed at 6:15 and 6:30 PM, review of the hallway video identified that no staff were visible in the hallway during this time. At 7:33 PM, Patient #13 is seen entering Patient #17's room and leaving at 7:35 PM, 2 minutes later. Another patient is seen peering into the room and leaves to approach staff who are not visible in the hallway.
   Interview with RN #11 on 1/22/19 at 1:00 PM identified that patient census checks are done

every 15 minutes but male and female patient rooms are not separated and it could be easy for anyone to sneak into another patient's room. RN #11 identified that although he/she was not working at the time of the incident, he/she heard that staff were in the "bubble" when the incident occurred.
Interviews with the Chief Nursing Officer (CNO) and Quality Director and on 1/22/19 at 2:15 PM identified that the Directors of Nursing are working with Supervisors to ensure staff are on the unit supervising patients and not in the "bubble". There are times that the Directors have had to issue direct orders to ensure staff are not sitting in the "bubble" when they should be out on the units with patients.

The following is a violation of the Regulation of Connecticut State Agencies Section 17-227-14g Nursing (D)(1).

3. *Based on clinical record review, interviews, review of policies and job descriptions and observation of video for 1 of 5 patients reviewed for staff to patient interaction, the facility failed to ensure that a staff member maintained appropriate boundaries. The findings include:
   a. Patient #1 was admitted on 8/29/18 with diagnoses of PTSD and borderline personality disorder. Review of video (time stamped 9/4/18 at 5:34 PM) identified Patient #1 was lying in bed and raised his/her arms towards the hallway. RN #10 entered the room, leaned over Patient #10, then hugged and kissed Patient #10 on the forehead.
   Review of hospital documentation identified that RN #10's actions were a breach in boundaries.
   Interview with DON #1 on 1/17/18 at 10:25 AM identified that the incident was first noted by another DON during random review of patient related video. Interview with RN #10 on 1/17/19 at 12:00 PM identified that he/she hugged Patient #10 and "pecked" his/her forehead and was not thinking that it was wrong.
   The hospital policy for agency code of conduct identified that staff are expected to act in a professional manner.

   The Whiting Service Nurse competency-based job description identified that the nurse demonstrates knowledge of the boundaries of the therapeutic relationship and the characteristics of acceptable techniques in working with patients.

The following is a violation of the Regulation of Connecticut State Agencies Section 17-227-14g Nursing (D)(1).

4. Based on observations and staff interviews the facility failed to ensure that nursing staff offered an alternate activity when the scheduled unit activity could not be held. The findings include:
   a. Observation on 1/22/19 at 10:10AM identified on unit 6, 4 patients walking the hallway, 1 patient in the dayroom and several patients lying in bed. Staff (5) were identified sitting in the enclosed nursing station drinking coffee, talking and/or reading the newspaper. Upon

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surveyor inquiry of where the activity program calendar was posted, FTS# 1 came out to the hallway to show where the calendar was located. Review of the Unit 6 Activity Calendar and Patient group Calendar for 1/22/19 identified individual music therapy between 9:15AM-10:15AM and 3 programs running between 10:15AM-11:15AM including Computer skills, Band, and Art group. FTS # 1 pointed to the wall and stated that most patients are lying down because they could not go outside (courtyard) due to inclement weather. FTS# 1 further stated that nothing else was put into place for an activity program. Interview with the DON at that time stated that if patients were unable to go outside due to weather staff could have offered another program such as using the weight room and/or what was scheduled on the recreation and group schedules.

The Whiting Service Nurse competency-based job description identified that the nurse leads groups of clients in rehabilitative, educational and recreational activities.

The Forensic Treatment Specialist (FTS) competency-based job description identified that the FTS demonstrates the required clinical ability to implement standards of patient care within the therapeutic milieu by performing patient focused activities.

Interview with the CNO on 1/17/19 at 2:30PM stated that not all staff should be in the nursing station. Staff should be out in the milieu monitoring, engaging with patients and/or providing activities. The CNO stated that unless there is a reason for them to be in the nursing station they should be out on the unit.

Interview with the 7 to 3 DON on 1/22/19 at 10:46AM stated the expectation is that staff are to be out on the unit engaging with and monitoring the patients and doing programs.

The following is a violation of the Regulation of Connecticut State Agencies Section 17-227-14g Nursing (D)(1).

5. *Based on clinical record review, facility documentation and staff interviews for 4 of 4 sampled patients reviewed for unit 6 daily activity groups and/or engagement activities, the Forensic Treatment Specialists (FTS) failed to document the patient's participation as it relates to achieving treatment plan goals and/or clinicians and nursing staff failed to ensure that patient's met their stated weekly group activities in accordance with the treatment plan. The findings include:

a. Patient # 11's diagnoses included Schizophrenia. Review of the Integrated Treatment Plan from August 2018 through January 2019 identified the FTS (Forensic Treatment Specialist) will monitor Pt # 11's interactions in group settings and unit based activities, help negotiate conflicts, provide positive feedback for appropriate interactions, reassure of safety and monitor patient responses to paranoid delusions two times per week in 15 minute intervals. Review of the Nursing Milieu Activities sheet instructions identified for the FTS to enter the name of the group or engagement activity, the amount of time for each activity and comments on participation as it related to achieving treatment plan goals. The treatment plan further identified that the patient should participate in approximately 404.25 minutes (6.7 hours) of groups and/or

activities each week. The Milieu sheet identified that on a daily basis the evening staff will total the number of hours/minutes for the activities and on Sunday the evening shift will total the number of hours/minutes for all weekly activities and this will be entered onto a spread sheet. Interview with the DON identified that the nursing supervisors were responsible for reviewing the milieu activity sheets.

I. Review of Pt # 11's weekly Milieu sheets dated from 8/20/18 through 8/26/18 identified the Milieu sheet failed to identified the type of group/engagement activity the patient participated in. Further review noted the patient only participated in 3 hours 30 minutes of group and/or engagement activity for the week. Additionally, 23 blocks of group/engagement activity were left blank.

II. Review of Pt # 11's weekly Milieu sheets from 9/24/18 through 9/30/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted the patient only participated in 3 hours 30 minutes of group activity for the week and no engagement time was recorded. Additionally, 38 blocks of group/engagement activity were left blank.

III. Review of Pt # 11's weekly Milieu sheets from 10/15/18 through 10/21/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted the patient only participated in 3 hours of group activity for the week and no engagement time was recorded. Additionally, 40 blocks of group/engagement activity were left blank.

IV. Review of Pt# 11's weekly Milieu sheets from 10/22/18 through 10/28/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 4 hours and 30 minutes of group activity for the week and no engagement time was recorded. Additionally, 38 blocks of group/engagement activity were left blank.

V. Review of Pt #11's weekly Milieu sheets from 11/5/18 through 11/11/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 4 hours 30 minutes of group activity for the week and no engagement activity was recorded. Additionally, 36 blocks of group/engagement activity were left blank.

VI. Review of Pt #11's weekly Milieu sheets from 12/10/18 through 12/16/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 4 hours 30 minutes of group activity for the week and no engagement activity was recorded. Additionally, 34 blocks of group/engagement activity were left blank.

VII. Review of Pt #11's weekly Milieu sheets from 12/17/18 through 12/23/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 6 hours 30 minutes of group activity for the week and no engagement activity was recorded. Additionally, 34 blocks of group/engagement activity were left blank.

VIII. Review of Pt #11's weekly Milieu sheets from 12/24/18 through 12/30/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 2 hours of group activity for the week and no engagement activity was recorded. Additionally, 40 blocks of group/engagement activity were left blank, and on 12/25/18 a line was drawn through the date and noted "holiday."

IX. Review of Pt #11's weekly Milieu sheets from 12/31/18 through 1/6/19 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 3 hours of group activity for the week and no engagement activity was recorded. Additionally, 39 blocks of group/engagement activity were left blank.

X. Review of Pt #11's weekly Milieu sheets from 1/7/19 through 1/13/19 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 4 hours of group activity for the week and no engagement activity was recorded. Additionally, 37 blocks of group/engagement activity were left blank.

b. Patient # 15's diagnoses included Schizophrenia and violent behaviors. Review of the Integrated Treatment Plan from August 2018 through January 2019 identified Patient # 15 will engage in meaningful conversation for 10 minutes daily with staff, refrain from physical aggression, and engaging in social and leisure activities. The treatment further noted this would be monitored and documented. The treatment plan further identified that the patient should participate in approximately 455 minutes (7.6 hours) of groups and/or activities each week.

I. Review of Pt# 15's weekly Milieu sheets from 8/20/18 through 8/26/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 1 hours and 30 minutes of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 26 blocks of group/engagement activity were left blank.

II. Review of Pt# 15's weekly Milieu sheets from 9/24/18 through 9/30/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 2 hours of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 23 blocks of group/engagement activity were left blank.

III. Review of Pt# 15's weekly Milieu sheets from 10/15/18 through 10/21/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 1 hours and 30 minutes of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 29 blocks of group/engagement activity were left blank.

IV. Review of Pt# 15's weekly Milieu sheets from 10/22/18 through 10/28/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 1 hours and 30 minutes of group

activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 26 blocks of group/engagement activity were left blank.

V. Review of Pt# 15's weekly Milieu sheets from 11/5/18 through 11/11/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 6 hours of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 20 blocks of group/engagement activity were left blank.

VI. Review of Pt# 15's weekly Milieu sheets from 12/3/18 through 12/9/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 3 hours group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 26 blocks of group/engagement activity were left blank.

VII. Review of Pt# 15's weekly Milieu sheets from 12/10/18 through 12/16/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 5 hours of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 21 blocks of group/engagement activity were left blank.

VIII. Review of Pt# 15's weekly Milieu sheets from 12/17/18 through 12/23/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 4 hours of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 20 blocks of group/engagement activity were left blank.

IX. Review of Pt# 15's weekly Milieu sheets from 12/24/18 through 12/30/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 1 hours and 30 minutes of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 28 blocks of group/engagement activity were left blank.

X. Review of Pt# 15's weekly Milieu sheets from 12/31/18 through 1/6/19 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 2 hours and 30 minutes of group activity and 2 hours and 45 minutes of engagement activity for the week was recorded. Additionally, 28 blocks of group/engagement activity were left blank.

XI. Review of Pt# 15's weekly Milieu sheets from 1/7/19 through 1/13/19 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 2 hours of group activity and 3 hours of engagement activity for the week was recorded. Additionally, 28 blocks of group/engagement activity were left blank.

c. Patient #12's diagnoses included chronic psychosis with mood lability and aggression. Review of the Integrated Treatment Plan dated 12/20/18 identified the FTS (Forensic Treatment

Specialist) will monitor Pt # 12's mood, behaviors and affect throughout the shift, monitor for increased acting out or focusing on peers and other precursors to aggression, encourage to attend groups and participate in individual meetings, and reinforce stress and anger management. The treatment plan further identified that the patient should participate in approximately 285 minutes (4.75 hours) of groups and/or activities each week.

I. Review of Pt# 12's weekly Milieu sheets from 12/17/18 through 12/23/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 30 minutes of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 26 blocks of group/engagement activity were left blank.

II. Review of Pt# 12's weekly Milieu sheets from 12/24/18 through 12/30/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 1 hour and 30 minutes of group activity and 3 hours and 30 minutes of engagement activity for the week was recorded. Additionally, 28 blocks of group/engagement activity were left blank.

III. Review of Pt# 12's weekly Milieu sheets from 12/31/18 through 1/6/19 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 30 minutes of group activity and 2 hour and 45 minutes of engagement activity for the week was recorded. Additionally, 30 blocks of group/engagement activity were left blank.

d. Patient #16's diagnoses included Autism with poor social boundaries and severe aggression. Review of the Integrated Treatment Plan dated 12/18/18 identified nursing staff will ensure Patient #16 attends medication education group twice per week, teach risks and benefits of medication and their role in recovery, and meet weekly to discuss goal of weight reduction. The FTS will monitor Pt # 16 for medication side effects and work with the patient on maintaining a clean room and clothing and help maintain a safe and healthy living space. The treatment plan further identified that the patient should participate in approximately 1,160 minutes (19.3 hours) of groups and/or activities each week.

I. Review of Pt# 16's weekly Milieu sheets from 12/10/18 through 12/16/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 6 hours of group activity for the week and no time with engagement activity was recorded. Additionally, 34 blocks of group/engagement activity were left blank.

II. Review of Pt# 16's weekly Milieu sheets from 12/17/18 through 12/23/18 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 2 hours and 30 minutes of group activity for the week and no time with engagement activity was recorded. Additionally, 37 blocks of group/engagement activity were left blank.

III. Review of Pt# 16's weekly Milieu sheets from 12/24/18 through 12/30/18 failed to identify the type of group/engagement activity the patient participated in. Further review

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noted that the patient only participated in 1 hour and 150 minutes of group activity for the week and no time with engagement activity was recorded. Additionally, 39 blocks of group/engagement activity were left blank.

IV. Review of Pt# 16's weekly Milieu sheets from 12/31/18 through 1/6/19 failed to identify the type of group/engagement activity the patient participated in. Further review noted that the patient only participated in 1 hour and 30 minutes of group activity for the week and no time with engagement activity was recorded. Additionally, 40 blocks of group/engagement activity were left blank.

The following is a violation of the Regulation of Connecticut State Agencies Section 17-227-14g Nursing (D)(1).

6. Based on clinical record review, facility documentation and staff interview for 2 of 2 patients reviewed for patient to patient physical aggression, Pt #11 and Pt #15, the facility failed to ensure treatment plans were updated after altercations occurred. The findings include:
   a. Pt # 11's diagnoses included Schizophrenia. Review of Pt # 11's Integrated Treatment Plan from August 2018 through January 2019 identified for the FTS's to help negotiate conflicts, provide positive feedback for appropriate interactions and reassure safety. Additionally, the treatment plan noted that the RN will meet with patient to assess for symptoms of aggression, threats and/or posturing, encourage the use of PRN medications and/or personal preference to manage aggression.
   b. Pt# 15's diagnoses included Schizophrenia and violent behaviors. Review of Pt# 15's Integrated Treatment Plan from August 2018 through January 2019 identified long history of psychosis with significant acts of aggression. Interventions included engaging in meaningful conversation, engaging in social and leisure activities and taking medications as ordered.
      I. Review of Incident report dated 8/21/18 at 9:35AM identified Pt #15 kicked Pt # 11 in the upper thigh while in the dayroom. The patients were separated and Pt# 15 was medicated and placed on a constant observation for one half of an hour. The treatment plans for both Pt # 11 and # 15 lacked any new interventions to ensure both patients were free from assaultive behaviors.
      II. Review of incident report dated 8/23/18 at 11:50AM identified Pt# 11 reported he/she was in the dayroom when Pt # 15 entered the room and as Pt # 11 was trying to leave the dayroom Pt # 15 kicked Pt # 11 in the upper right thigh. The patients were separated, Pt # 15 was medicated and returned to his/her room. The treatment plans for both Pt # 11 and # 15 lacked any new interventions to ensure both patients were free from assaultive behaviors.
      III. Review of incident report dated 9/28/18 at 1:55PM identified as staff was walking by the bathroom Pt # 11 and # 15 were standing in the bathroom, Pt # 11 reported that Pt # 15 swung at him/her, and Pt # 15 reported that Pt # 11 hit him/her "hard in

the gut". The patients were assessed for injury and separated. The treatment plans for both Pt # 11 and # 15 lacked any new interventions to ensure both patients were free from assaultive behaviors.

IV. Review of incident report dated 10/15/18 at 3:35PM identified Pt #15 struck Pt #11 in the left elbow with a closed fist. The patients were separated and Pt #15 was administered PRN medications. The treatment plans for both Pt #11 and #15 lacked any new interventions to ensure both patients were free from assaultive behaviors.

V. Review of incident report dated 10/27/18 at 12:30PM identified Pt # 15 was witnessed punching towards Pt # 11. Pt # 15 was redirected, administered PRN medications and Pt # 11 sustained a small abrasion to the base of the right thumb. The treatment plans for both Pt # 11 and # 15 lacked any new interventions to ensure both patients were free from assaultive behaviors.

On 1/16/19 a Patient Group Schedule was observed posted on Unit 6. The schedule was last revised on 7/19/18. Review of the group schedule identified groups were noted in 4 blocks of time (9:15AM-12PM, 1PM-4:30PM, 5PM to 6PM, and 6:00PM to 8:00PM) between 9:15am to 7:30PM. Additionally, within the 4 blocks of time, groups either ran concurrently or the time frames for groups/programs overlapped each other. Further review noted from Monday through Friday identified 9 to 13 group activity opportunities in a day. On Saturday and Sunday there were 6 groups identified during the 7-3:00 PM shift and no group activities offered on the 3-11: 00 PM shift. It was unclear if any group activities were led by a unit nurse or unit FTS.

The Forensic Treatment Specialist (FTS) competency-based job description identified that the FTS demonstrates the required clinical ability to implement standards of patient care within the therapeutic milieu by performing patient focused activities.

The Whiting Service Nurse competency-based job description identified that the nurse leads groups of clients in rehabilitative, educational and recreational activities.

Interview with the CNO and the Quality Officer on 1/17/19 at 2:40PM identified that staff are found sitting in the nursing station or "bubble" most of the time when they should be running groups with the patients. The CNO stated that there should be therapeutic activities throughout the day, every day. Review of the Nursing Milieu Activity sheets for Patients # 11, 12, 15, and 16 with the CNO on 1/22/19 at 3:45PM identified most of the Milieu sheets were blank, lack documentation of what type of group or engagement the patient participated in and how long the patient attended. The CNO identified that they were aware that staff are not providing therapeutic activities throughout the day and they are working on correcting it. Nursing supervisors were expected to monitor milieu activities but that has not been as effective as expected. The

DATES OF VISIT: September 25, October 4, November 20, 2018, January 16, 17, 22, April 4, May 1 and 2, 2019

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Quality Officer identified that it was identified that staff were in the "bubble" most of the time and that milieu activities were not occurring as expected. The Quality Officer, CNO and CEO met regularly to put policies, strategies and processes in place to guide staff in implementing staff-lead milieu activities. The CNO identified that she has had to issue direct orders to staff in order to get them out onto the units and interacting with patients.

The following is a violation of the Regulations of Connecticut State Agencies Section 17-227-14 (g) Nursing (C)(1) and/or (D).

7. *Based on clinical record review, facility documentation, observations, and interviews with facility personnel for one of one sampled patients (Patient #1), the facility failed to ensure that environmental risks were removed for patients determined to be at risk for ingesting items. The finding includes:

   a. Patient #1 was admitted to the hospital on 8/29/18. Patient #1 had a history of self-injurious behavior, aggression toward other and ingesting items. Review of the physician orders dated 8/29/18 identified that the patient was on constant observation (CO) with one additional staff member at all times. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions to remain on CO with two staff members, preferably males.

   Review of facility documentation on 9/25/18 identified that after an incident on 9/15/18 where Patient #1 ingested a glove, the facility implemented an environmental monitor/protocol constant observation to migrate the risk of ingesting items.

   During tour of Unit One on 11/20/18, it was observed that Patient #1 was walking down the hallway with one staff member in front and one staff member in back of her/him with no environmental staff member to assess the environment for potential items. Further observation identified in the hallway was a yellow cart with bins that had toiletries assigned to each patient on the unit. Patient #1 was able to walk by the yellow bins with patient supplies without anyone removing them before he/she walked by to mitigate the patient's risk.

   Review of the environmental risk monitor/protocol identified that when the patient is walking through the hallways, open spaces, or in route to a meeting or room, the environmental monitor will proceed in front of the patient in such a manner as to scan the environment in order to assess for and immediately remove ingestible items.

   Interview with the Director of Quality Improvement on 11/20/18 identified that an environmental staff member is to be in front of Patient #1 to check that no ingestible items are for patient access while the patient has access to the hallways.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 17-227-14 (g) Nursing (C) (1) and/or (D).

8. *Based on medical record review, review of facility documentation, review of facility policies and procedures and interviews for one of three sampled patients (P#1), who had a history ingesting items, the facility failed to provide adequate supervision to prevent self-injury which resulted in multiple hospital procedures. The findings include:
   a. Patient #1 was admitted to the hospital on 8/29/18. Patient #1 had a history of self-injurious behavior, aggression toward other and ingesting items. Review of the physician orders dated 8/29/18 identified that the patient was on constant observation (CO) with one additional staff member at all times. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions to remain on CO with two staff members preferably males.
      i. Review of the nurses notes dated 9/5/18 identified that Patient #1 was showering and broke off a piece of a comb and swallowed it. Review of the nurse note dated 9/6/18 identified that the patient had coughed up the comb and complained of throat irritation. Review of hospital documentation lacked an incident report and/or an investigation that was conducted after the event. The facility failed to maintain Patient #1's safety when the patient was on constant observation of two staff members.
      ii. Review of the nurse's notes dated 9/15/18 identified that Patient #1 became combative and was being escorted to the seclusion room by two male staff members (one walking in the front of the patient and one walking in the back of the patient) and the patient grabbed a box of gloves. Further review identified that staff tried to retrieve the glove box but the patient threw the glove box and kept one glove. Patient #1 entered the seclusion room and placed the glove in his/her mouth. Patient #1 proceeded to swallow the glove, psychiatric code was called and the patient was transferred to the hospital. Review of the hospital record dated 9/15/18 identified that Patient #1 had an endoscopy which indicated that a glove and a 12.5cm ballpoint pen were retrieved.

      Review of the video (time stamped 9/15/18 at 8:44pm) identified Patient #1 was being escorted to the seclusion room by FTS #1 and FTS#2 (one walking in the front of the patient and one walking in the back of the patient). Patient #1 started walking to the right side of the hallway and grabbed a box of gloves. Further review identified that staff tried to retrieve the glove box but the patient threw the glove box and kept one glove without staff being aware. Patient #1 was observed entering the seclusion room and placed one glove in his/her mouth. Patient #1 proceeded to swallow the glove, a psychiatric code was called and the patient remained in the seclusion room with multiple staff members until he/she was transferred to the hospital. Further review identified that FTS#1 and FTS#2 failed to maintain Patient #1's safety while on CO and/or failed to observe the patient's hands to maintain patient safety to prevent the ingestion of a glove.

      The hospital failed to implement an environmental risk protocol when Patient #1 was admitted to the unit when staff were aware of the patient's history of ingesting items.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of facility documentation on 9/25/18 identified that after the incident on 9/15/18 when Patient #1 ingested a glove, the facility implemented an environmental monitor/protocol constant observation to migrate the risk of ingesting items which directed a staff member to walk and/or observe Patient #1's environment so that environmental risks can be removed prior to placing the patient in the environment.

c. Review of the physician orders dated 8/29/18 identified that the patient was on constant observation (CO) with one additional staff member at all times and a staff member to monitor the patient's environment. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions remain on CO with two staff members preferably males. Review of the facility incident report dated 9/26/18 identified that Patient #1 had swallowed the cap of a toothpaste bottle while being observed by staff brushing his/her teeth in the bathroom. Patient #1 was evaluated and the plan was to monitor for safety. The facility failed to maintain Patient #1's safety when the patient was on constant observation of two staff members.

d. Review of the physician orders dated 8/29/18 identified that the patient was on constant observation (CO) with one additional staff member at all times and a staff member to monitor the patient's environment. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions remain on CO with two staff members preferably males. Review of the facility incident report dated 10/4/18 identified that Patient #1 had regained the privilege of wearing regular clothes on that day. Patient #1 attempted to swallow a sock while in the female bathroom. Further review identified that staff were able to obtain one sock from the patient's mouth however they were unable to locate the matching sock. Patient #1 was sent to the hospital for an evaluation. Review of the hospital record dated 10/4/18 identified that the questionable ingested item was not found. The facility failed to maintain Patient #1's safety when the patient was on constant observation of two staff members.

e. Review of the physician orders dated 8/29/18 identified that the patient was constant observation (CO) with one additional staff member at all times and a staff member to monitor the patient's environment. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions remain on CO with two staff members preferably males. Review of the facility incident report dated 10/14/18 identified that Patient #1 was sitting on the toilet when staff observed that he/she removed an EKG lead (from previous hospitalization 10 days prior) under his/her left breast and swallowed it. Patient #1 was sent to the hospital for an evaluation. Review of the hospital record dated 10/1/18 identified that the hospital team felt that the EKG lead was small enough to pass through the digestive system without any complications. The facility failed to maintain Patient #1's safety when the patient was on constant observation of two staff members.

f. Review of the physician orders dated 8/29/18 identified that the patient was constant

observation (CO) with one additional staff member at all times and a staff member to monitor the patient's environment. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions remain on CO with two staff members preferably males. Review of the incident report dated 10/20/18 identified that Patient #1 had a plan in place for staff to inspect the environment before transitioning to another area on the unit. Patient #1 was brought into an exam room where he/she grabbed a glove from the trash can under the exam table and ingested the glove. Patient #1 was sent to the hospital for an evaluation. Review of the hospital record dated 10/20/18 identified that a blue glove was removed endoscopically. The facility failed to maintain a hazard free environment and Patient #1's safety even when the patient was on constant observation of two staff members.

g. Review of the physician orders dated 8/29/18 identified that the patient was constant observation (CO) with one additional staff member at all times. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions remain on CO with two staff members preferably males. Review of the incident report dated 10/27/18 identified that Patient #1 was given a snack and swallowed a 2.cm x 10cm "cheese nip" wrapper. Patient #1 was sent to the hospital for an evaluation, no endoscopy performed as physician believed it would pass on its own. The facility failed to maintain Patient #1's safety when the patient was on constant observation of two staff members.

Interview with the Director of Quality Improvement on 9/25/18 identified that after the event on 9/15/18, the hospital put an environmental monitor protocol in place for mitigating the environmental risk which included removing ingestible items for patient access. Further interview indicated that the hospital was aware of Patient #1's history of ingesting items on admission on 8/28/18 and should have had an environmental risk protocol in place when the patient was admitted to ensure Patient #1's safety.

The facility policy for special observation identified that this included every 15 minute observations and CO. The policy further identified that the nursing staff assigned to the Special Observation is responsible and accountable for ensuring patient safety. The policy directed that the patient's hands, face, and neck must be in clear view at all times unless otherwise specified in the MD order.

The facility policy for patient safety event and incident management identified the following: 1. Ingestion of foreign bodies was considered an aggressive act to self. 2. A patient safety event was an event, incident or condition that could have resulted or did result in harm to a patient. 3. An exam is required for all patient injuries. 4. The incident report form is an administrative form only and does not substitute for the necessary clinical documentation in the medical record. The facility client and family handbook identified a patient right to have complaints of pain appropriately assessed and interventions made in a timely manner.

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The facility policy for CO identified that with CO, the patient required ongoing monitoring to ensure his/her safety and/or the safety of others. The policy further noted that nursing staff assigned provided this by having a clear view of and unimpeded access to the patient at all times. The facility client and family handbook identified a patient right to receive individualized treatment.

The following is a violation of the Regulations of Connecticut State Agencies Section 17-227-14 (Medical Staff) (B) and/or (c) management (c) and/or (g) Nursing (C).

9. *Based on medical record review, review of facility documentation, review of facility policies and procedures and interviews for one of three sampled patients (P#1), who had a history ingesting items, the facility failed conduct a comprehensive investigation and/or a comprehensive physician assessment after the patient had ingested a glove while on constant observation (CO). The findings include:
    b. Patient #1 was admitted to the hospital on 8/29/18. Patient #1 had a history of self-injurious behavior, aggression toward other and ingesting items. Review of the physician orders dated 8/29/18 identified that the patient was on constant observation (CO) with one additional staff member at all times. Review of the treatment plan dated 8/29/18 identified that the patient had exhibited behaviors of hurting someone or hurting his/herself with interventions remain on CO with two staff members preferably males.
    b. Review of the facilities incident/accident report indicated that although an accident/incident report was completed for incidents on 10/20/18 and 10/27/18, the facility failed to complete a comprehensive physician assessment after Patient #1 ingested items.

    Interview and review of facility documentation with the Chief Nursing Officer on 4/4/19 at 11:00 AM identified that there was no physical assessment of Patient #1 for incidents on 10/20/18 and 10/27/18 by the physician before the patient was sent to the hospital.

    Review of the hospital policy entitled patient safety event and incident management identified that a critical incident is an occurrence which adversely affects or has the potential of adversely affecting an individual's health, safety, or well-being and/or the operation of the hospital. After a critical incident, the appropriate supervisor on duty completes a detailed summary of findings from the investigation of the incident and documents any additional measures to be taken including notifications that need to occur. The physician is notified and an assessment of the patient is completed with a treatment plan and/or need for further treatment documented on the incident report.

    Further review of hospital policy identified that after unit staff documents an incident, it is subject to three levels of review. The first level of review will be completed by the Unit Director or RN supervisor and documented on the Incident Report Form within five working days. The second review is to be completed by the CEO or designee and documented on the Incident Report Form within ten working days. The third level of

review is to be completed by the Governing Body and documented in committee minutes within 45 days for all sentinel events and within 60 days for all other adverse events determined to be critical incidents.

# STATE OF CONNECTICUT

*DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES*

**WHITING FORENSIC HOSPITAL**

Approved
5/23/19
SHN

May 17, 2019

Susan Newton, R.N., B.S., Supervising Nurse Consultant
Facility Licensing and Investigations Section
410 Capitol Avenue, P.O. Box 340308
Hartford, CT 06134

Dear Ms. Newton:

In response to the DPH Violation Letter of May 7, 2019, attached you will find Whiting Forensic Hospital's response to the findings submitted today (May 17, 2019) as requested. The Whiting team appreciates and acknowledges the consultative nature of the series of visits by DPH in developing the findings.

We look forward to our meeting of June 4, 2019 to discuss our response. In the interim, should you have any questions or concerns, kindly contact me or Christine Bouey, LCSW, Chief Quality and Compliance Officer.

Thank you,

Hal Smith

Hal Smith, MPS
Chief Executive Officer
Whiting Forensic Hospital

Cc: Miriam Delphin-Rittmon, Ph.D., Commissioner

**Phone: (860) 262-5400**
**P.O. Box 70, MIDDLETOWN, CT 06457**

# Whiting Forensic Hospital Plan of Correction 5/17/19

| NON-COMPLIANCE ITEM | CORRECTIVE ACTION / STEPS TO PREVENT REOCCURENCE | EFFECTIVE DATE | MONITORING PLAN/STAFF RESPONSIBLE |
|---|---|---|---|
| Section 17-227-14g Nursing: the facility failed to ensure nursing staff were present in the milieu supervising, interacting and/or assisting patients | Of the four incidents cited, emergency response codes were called, Patients #11 and #15 were assessed by the attending physician and appropriate treatment was ordered.<br><br>Patients #11 and #15 received coaching regarding boundaries and safety.<br><br>Patient #11 was reviewed in the weekly Forensic Review Committee (FRC) 7 times between 9/18 and 2/19.<br><br>Patient's behavioral plan was reviewed and a referral for Behavioral Intervention Services (BIS) was discussed.<br><br>FRC is chaired by the Chief Executive Officer and composed of senior medical/clinical leadership and the DMHAS Consulting Forensic Psychiatrists (CFPs) and includes a review of all client movement, high risk issues and recent incidents.<br><br>Patient # 15 was transferred to a different unit.<br><br>Patient #16 was reviewed in FRC on 10/29/18 and 12/3/18, resulting in a referral for BIS.<br><br>The Service Medical Director and Chief Medical Officer met with unit team to identify strategies to mitigate risk posed by Patient #16 and treatment plan was updated accordingly. | 12/11/18, 12/19/18, 12/22/18, 1/7/19<br><br>12/11/18, 12/19/18, 12/22/18, 1/7/19<br><br>2/4/19<br><br>2/2/19<br><br>2/12/19<br><br>1/10/19 | |
| | The Service Medical Director assessed vulnerable patients on unit to determine their risk of victimization, an extra staff was assigned to unit to mitigate risk | 1/10/19 | |

| NON-COMPLIANCE ITEM | CORRECTIVE ACTION / STEPS TO PREVENT REOCCURENCE | EFFECTIVE DATE | MONITORING PLAN/STAFF RESPONSIBLE |
|---|---|---|---|
| Section 17-227-14g Nursing: the facility failed to ensure nursing staff were present in the milieu supervising, interacting and/or assisting patients | A new Milieu Management Policy, which outlines the expectation for nursing staff presence in the milieu and patient engagement, was developed for both Whiting and Dutcher services. | 4/8/19 | |
| | Staff education: The Milieu Management Policy training was distributed and will be included as an annual training and in New Employee Orientation | 5/19/19 | Chief Nursing Officer will monitor Workforce Development Compliance Report for Learning Management System (LMS) New Employee Orientation and Annual training of policy to ensure 90% compliance ongoing; results of compliance will be reviewed in Staff Development Committee monthly and Governing Body quarterly |
| | Nurse Supervisor will conduct and document 1 observation per unit, per shift, per day to ensure Milieu Management Policy is implemented. Any performance issues will be addressed immediately by the Nurse Supervisor and reported to the Director of Nursing and Chief Nursing Officer. | 5/20/19 | Chief Nursing Officer will monitor audits on weekly basis, will report findings to Quality Safety Risk Committee (QRS) monthly and to Governing Body quarterly until 90% compliance rate is obtained for a minimum of 6 months |
| | Director of Nursing conducts video reviews for all codes, Restraint and Seclusion, as well as random reviews, every shift, each day. These video reviews are forwarded to senior management daily. During these reviews, the Director of Nursing will observe staff location at time of incident and will address any performance issues immediately. The Director of Nursing will forward any Milieu Management policy violations to the Chief Nursing Officer, who will determine additional course of action | 5/20/19 | Chief Nursing Officer will monitor 100% of video review reports, ongoing, take action as indicated and report findings to Quality Safety Risk Committee (QRS) monthly and to Governing Body quarterly. |
| | | | Responsibility for Oversight: Chief Nursing Officer |
| Section 17-227-14g Nursing: the hospital failed to ensure staff were present on the unit supervising patients during the period of time of alleged sexual contact | Patient #13 was immediately evaluated by the on call physician. Patient was seen at local emergency department on date of incident.<br><br>Patient #13 placed on Constant Observation, female staff only, for support and observation upon return from Emergency Department.<br><br>Patient #17 was temporarily transferred to other unit overnight | 12/2/18<br><br>12/2/18<br><br>12/2/18 | |

| NON-COMPLIANCE ITEM | CORRECTIVE ACTION / STEPS TO PREVENT REOCCURENCE | EFFECTIVE DATE | MONITORING PLAN/STAFF RESPONSIBLE |
|---|---|---|---|
| Section 17-227-14g Nursing: the hospital failed to ensure staff were present on the unit supervising patients during the period of time of alleged sexual contact | Patient #13 and #17 rooms were changed to opposite ends of hallway<br><br>The incident was thoroughly investigated. Staff adhered to relevant policy | 12/2/18<br><br>1/14/19 | |
| | A new Milieu Management Policy, which outlines the expectation for nursing staff presence in the milieu and patient engagement, was developed for both Whiting and Dutcher services. | 4/8/19 | |
| | Staff education: The Milieu Management Policy training was distributed and will be included as an annual training and in New Employee Orientation | 5/19/19 | Chief Nursing Officer will monitor Workforce Development Compliance Report for LMS New Employee Orientation and Annual training of policy to ensure 90% compliance ongoing; results of compliance will be reviewed in Staff Development Committee monthly and Governing Body quarterly |
| | Nurse Supervisor will conduct and document 1 observation per unit, per shift, per day to ensure Milieu Management Policy is implemented. Any performance issues will be addressed immediately by the Nurse Supervisor and reported to the Director of Nursing and Chief Nursing Officer. | 5/20/19 | Chief Nursing Officer will monitor audits on weekly basis, will report findings to Quality Safety Risk Committee (QRS) monthly and to Governing Body quarterly until 90% compliance rate is obtained for a minimum of 6 months |
| | Director of Nursing conducts video reviews for all codes, Restraint and Seclusion, as well as random reviews, every shift, each day. These video reviews are forwarded to senior management daily. During these reviews, the Director of Nursing will observe staff location at time of incident and will address any performance issues immediately. The Director of Nursing will forward any Milieu Management policy violations to the Chief Nursing Officer, who will determine additional course of action | 5/20/19 | Chief Nursing Officer will monitor 100% of video review reports, ongoing, take action as indicated and report findings to Quality Safety Risk Committee (QRS) monthly and to Governing Body quarterly. |
| | | | Responsibility for Oversight: Chief Nursing Officer |
| Section 17-227-14g Nursing: the facility failed to ensure that a staff member maintained appropriate boundaries | Investigation was conducted during which time employee was removed from patient care; appropriate disciplinary action was taken | 9/19/19 | |

| NON-COMPLIANCE ITEM | CORRECTIVE ACTION / STEPS | EFFECTIVE DATE | MONITORING PLAN/STAFF RESPONSIBLE |
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|---|---|---|---|
| | **TO PREVENT REOCCURENCE** | | |
| Section 17-227-14g Nursing: the facility failed to ensure that a staff member maintained appropriate boundaries | All nursing staff will be reeducated on the Agency Compliance, Code of Conduct and Guidelines Concerning the Prohibition on Sexual or Otherwise Exploitative Relationships Between Employees and Patients/Clients (DMHAS Work Rule #24) | 5/27/19 | Chief Nursing Officer will monitor Workforce Development Compliance Report for LMS to ensure 100% |
| | Staff Development will create an LMS training on boundaries which will be included in New Employee Orientation, as well as an annual training | 6/24/19 | Chief Nursing Officer will monitor Workforce Development Compliance Report for LMS New Employee Orientation and Annual training of policy to ensure 90% compliance ongoing; results of compliance will be reviewed in Staff Development Committee monthly and Governing Body quarterly |
| | | | Responsibility for Oversight: Chief Nursing Officer |
| Section 17-227-14g Nursing: the facility failed to ensure that nursing staff offered an alternate activity when the scheduled unit activity could not be held | Chief Operating Officer has established a monthly Programming Committee; meeting with all discipline heads, specifically identifying strategies to increase programming, decrease group cancellations and to ensure programming meets patients' clinical needs by addressing diagnosis, stage of development, as well as the reason for patients' continued need for inpatient treatment. | 3/18/19 | Chief Operating Officer will report status to Governing Body on a monthly basis on an ongoing basis. |
| | Rehabilitation, Social Work, Psychology and Nursing scheduled groups/activities will be tracked via the Alternative Programming Tracker. In rare event where a group/activity cannot occur as scheduled, an alternative will be provided | 6/28/19 | Chief Operating Officer and Chief Nursing Officer will monitor ongoing to ensure 100% of groups and/or alternate activities occur; results of auditing will be reviewed monthly in Quality Risk and Safety Committee and quarterly in Governing Body |
| | In addition to individual patient engagement, Forensic Treatment Specialists/Mental Health Assistants will provide three group activities per 1st and 2nd shifts, 7 days a week. Activities will be documented in daily progress notes. These groups will be included on the unit master schedule. | 6/28/19 | Chief Nursing Officer will audit Nursing Milieu Activities audits conducted by Nurse Supervisor for 100% compliance of :<br>1) documentation completion<br>2) alternative activity offered when scheduled group cancelled<br>3) patient on engagement plan offered alternative activity by FTS/MHS if patient refuses to attend scheduled group<br><br>Results of audits will be reviewed monthly in Quality Risk and Safety Committee and Governing Body quarterly<br><br>Chief Nursing Officer will monitor ongoing, using the Daily FTS/MHA Led Activity Tracker to ensure 100% of groups and/or alternate activities occur results of auditing will be reviewed monthly in Quality Risk and Safety Committee and quarterly in Governing Body |
| **NON-COMPLIANCE ITEM** | **CORRECTIVE ACTION / STEPS** | **EFFECTIVE DATE** | **MONITORING PLAN/STAFF RESPONSIBLE** |

| | TO PREVENT REOCCURENCE | | |
|---|---|---|---|
| Section 17-227-14g Nursing: the facility failed to ensure that nursing staff offered an alternate activity when the scheduled unit activity could not be held | Forensic Treatment Specialist/Mental Health Assistants will receive training in facilitating group activities; this training will be included in New Employee Orientation | 6/28/19 | Chief Nursing Officer will monitor Staff Development training records until 100% compliance is met. Compliance will be report to Staff Development Committee monthly and Governing Body quarterly |
| | Forensic Treatment Specialists/Mental Health Assistants will not cancel scheduled activities without Nurse Supervisor /Unit Director approval; the Nurse Supervisor will ensure alternative programming | 6/28/19 | Chief Nursing Officer will monitor ongoing, using the Alternative Programming Tracker audit, to ensure 100% of groups and/or alternate activities occur ; results of auditing will be reviewed monthly in Quality Risk and Safety Committee and quarterly in Governing Body |
| | All disciplines will utilize the centralized database Recovery Management System to document patients' group/activity attendance such that reports can be generated to demonstrate/track patients' total treatment hours. These reports will inform treatment planning and be included in their medical record. | 6/28/19 | Chief Operating Office and Chief Nursing Officer will monitor staff's use of RMS by comparing patients' monthly RMS group attendance report with the Alternative Programming Tracker and the FTS/MHA Activity Tracker audit. Result will be reviewed in Quality Risk and Safety Committee monthly and Governing Body quarterly ongoing until such time as the hospital determines sufficient compliance |
| | | | Responsibility for Oversight: Chief Nursing Officer |
| Section 17-227-14g Nursing: FTSs failed to document the patient's participation as it relates to achieving treatment plan goals and/or clinicians and nursing staff failed to ensure that patient's met their stated weekly group activities in accordance with treatment plan | Staff assigned to conduct groups/activities may not cancel for any without approval from their discipline head (Unit Director in their absence) during regular business hours or Director of Nursing (after hours) | 6/3/19 | Chief Operating Officer and Chief Nursing Officer will monitor ongoing, using the Alternative Programming Tracker audit, to ensure 100% of groups and/or alternate activities occur ; results of auditing will be reviewed monthly in Quality Risk and Safety Committee and quarterly in Governing Body |
| | The discipline head/Unit Director will be responsible to arrange coverage for planned and unplanned staff absence, who are scheduled to provide groups | 6/3/19 | Chief Operating Officer and Chief Nursing Officer will monitor ongoing, using the Alternative Programming Tracker audit, to ensure 100% of groups and/or alternate activities occur ; results of auditing will be reviewed monthly in Quality Risk and Safety Committee and quarterly in Governing Body |
| | Rehabilitation, Social Work, Psychology and Nursing scheduled groups/activities will be tracked via the Alternative Programming Tracker. In rare event where a group/activity cannot occur as scheduled, an alternative will be | | Chief Operating Officer and Chief Nursing Officer will monitor ongoing, using the Alternative Programming Tracker audit, to ensure 100% of groups and/or alternate activities occur results of auditing will be reviewed monthly in Quality Risk and Safety Committee and quarterly in Governing Body |
| | Group facilitators are responsible to prepare group activities curriculum to be used in their absence | 6/3/19 | |
| | | | Responsibility for Oversight: Chief Operating Officer |
| **NON-COMPLIANCE ITEM** | **CORRECTIVE ACTION / STEPS** | **EFFECTIVE DATE** | **MONITORING PLAN/STAFF RESPONSIBLE** |

| | TO PREVENT REOCCURENCE | | |
|---|---|---|---|
| Section 17-227-14g Nursing: facility failed to ensure treatment plans were updated after altercations occurred | Focus Treatment Plans were added as a standing agenda item in Morning Report, a hospital wide meeting, where all incident are reviewed., as of 4/1/19 | 4/1/19 | Chief Operating Officer will monitor to ensure 100% of Focus Treatment Plans are completed per policy, within the required timeframe and include new interventions or rationale for lack thereof Results will be reported to Quality Safety Risk Committee monthly and Governing Body quarterly on an ongoing basis or until such time as the hospital determines sufficient compliance. |
| | All psychiatrists were provide re-education including expectation that new interventions or rationale for lack thereof are included in Focus Treatment Plans | 5/13/19 | Chief Medical Officer will ensure 100% of attending physician receive re-education regarding the requirement to identify new interventions/complete the Change in Treatment Interventions section of the Focus Treatment Plan |
| | The Focus Treatment Plan format was revised to include: Summary of Change of Condition and Change in Treatment Interventions | 1/10/19 | |
| | Integrated Treatment Planning Process Policy was revised to include specific incidents/events which require a Focus Treatment Plan Review | 4/8/19 | |
| | All staff was educated on the revised Integrated Treatment Planning Process policy. | 5/31/19 | Chief Nursing Officer will monitor Staff Development training records until 100% compliance is met. Compliance will be report to Staff Development Committee monthly and Governing Body quarterly |
| | | | Responsibility for Oversight: Chief Operating Officer |
| Section 17-227-14g Nursing: facility failed to ensure that environmental risks were removed for patients determined to be at risk for ingesting items | Upon admission, patient #1 was placed on Constant observation with an extra staff due to risk of self-injurious behavior.<br>From 9/15/18-10/27/18 (incident dates cited), individualized orders specified patient's ability to access utensils, clothing, diet, etc. Referrals were made to Physical Therapy and Occupational therapy services. The patient also received individual sessions from the physician, psychologist, social worker, rehabilitation therapist and Unit Director. A behavioral plan was also initiated.<br><br>Patient was discharged from Whiting Forensic Hospital. | <br><br><br><br><br><br><br><br><br><br><br><br>1/30/19 | |

| NON-COMPLIANCE ITEM | CORRECTIVE ACTION / STEPS TO PREVENT REOCCURENCE | EFFECTIVE DATE | MONITORING PLAN/STAFF RESPONSIBLE |
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| Section 17-227-14g Nursing: facility failed to ensure that environmental risks were removed for patients determined to be at risk for ingesting items | Special Observation Policy requires staff to maintain line of sight at all times and therefore they cannot walk in front of patient to scan/ensure safe environment. Staff adhered to the Special Observation Policy when they remained behind patient in order to maintain visual observation while on Constant Observation. | | |
| | An Environmental Monitoring Protocol was established for use with patients who ingest/insert items allowing staff to walk ahead of a patient to mitigate/remove environmental risks. (The protocol includes specific guidelines for staff to mitigate/remove environmental risks by engaging in activities such as scanning the environment before patient enters a room. | 10/12/18 | |
| | Nursing staff was provided live training on Environmental Monitoring Protocol | 10/31/18 | Chief Nursing Officer monitored Staff Development compliance reports until 100% compliance was achieved. |
| | Psychiatric Admission Assessment was revised to include: assessment of ingestion/insertion of items and assessment for need of Environmental Monitoring Protocol . | 10/26/18 | Chief Medical Officer will review all Psychiatric Admission Assessment to ensure that the Environmental Monitoring Protocol is initiated for all patients with a history of ingestions/insertion, until 100% compliance is reached for 3 consecutive months; results will be reviewed in Medical Executive Committee monthly and Governing Body quarterly |
| | | | Responsibility for Oversight: Chief Medical Officer |
| Section 17-227-14g Nursing: facility failed to provide adequate supervision to prevent self-injury which resulted in multiple hospital procedures | Upon admission, patient #1 was placed on Constant observation with an extra staff due to risk of self-injurious behavior. From 9/15/18-10/27/18 (incident dates cited), individualized orders specified patient's ability to access utensils, clothing, diet, etc. Referrals were made to Physical Therapy and Occupational therapy services. The patient also received individual sessions from the physician, psychologist, social worker, rehabilitation therapist and Unit Director. A behavioral plan was also initiated. | | |

| NON-COMPLIANCE ITEM | CORRECTIVE ACTION / STEPS TO PREVENT REOCCURENCE | EFFECTIVE DATE | MONITORING PLAN/STAFF RESPONSIBLE |
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| Section 17-227-14g Nursing: facility failed to provide adequate supervision to prevent self-injury which resulted in multiple hospital procedures | Patient was discharged from Whiting Forensic Hospital.<br><br>Special Observation Policy requires staff to maintain line of sight at all times and therefore they cannot walk in front of patient to scan/ensure safe environment. Staff adhered to the Special Observation Policy when they remained behind patient in order to maintain visual observation while on Constant Observation | 1/30/19 | |
| | An Environmental Monitoring Protocol was established for use with patients who ingest/insert items allowing staff to walk ahead of a patient to mitigate/remove environmental risks. (The protocol includes specific guidelines for staff to mitigate/remove environmental risks by engaging in activities such as scanning the environment before patient enters a room. | 10/12/18 | |
| | Nursing staff was provided live training on Environmental Monitoring Protocol | 10/31/18 | Chief Nursing Officer monitored Staff Development compliance reports until 100% compliance was achieved. |
| | A patient with a similar clinical profile was assessed and the Environmental Monitoring Protocol was implemented. | | |
| | Psychiatric Admission Assessment was revised to include: assessment of ingestion/insertion of items and assessment for need of Environmental Monitoring Protocol | 10/26/18 | Chief Medical Officer will review all Psychiatric Admission Assessment to ensure that the Environmental Monitoring Protocol is initiated for all patients with a history of ingestions/insertion, until 100% compliance is reached for 3 consecutive months; results will be reviewed in Medical Executive Committee monthly and Governing Body quarterly |
| | | | Responsibility for Oversight: Chief Medical Officer |

| NON-COMPLIANCE ITEM | CORRECTIVE ACTION / STEPS TO PREVENT REOCCURENCE | EFFECTIVE DATE | MONITORING PLAN/STAFF RESPONSIBLE |
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| Section 17-227-14 Medical Staff and/or Management and/or Nursing: facility failed to conduct a comprehensive investigation and/or a comprehensive physician assessment after the patient had ingested a glove while on constant observation | Critical Incident Reviews were added as a standing item on Governing Body Agenda | 5/6/19 | Chief Quality and Compliance Officer will ensure that all CIRs are reviewed at Governing Body no later than one month after root cause analysis and corrective action plan are identified |
| | Policy 2.13 Outpatient and Emergency Visits was revised to include physician progress note that includes assessment of patient and rationale for ED assessment/treatment | 5/15/19 | Chief Medical Officer will ensure a physician's progress note, which includes assessment for need of acute evaluation and/or medical care, is written 100% of the time when a patient is transferred to an emergency department. Monitoring will occur for 6 months and/or until 100% compliance is met. Results will be reviewed in Medical Executive Committee monthly and Governing Body quarterly. |
| | Physicians will be trained in the revised 2.13 Outpatient and Emergency Visits policy | 5/28/19 | Chief Medical Officer will monitor Workforce Development Compliance Report for LMS training to ensure 100% compliance; compliance will be reviewed in Staff Development Committee until 100% obtained |
| | | | Responsibility for Oversight: Chief Medical Officer |