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CHERRY HOSPITAL	**201 STEVENS MILL ROAD** **GOLDSBORO, NC 27530**

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A 000	INITIAL COMMENTS A full survey was conducted from August 26, 2008 - August 31, 2008 to determine the hospital's compliance with the Medicare Conditions of Participation and to follow up on the outstanding Immediate Jeopardy (IJ) to patients' health and safety that began on April 28, 2008 and was identified on August 9, 2008. Based on investigative findings and an evaluation of the corrective action plan, the IJ was determined to be ongoing. The investigation revealed the hospital failed to provide a safe environment to ensure patients were free from abuse by failing to ensure systems were in place to assure staff immediately reported known or suspected abuse and by failing to ensure systems were in place to assure staff took measures to prevent patient to patient assault. The hospital's administrative staff was notified of the ongoing IJ on August 28, 2008 at 1735. Findings of the investigation revealed on 08/18/2008 at 1320 Patient #1, a 30 year old male diagnosed with schizoaffective disorder, bipolar type and borderline intellectual functioning (mild mental retardation), was beaten by 2 Health Care Technicians (HCTs) while in a hospital breezeway. Findings revealed 2 other HCTs witnessed the event and did not immediately report the abuse or take measures to protect the patient or other patients at the hospital. Interviews with both HCTs that witnessed the abuse of Patient #1 revealed they did not immediately report the abuse because they were afraid for their own safety. Findings revealed the patient reported the abuse to 4 other staff members, including 3 Registered Nurses (RNs) and 1 Therapeutic Recreation Specialist (TRS), within 30 minutes following the abuse. Findings	A 000		

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

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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revealed the 4 staff members to which the patient reported the abuse did not immediately report the abuse or take measures to protect the patient or other patients at the hospital. Findings revealed none of the RNs to which the patient reported the abuse assessed the patient for injuries or notified the physician so that the patient could be medically evaluated. The hospital failed to provide a safe environment to ensure patients were free from abuse by failing to ensure systems were in place to assure staff immediately reported known or suspected abuse.

Findings of the investigation also revealed Patient #20, admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several elderly residents and threatened to kill staff working at his previous residential facility. Findings revealed the patient was involved in 8 patient to patient violent/assaultive behaviors and 4 patient to staff violent/assaultive behaviors during the hospitalization. Findings revealed on 08/10/2008 at 1758 Patient #20 assaulted Patient #14. Findings revealed Patient #14 sustained a "comminuted depressed fracture of the left zygomatic arch." Review revealed a maxillary facial surgery consult was obtained and surgical repair scheduled during the admission. Findings revealed staff failed to monitor the patients immediately prior to the assault. Findings revealed staff failed to initiate progressive interventions with Patient #20 relating to repeated assaultive behaviors.

A corrective action plan was received from administrative staff on August 30, 2008 at 1746 via email. The amended corrective action plan

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A 000	Continued From page 2 included: · On 08/29/2008 a list of all patients currently in-house with assaultive incidents within the past 30 days. Twenty one patients were identified: 6 patients with 3 or more occurrences and 15 patients with 2 or less occurrences. The Clinical Director conducted case reviews and treatment team reviews and modified treatment plans to reduce the risk of violence for each of the 6 patients with 3 or more assaults. On 08/30/2008 the Clinical Director completed case reviews for the remaining 15 patients. Treatment team and case review treatment modifications are to be communicated to patient care staff by the RN and in shift report to the oncoming staff. - Alleged Compliance Date - 08/30/2008. · A memorandum from the Director of Nursing was sent to all nursing staff on 08/29/2008 which outlined nursing performance expectations and instructions for responding to patient assaults and facilitation of safe patient behavior. All staff must read and sign the memo as evidence of review. - Alleged Compliance Date - 08/31/2008. · Whenever an assault occurs, the RN will notify the Clinical Director, the nursing office and the hospital police. The RN will also complete an incident report and send it to the nursing office and the performance improvement office. The assaultive patient will immediately be placed on Close Observation (CO) until a psychiatric assessment is completed. The Clinical Director/designee is contacted and will assess the patient as soon as possible, but within no more than 24 hours, to determine the need for continued precautions, medication changes, crisis plan referral, special treatment team review or other needs, and will communicate with staff about managing patient in the milieu. The treatment team will review the incident and	A 000		

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clinical assessment and will modify the treatment plan as indicated. Changes to the plan will be communicated to patient care staff by the RN involved in the treatment team review. - Alleged Compliance Date - 08/29/2008.

· Monitoring: Clinical Services will track notifications of assaults and subsequent recommendations and interventions to reduce further risk. Information will be submitted to PI monthly. PI will incorporate this information into monthly data reports and review with the Executive Committee. - Alleged Compliance Dated - 08/29/2008.

· Nursing Services revised its ward reporting requirements to include documentation of assaultive behavior incidents. The data from these reports will be included on the Nursing Service Report and will be reviewed daily by the Hospital Director, Clinical Director, Director of Nursing and hospital police. - Alleged Compliance Date - 08/29/2008.

· Nursing Service Report assaultive behavior incidents data will be aggregated by PI ("Performance Improvement") and analyzed twice monthly for a minimum of 4 months beginning 09/09/2008, and then at least quarterly based upon sustained improvement. - Alleged Compliance Date - 09/15/2008.

· Education and training for all nursing staff regarding reporting staff to patient abuse, including:

o Phase 1: Provision of a memorandum from the hospital director to staff members that included: Definitions of abuse, neglect and exploitation; legal and performance requirements regarding reporting of abuse, including mandatory disciplinary action for failure to report abuse and acknowledgement of employee fear of retaliation by coworkers who are reported for abuse and the

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implementation of a toll-free number to which staff can anonymously report abuse - Alleged Compliance Date - 08/29/2008.
o Phase 2: Mandatory staff participation in small group meetings (to discuss abuse and provide staff an opportunity to express their concerns and provide ideas for promoting a violence-free environment) led by clinical staff to be held on the wards with available staff at various times, beginning on 08/29/2008 and continuing through 09/07/2008 until all staff have participated. Nurse Managers will ensure that all staff attend a group meeting. - Alleged Compliance Date - 09/07/2008.
· The hospital conducted an analysis of assault data for the past 12 months on 08/30/2008, through which they identified specific target wards where the assaults occur. A Continuous Quality Improvement Project Team will be initiated on 09/02/2008 to formalize the organizational process that will focus on strategies to reduce and prevent patient-to-patient and patient-to-staff assaults. - Alleged Compliance Date - Ongoing.
· Four new Advocacy positions were approved. Once these positions are filled, one Advocate will be assigned to each Adult Admissions ward. - Alleged Compliance Date - Undated.
· Pursuant to the plan implemented on 08/15/2008, as detailed in the Plan of Correction dated 08/22/2008, to augment nursing management and supervision on the adult admission wards through 09/01/2008, Nursing Services has extended this initiative for an additional 60 days through 10/30/2008 and expanded the scope hospital-wide. - Alleged Compliance Date - 08/29/2008.
· Implementation of a Supervision of Patient Movement Form to document and track whether staff is positioned in the front and rear of the

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A 000	Continued From page 5 group of patients. This form is completed daily and filed with accountability forms on each ward. - Alleged Compliance Dated - 08/29/2008. · The Assistant Director of Nursing/designee will review video footage of patient transport to and from the dining room and Treatment Malls according to a designated schedule beginning on 08/30/2008 to observe staff compliance with the requirement to be positioned in the front and rear of groups of patients. Data is collected on the Video Surveillance Monitoring Checklist and is aggregated, analyzed and reported to Nurse Leaders twice monthly for 4 months beginning 09/11/2008. Nurse managers and supervisors issue STAR certificates to employees who demonstrate exemplary performance and progressive disciplinary action to those with performance deficits. The Director of Nursing/designee will report findings and actions taken to the Executive Committee twice monthly beginning 09/09/2008. - Alleged Compliance Date - 08/30/2008. · Beginning 08/30/2008, for a 60 day period, administrative nursing staff and nurse leaders are spending time on selected wards during a portion of selected shifts to monitor and ensure that position-specific functions are adequately performed and to provide feedback and coaching as indicated. The nurse leader will document observations, interventions and recommendations after each oversight experience and submit to the Director of Nursing, who will review the information to identify trends in performance that may negatively impact patient care and safety. - Alleged Compliance Date - Ongoing. · 10 new Nurse Preceptor positions were approved. These positions will be posted and filled as soon as possible. Additionally, 2 Clinical Nurse Specialist positions had been approved in	A 000		

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A 000	Continued From page 6 2008, one of which has been filled and the nurse is to begin work on 09/08/2008. The positions provide for an influx of experienced nurse educators who will train, coach, mentor and address difficult patient issues with staff in the ward environment and in the classroom. - Alleged Compliance Date - Undated. On 08/31/2008 the corrective action plan was evaluated through observations, staff interviews and reviews of documents and data provided by the administrative staff. Observations during tour of nursing units, open medical record reviews and staff interviews between 1500 and 1900 revealed: · Medical record review of Patient #43 revealed a 72 year-old male that was admitted on 08/16/2008 to the W-3W nursing ward for dementia with Alzheimer's Disease. Record review revealed the patient assaulted two staff members on 08/30/2008 at about 1645 while they were changing his diaper in bed. Record review revealed the nurse assessed the patient, placed him on Close Observation and then notified the following people: Physician Assistant, Clinical Director, Nursing Office, Hospital Police, Social Worker (who was to notify the patient's family) and the patients treating physician. The patient remained on Close Observation (CO) until the Clinical Director assessed the patient on 08/31/2008 at 0430. Review of the Clinical Director's progress note dated 08/31/2008 at 0430 revealed, "Case reviewed due to aggressive behavior on 08/30/08. Meds reviewed. Tx (treatment) plan reviewed. Discussed with staff. Staff able to clearly identify signs of escalating aggression (not responding to his name being called) (and) usefulness of giving him space 15-30 min (minutes) when he does not respond.	A 000		

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A 000	Continued From page 7 This information needs to be incorporated into tx plan along with other info (information) from staff about what is noted to help calm him down or noted to be signs of pending escalation....Recommend special tx plan review Tuesday to incorporate addl (additional) information. D/C (discontinue) CO." Interview on 8/31/2008 at 1530 with the RN in charge of the ward from 0700-1900 and responsible for Patient #43's treatment revealed the nurse was aware the patient assaulted two staff members on 08/30/2008. Interview revealed the RN was aware the Clinical Director had evaluated the case of the assaultive behavior before the RN came on duty at 0700. Interview revealed the RN had not read the case review note documented by the Clinical Director at 0430. Interview revealed the nurse knew the patient was scheduled for a treatment team meeting on Tuesday due to his assaultive behavior because "(Name of Nurse Manager) told the me this afternoon at about 2 PM that he (the patient) was being referred to the treatment team on Tuesday". Interview revealed the nurse did not know the recommendations made by the Clinical Director to aid in the prevention of escalating aggression of the patient, including giving the patient space for 15-30 minutes when he does not readily respond to staff. Interview revealed the night shift RN did not report the Clinical Director's recommendations at the 0700 shift report. Interview at 1640 with the Health Care Technician (HCT) assigned to Patient #43 from 1500-2300 revealed the HCT had also worked with the patient on the previous day and was one of the two staff members assaulted by the patient.	A 000		

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A 000	Continued From page 8 Interview revealed the patient had soiled his bed. The HCT, along with another HCT, went in to clean the patient up and get him ready for dinner. Interview revealed the patient started "kicking and swinging" at the HCT. Interview revealed, "He got agitated and combative." Interview revealed the HCT reported the assault to the RN and completed an incident report. Interview revealed the HCT did not know the recommendations made by the Clinical Director to aid in the prevention of escalating aggression of the patient, including giving the patient space for 15-30 minutes when he does not readily respond to staff. Interview revealed the HCT documents information received in shift report on a "Health Care Technician Assignment Worksheet" regarding patient care, such as special precautions, the patient's diet, monitoring of intake and output and vital signs. Review of the HCT's Assignment Worksheet for 08/31/2008 revealed no documentation of Patient #43's assaultive behavior. Interview revealed, "In report they didn't say we do anything different today for him." Interview at 1930 with the Nurse Manager of the W-3W nursing ward revealed that at approximately 0700 the Clinical Director "shared her assessment with me. She (the Clinical Director) said she had reviewed the chart and had talked to the HCTs and they said they knew if they called his (the patient's) name 3 times if he didn't respond they would know he was having a bad day and to back off." Further interview revealed the manager told the RN on the ward during the dayshift of 08/31/2008 that the patient was scheduled for a treatment team review on Tuesday. Interview revealed, "I don't think I told her (the dayshift RN) about the doctor's	A 000		

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recommendation because I was thinking the staff she (the Clinical Director) had talked to was working." Further interview revealed, "I have reviewed (monitored) the staff's response to (Patient #43's) assaultive behavior. I had no concerns because I knew the staff knew him and I knew him when he came in." Interview revealed the manager was unaware of any monitoring tool available to use during her review of the incident. Interview revealed there was no written audit of the process.

Review of the Nursing Service Report dated 08/29/2008-09/03/2008 revealed the incident of Patient #43's assaultive behavior on 08/30/2008 was included on the report. Review of the report revealed no documentation that administrative nursing staff had identified the failure of off-going nursing staff to report the recommendations of the Clinical Director to aid in the prevention of escalating aggression of the patient to the on-coming nursing staff.

· 3 of 3 nursing staff members interviewed conducted August 31, 2008 on the W-3W ward were unaware of a procedure to anonymously report patient abuse and 2 of 2 nursing staff members interviewed on the U2-2E were unable to verbalize the procedure to anonymously report patient abuse until prompted.

Review of "Hospital Director Memorandum" dated August 29, 2008 revealed "...if any staff member feels he/she may be intimidated or threatened, if they report abuse, neglect or mistreatment, he/she is encouraged to self-report concerns anonymously by leaving a message on our toll free # (number)...". A call placed by the survey team to the number revealed the number was not in service.

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A 000	Continued From page 10 · 2 of 3 nursing staff members interviewed defined "assaultive behavior" as patient to staff assault (assaultive behavior was outlined in the "Hospital Director Memorandum" to staff dated August 29, 2008 as any form of abuse, neglect or exploitation toward a patient). The Immediate Jeopardy was determined to be on-going.	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on review of policies and procedures, Alleged Abuse/Neglect/Exploitation Incident Log, Abuse, Neglect and /or Exploitation reports, medical records, digital videos, incident reports, police reports, investigative reports, personnel files, facility meeting minutes, quality assessment and performance improvement data, observations during tour of clinical areas and observations as referenced in the Life Safety survey completed 8/28/2008, and staff interviews the hospital's governing body failed to provide leadership oversight in order to provide: a safe care environment in the prevention of patient abuse by staff and other violent patients, the promotion and protection of the rights of its patients in regards to the reporting of abuse, supervision of patient care by the nursing staff, a system to aggregate and analyze patient incident data in order to prioritize organization-wide performance improvement	A 043		

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activities related to patients' rights and safety, and, oversight for the quality of care provided by contracted services.

Findings include:

A. Facility staff failed to ensure adequate monitoring and supervision of patients to prevent patient neglect. The facility failed to have a system in place to promote patient and staff safety while patients transitioned from assigned wards to other facility locations.

Patient #35, a House Bill 95 ("no outside passes") patient with a diagnosis of mild mental retardation and undifferentiated type schizophrenia was observed August 28, 2008 at 9:20AM in the locked stairwell of Building U3 without staff in attendance. Patient #35 was observed at the top of 2 West stairwell attempting to enter a locked door. Interview with Treatment Mall Staff (TMS) #1 revealed the staff member was unable to identify Patient #35. TMS #1 stated Patient # 35 was on his way to a group session in the Treatment Mall. Patient #35 indicated the patient had knocked on the locked door and received no response. Walkthrough observations of the unit revealed the stairwell led down to 1East which egresses to a breezeway directly into the open door of 1West. Further observations revealed facility staff failed to have a system in place to ensure the accountability of patients patients while transitioning from assigned wards to other facility locations. Observations revealed staff posted at the front of the patient line, directing patients. Staff members were not posted at the rear of patient lines to ensure accountability of patients while patients transitioned from assigned wards to other facility

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locations. Interview with U1 nurse manger and Treatment Mall staff revealed staff had "never been told they needed 1:1 to get patients upstairs".

B. The facility's leadership staff failed to provide a safe environment of care by failing to ensure the integrity and accuracy of investigations of alleged patient abuse and failing to monitor and progressively discipline staff members with multiple allegations of patient abuse against them for 7 of 8 staff members with multiple allegations of patient abuse against them (HCT#15, HCT#12, HCT#14, HCT#11, HCT#16, and HCT#13).

Review of current hospital policy entitled "Disciplinary Action Review" dated 11/07/2006 revealed, "Definition: Active Disciplinary Action is any disciplinary action which was administered...and an eighteen (18) month period from date of issuance has not occurred. In addition, when disciplinary action is in an active status, it may be extended or used toward satisfying the requirement for a suspension without pay, demotion, or dismissal based on job performance...."

Interview with the Hospital Director on 8/29/2008 at 1015 revealed "I have maintained a 'hit list' of names of employees for the past two years that have had allegations of abuse toward patients." Further interview revealed there had been no actions taken based on the aggregation of the data. Interview revealed "We still have some high-risk employees" participating in patient care.

B.1. Review of hospital documentation of allegations made against HCT #1 from 08/30/2005 through 01/24/2008 revealed 6

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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 043	Continued From page 13 allegations of physical abuse of patients had been made (two and a half years). Review revealed all 6 allegations had been unsubstantiated by the hospital. Review of a sample of two investigations revealed: An allegation that HCT #1 punched Patient #40 in the mouth and put his knee into his back on 05/01/2007. Review of the investigative report revealed, "Patient sustained a busted lower lip and skin tear on his chin....Patient also complained of back pain and tooth pain per the nursing assessment...." Review of the documented interview with Patient #40 on 05/02/2007 at 1410 revealed, "they gave me a shot and it knocked me out....He sucker punched hit him in the mouth in the bathroom....I told the social worker....He did the same thing in the adolescent unit. After he hit me, we were in the bathroom....He is crazy....if you push at the worker, he will respond." Further review of the report revealed documentation of an interview with a witness, HCT #17. Review of HCT #17's interview revealed, "(HCT #1) came onto the ward and was trying to assist. The situation ended in the bathroom. The door closed and (HCT #1) and (Patient #40) were in the bathroom. I couldn't get in. When I did get in...(the patient) was already on the floor. There was blood from somewhere....The patient was face down....I did not see him with his knee in his back...." Review of the documented interview with HCT #1 revealed the HCT did not mention the bathroom at all in his interview, but stated, "He started toward the nursing station and (HCT #17) and I grabbed him. I did not have any intent to hurt him. It kind of hurt that he did hit me." Review of the report revealed there were no witnesses to the event in the bathroom. Review of the documented conclusion of the investigation	A 043		

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A 043	Continued From page 14 revealed, "The allegation is unsubstantiated for physical abuse. The incident supports the need to avoid bathrooms in excalating and aggressive situations....In summation, while the truth is not known, the incident could well have been a man to man encounter rather than the needed staff patient therapeutic intervention." Review of the "Investigation Team Recommendations" revealed, "Action to be taken: Appropriate disciplinary action for (HCT #1)." Review of HCT #1's personnel file on 08/27/2008 revealed no documentation of a disciplinary action related to the incident on 05/01/2007. An allegation that HCT #1 hit Patient #41 in the head on 01/24/2008: Review of the investigative report revealed the patient claimed after breakfast he was drinking his coffee slowly in the dining room when "an old black man tried to drink his coffee and he threw the coffee on the man, who then hit him in the head. Review of the documented interview with HCT #1 in the report revealed, "I told him it was time to come upstairs....He got mad, cursed me out and threw coffee on me. He tripped over chair and then we went upstairs....I helped him up and then he went upstairs...." Review of documented interviews with the only two witnesses, both dining room workers, revealed neither staff member saw how the patient got on the floor, but they both saw the patient get up off the floor by himself while HCT #1 was at the sink washing coffee off. Review of the documented conclusion of the investigation revealed, "The allegation is unsubstantiated as there are no witnesses to any action other than that of a patient falling after throwing coffee on a staff member....Witnesses say that they saw the patient getting up on his own. This creates a problem of credibility with (HCT #1)." Review of the "Investigation Team Recommendations"	A 043		

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A 043	Continued From page 15 revealed, "Action to be taken: Action as determined necessary by Nursing Services concerning the issue of truthfulness about helping the patient up in the dining room." Review of HCT #1's personnel file on 08/27/2008 revealed no documentation of a disciplinary action related to the incident on 01/24/2008. Interview on 08/28/2008 at 1130 with the U2 Nurse Manager revealed investigations into abuse are difficult to conduct at the hospital because staff members are not forthcoming with information. Interview revealed, "The situation has improved in the two years since I've been manager. Staff do report abuse more often. The cameras have helped....There is still a strong culture (at the hospital) that is difficult and challenging to deal with....People here won't tell you names and won't tell you they've been threatened, even when we ask them....People lie to us, even when we see that they were present on camera." Further interview on 08/29/2008 at 1145 with the U2 Unit Nurse Manager revealed Patient #40 did not have a bloody lip prior to going into the bathroom with HCT #1 on 05/01/2007, but did had a bloody lip afterwards. Interview revealed HCT #1 told the manager, "I don't know what happened to his lip. He hit the floor." Interview revealed the allegation of abuse was unsubstantiated because there had been no witnesses. Interview revealed, "(HCT #1) was cited for using an unapproved restraint technique that resulted in patient injuries." Interview revealed the manager disciplined HCT #1 with a written warning. Interview revealed the manager was unaware that there was no documentation of a written warning related to the incident in the personnel file. After reviewing her files in her office, the manager produced a copy of a written	A 043		

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A 043	Continued From page 16 warning dated 05/15/2007 for HCT #1. Review of the written warning revealed, "By your own admission you utilized an unapproved physical restraint technique which resulted in patient injuries....Follow-Up Conference scheduled for 30 days after issuance...." Interview revealed the manager did not have a follow-up conference with HCT #1, 30 days after the written warning was issued. Interview revealed, "(HCT #1) should have had a 30 day conference with his supervisor." Interview revealed written warnings remain active for 18 months and any other performance issues identified during that time should result in further disciplinary action, which could include another written warning, suspension without pay or dismissal. Further interview revealed the allegation of the abuse of Patient #41 by HCT #1 on 01/24/2008 had been unsubstantiated because there were no witnesses. Interview revealed, "(HCT #1) received a supervisory conference related to truthfulness about helping the patient get up in the Dining Room." Interview revealed the manager did not conduct this disciplinary conference, but rather the supervisor (RN #6) did. Interview confirmed HCT #1 was "still under the 18 months written warning" time frame following the written warning received on 05/15/2007 (8 months earlier). Interview revealed there had been no change in the level of supervision of HCT #1, the monitoring of his interactions with patients or his assignments following the allegations of abuse made against him on 05/01/2007 and 01/24/2008. Interview revealed all ongoing investigations are discussed in a hospital leadership meeting that is held every Monday morning at 1000 (unsure of the name of the group). Interview revealed this group consists of the Hospital Director, Assistant Hospital Director,	A 043		

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A 043	Continued From page 17 Director of Nursing, Assistant Director of Nursing, all of the Nurse Managers and all of the patient advocates. Interview revealed minutes of the Monday morning meetings are not kept. Interview revealed the nurse manager did not provide HCT #1 with progressive disciplinary action (such as suspension or dismissal) following the investigation of the alleged abuse of Patient #41 because "that was not the direction we were told to go" at the Monday morning meeting during which the case was discussed. Interview confirmed HCT #1 physically abused Patient #1 on 08/18/2008, less than 16 months after receiving a written warning for using an unapproved physical restraint technique which resulted in patient injuries (during an incident of alleged abuse of Patient #40) and 7 months after he was found to be untruthful during the investigation of the alleged abuse of Patient #41, at which time he did not receive progressive disciplinary action. Interview on 08/29/2008 at 1515 with RN #6 revealed the nurse was the nurse supervisor on the U2 2E and 2W wards. Interview revealed, "I don't do the written warnings and do not have any part of the process, including the 30 day conference (after the written warning). I do supervisory conferences. Once it (performance) progresses to the written warning level, the manager handles it." Interview revealed RN #6 did not do a 30 day conference with HCT #1 following the written warning that he received on 05/15/2008. Interview revealed the supervisor did have a supervisory conference with HCT #1 after the incident of the alleged abuse of Patient #41 on 01/24/2008, but he "couldn't find the documentation of that conference".	A 043		

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A 043	Continued From page 18 B.2. Review of a memorandum from the Hospital Director to HCT #15 dated August 31, 2008 revealed "Subject: Patient Safety". Further review revealed "As you know, management has been concerned for sometime now about the safety of our patients....In addressing these issues, we have conducted an extensive review of advocacy investigations involving allegations of abuse, neglect, and exploitation made by patients against staff from 2005 to present. We also reviewed our database covering the same timeframe to identify staff who were most frequently reported by patients. You have been involved in 14 separate incidents since 2005." Review of a memorandum from the Director of Nursing to HCT #15 dated August 31, 2008 revealed "Subject: Re-training". Further review revealed "I am writing to follow-up to (name of Hospital Director)'s letter dated August 31, 2008 regarding patient safety. You have been scheduled to report to Nursing Education on September 08, 2008 at 8:00am. You are required to successfully complete the entire curriculum for New Employee Orientation..." B.3. Review of a memorandum from the Hospital Director to HCT #12 dated August 31, 2008 revealed "Subject: Patient Safety". Further review revealed "As you know, management has been concerned for sometime now about the safety of our patients....In addressing these issues, we have conducted an extensive review of advocacy investigations involving allegations of abuse, neglect, and exploitation made by patients against staff from 2005 to present. We also reviewed our database covering the same timeframe to identify staff who were most frequently reported by patients. You have been involved in 11 separate incidents since 2005."	A 043		

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A 043	Continued From page 19 Review of a memorandum from the Director of Nursing to HCT #12 dated August 31, 2008 revealed "Subject: Re-training". Further review revealed "I am writing to follow-up to (name of Hospital Director)'s letter dated August 31, 2008 regarding patient safety. You have been scheduled to report to Nursing Education on September 08, 2008 at 8:00am. You are required to successfully complete the entire curriculum for New Employee Orientation..." B.4. Review of a memorandum from the Hospital Director to HCT #14 dated August 31, 2008 revealed "Subject: Patient Safety". Further review revealed "As you know, management has been concerned for sometime now about the safety of our patients....In addressing these issues, we have conducted an extensive review of advocacy investigations involving allegations of abuse, neglect, and exploitation made by patients against staff from 2005 to present. We also reviewed our database covering the same timeframe to identify staff who were most frequently reported by patients. You have been involved in 8 separate incidents since 2005." Review of a memorandum from the Director of Nursing to HCT #14 dated August 31, 2008 revealed "Subject: Re-training". Further review revealed "I am writing to follow-up to (name of Hospital Director)'s letter dated August 31, 2008 regarding patient safety. You have been scheduled to report to Nursing Education on September 08, 2008 at 8:00am. You are required to successfully complete the entire curriculum for New Employee Orientation..." B.5. Review of a memorandum from the Hospital Director to HCT #11 dated August 31, 2008 revealed "Subject: Patient Safety". Further	A 043		

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A 043	Continued From page 20	A 043		

review revealed "As you know, management has been concerned for sometime now about the safety of our patients....In addressing these issues, we have conducted an extensive review of advocacy investigations involving allegations of abuse, neglect, and exploitation made by patients against staff from 2005 to present. We also reviewed our database covering the same timeframe to identify staff who were most frequently reported by patients. You have been involved in seven separate incidents since 2005." Review of a memorandum from the Director of Nursing to HCT #11 dated August 31, 2008 revealed "Subject: Re-training". Further review revealed "I am writing to follow-up to (name of Hospital Director)'s letter dated August 31, 2008 regarding patient safety. You have been scheduled to report to Nursing Education on September 08, 2008 at 8:00am. You are required to successfully complete the entire curriculum for New Employee Orientation..."

B.6. Review of a memorandum from the Hospital Director to HCT #16 dated August 31, 2008 revealed "Subject: Patient Safety". Further review revealed "As you know, management has been concerned for sometime now about the safety of our patients....In addressing these issues, we have conducted an extensive review of advocacy investigations involving allegations of abuse, neglect, and exploitation made by patients against staff from 2005 to present. We also reviewed our database covering the same timeframe to identify staff who were most frequently reported by patients. You have been involved in seven separate incidents since 2005." Review of a memorandum from the Director of Nursing to HCT #16 dated August 31, 2008 revealed "Subject: Re-training". Further review

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A 043	Continued From page 21	A 043		

revealed "I am writing to follow-up to (name of Hospital Director)'s letter dated August 31, 2008 regarding patient safety. You have been scheduled to report to Nursing Education on September 08, 2008 at 8:00am. You are required to successfully complete the entire curriculum for New Employee Orientation..."

B.7. Review of a memorandum from the Hospital Director to HCT #13 dated August 31, 2008 revealed "Subject: Patient Safety". Further review revealed "As you know, management has been concerned for sometime now about the safety of our patients....In addressing these issues, we have conducted an extensive review of advocacy investigations involving allegations of abuse, neglect, and exploitation made by patients against staff from 2005 to present. We also reviewed out database covering the same timeframe to identify staff who were most frequently reported by patients. You have been involved in 6 separate incidents since 2005." Review of a memorandum from the Director of Nursing to HCT #13 dated August 31, 2008 revealed "Subject: Re-training". Further review revealed "I am writing to follow-up to (name of Hospital Director)'s letter dated August 31, 2008 regarding patient safety. You have been scheduled to report to Nursing Education on September 08, 2008 at 8:00am. You are required to successfully complete the entire curriculum for New Employee Orientation..."

C. The facility's leadership staff failed to ensure oversight to prevent patient abuse by hospital staff for 1 of 1 sampled patients with substantiated staff to patient abuse (#1),

~cross refer to 482.13(c)(2) Patients' Rights:

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A 043	Continued From page 22 Care in Safe Setting Tag - A0144 D. The facility's leadership staff failed to ensure oversight to assure staff immediately reported abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1), ~cross refer to 482.13(c)(3) Patients' Rights: Free From Abuse/Harassment Tag - A0145 E. The facility's leadership staff failed to ensure oversight to promote and protect patients' rights by failing to monitor a patient with repeated assaultive behaviors (pt#20). ~cross refer to 482.13(c)(2) Patients' Rights: Care in Safe Setting Tag - A0144 F. The facility's leadership staff failed to ensure oversight to promote and protect patients' rights by failing to implement progressive interventions for repeated assaultive behaviors (pt#20). ~cross refer to 482.13(c)(2) Patients' Rights: Care in Safe Setting - Tag A0144 G. The facility's leadership staff failed to ensure oversight to promote and protect patients' rights by failing to failing to report and investigate assaults according to hospital policy (pt#20). ~cross refer to 482.13(c)(2) Patients' Rights: Care in Safe Setting - Tag A0144 H. The facility's leadership staff failed to ensure oversight to provide nursing supervision of patients by failing to prevent and report staff to patient abuse and assess a patient following an alleged incident of abuse for 1 of 1 sampled	A 043		

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patients with substantiated staff to patient abuse (#1).

~cross refer to 482.23 RN Supervision of Nursing Care - Tag A0395

I. The facility's leadership staff failed to ensure oversight to provide nursing supervision of patients by failing to monitor a patient with repeated assaultive behaviors (pt#20).

~cross refer to 482.23 RN Supervision of Nursing Care - Tag A0395

J. The facility's leadership staff failed to ensure oversight to provide nursing supervision of patients by failing to implement progressive interventions for repeated assaultive behaviors (pt#20).

~cross refer to 482.23 RN Supervision of Nursing Care - Tag A0395

K. The facility's leadership staff failed to ensure oversight to provide nursing supervision of patients by failing to provide safe and effective administration of medication for 7 of 8 medication passes observed (#42, #52, #53, #54, #55, #56, #57).

~cross refer to 482.23 RN Supervision of Nursing Care Tag A0395

L. The facility's leadership staff failed to ensure oversight to provide nursing supervision of patients by failing to supervise, and monitor the delivery of care to ensure basic needs (nutrition and hydration) were provided for 1 of 19 inpatient open records reviewed (#21).

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A 043	Continued From page 24 ~cross refer to 482.23 RN Supervision of Nursing Care - Tag A0395 M. The facility's leadership staff failed to ensure oversight to maintain the environment ensuring the safety and well being of patients as referenced in the Life Safety survey completed 8/28/2008. ~Cross-refer to 482.41(a). Physical Environment Standard - Tag A 701. N. The facility's leadership staff failed to ensure oversight to: A. develop a system to aggregate and analyze patient abuse, neglect and exploitation of patients and B. develop a system to aggregate and analyze incidents of patient aggression and violence. ~cross refer to 482.21(e)(2) Executive Responsibilities - Tag A0313 O. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure the services provided under contract were evaluated and performed in a safe and effective manner. ~cross refer to 482.21(e)(2) Executive Responsibilities - Tag A0084 P. The facility's leadership staff failed to ensure oversight to have a system in place to ensure the Dietary Department had current policies and procedures for dietary staff and accessible for nursing services. ~cross refer to 482.28 Dietary Services - Tag	A 043		

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A 043	Continued From page 25 A0618 Q. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure hot foods were served hot and cold foods were served cold. ~cross refer to 482.28 Dietary Services - Tag A0618 R. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure Dietary Department staff were knowledgeable in the operations of scales. Staff inability to operate scales to verify serving portions may result in the serving of diets contrary to physician orders. ~cross refer to 482.28 Dietary Services - Tag A0618 S. The facility's leadership staff failed to provide oversight to ensure dietary services was provided in a safe environment for staff. Observation on August 28, 2008 at 11:55AM revealed a dietary employee filling the "plate soak tub". Observations revealed the sink had a major leak. Water was leaking from left side sink. Interview with the dietary tech revealed he/she was assigned in the plate soak area on August 27, 2008 and the left sink was leaking. Interview at 12:00NOON with the Dietary Director revealed the left sink was " always leaking. Maintenance could not fix. Sometimes we can adjust and it will not leak". Further interview revealed the Dietary Director failed to inform the Vice President whom he/she reported to of the leaking sink.	A 043		

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A 043	Continued From page 26 ~cross refer to 482.28 Dietary Services - Tag A0618	A 043		
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on contract reviews, Governing Body Bylaws review, and Administrative staff interviews the Governing Body failed to have a system or process in place to ensure the services provided under contract were evaluated and performed in a safe and effective manner. The findings include: Review of the hospital's list of direct patient services contracts revealed 43 individual contracted services providing/performing direct patient services to the hospital patients. Review of contracts revealed services provided and/or performed under contract were translation services, temporary physician services, surgical services, digestive services, orthopedic services and gynecology and obstetrical services. Review of the "Bylaws of the Governing Body" revealed no documentation of a process, system or designee for evaluation of the patient care provided by contracted services. Interview on August 28, 2008 at 4:00PM with the Clinical Director revealed there was no defined process or system in place for the review / monitoring of care provided by bontracted services. Further interview revealed the Medical Staff Executive Committee reviews and approves	A 084		

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A 084	Continued From page 27 or disapproves if a problem with a person or services. The Medical Staff Executive Committee met on June 5, 2008 and discussed / reviewed all contracts. The interview revealed there was no documentation available of an evaluation of patient care provided by contracted services.	A 084		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on review of policy and procedure, Alleged Abuse/Neglect/Exploitation Incident Log, Abuse, Neglect and /or Exploitation reports, medical records, digital videos, incident reports, police reports, investigative reports, personnel files and staff interviews the hospital's staff failed to promote and protect patients' rights by failing to: A. prevent patient abuse by hospital staff for 1 of 1 sampled patients with substantiated staff to patient abuse (#1), B. assure staff immediately reported abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1),and failed to ensure adequate monitoring and supervision of patients to prevent patient neglect (#35). C. monitor a patient with repeated assaultive behaviors for 1 of 1 patients reveiwed with known repeated assaultive behaviors (pt#20), D. implement progressive interventions for repeated assaultive behaviors for 1 of 1 patients reveiwed with known repeated assaultive behaviors (pt#20); and E. failing to report and investigate assaults according to hospital policy for 1 of 1 patients reveiwed with known repeated assaultive behaviors (pt#20). Findings include:	A 115		

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A 115	Continued From page 28 A. The hospital's staff failed to prevent patient abuse by hospital staff for 1 of 1 sampled patients with substantiated staff to patient abuse (#1), ~cross refer to 482.13(c)(2) Patients' Rights: Care in Safe Setting Tag A0144 B. assure staff immediately reported abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1), and failed to ensure adequate monitoring and supervision of patients to prevent patient neglect (#35). ~cross refer to 482.13(c)(3) Patients' Rights: Free From Abuse/Harassment Tag A0145 C. The hospital's staff failed to promote and protect patients' rights by failing to monitor a patient with repeated assaultive behaviors for 1 of 1 patients reveiwed with known repeated assaultive behaviors (pt#20). ~cross refer to 482.13(c)(2) Patients' Rights: Care in Safe Setting Tag A0144 D. The hospital's staff failed to promote and protect patients' rights by failing to implement progressive interventions for repeated assaultive behaviors for 1 of 1 patients reveiwed with known repeated assaultive behaviors (pt#20). ~cross refer to 482.13(c)(2) Patients' Rights: Care in Safe Setting Tag A0144 E. The hospital's staff failed to promote and protect patients' rights by failing to failing to report and investigate assaults according to hospital policy for 1 of 1 patients reveiwed with known repeated assaultive behaviors (pt#20).	A 115		

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A 115	Continued From page 29 ~cross refer to 482.13(c)(2) Patients' Rights: Care in Safe Setting Tag A0144	A 115		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on review of policy and procedure, Alleged Abuse/Neglect/Exploitation Incident Log, Abuse , Neglect and /or Exploitation report and staff interview the advocacy department failed to send a resolution letter that included the steps taken to investigate the grievance, the results of the grievance and the date of completion for 1 of 4 sampled grievances. (grievance #9) The findings included: Review of the facility policy CCP Number-VI-A-1, "Abuse/Neglect/Exploitation of Patients, Prohibited", revised 07/21/2008 and 08/20/2008 revealed "...Notification to Patient, Guardian, Legally Responsible Person 1. The Patient Advocate shall inform the patient and /or the patient's guardian or legally responsible person of the investigation's conclusion within two (2) working days of completing the investigation. This notification shall be in writing and a copy of the letter shall be filed in the investigation case file in the Advocacy Department..." Review revealed the	A 123		

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notification documentation of the patient, guardian and legally responsible person had not been changed from the policy dated 07/21/2008 and revised 08/20/2008.

Review on 08/28/2008 of the Alleged Abuse, Neglect, Exploitation Incident Log revealed a patient reported grievance #9 on 07/04/2008 to the advocacy department.

Review of the Abuse, Neglect and /or Exploitation Report revealed the advocate initiated the investigation of grievance #9 on 07/04/2008 and completed the investigation on 07/23/2008. Review of the report failed to reveal documented evidence the advocate provided a letter to the complainant (36 days later).

Interview on 08/29/2008 at 1000 with the Advocacy Director revealed a letter is sent to all patients who report an allegation of abuse, neglect or exploitation to the advocacy department within two working days of completion of the investigation. Interview confirmed the advocate failed to send a letter to the complainant/patient.

A 144 — 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING — A 144

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by:
Based on review of policies and procedures, medical records and investigative reports, staff interviews, review of personnel files, digital videos, meeting minutes, incident reports, observation and police reports, the hospital failed to ensure a safe environment of care by failing to:

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A 144	Continued From page 31 A. prevent patient abuse and assure staff immediately reported abuse for 1 of 1 sampled patients with substantiated abuse by identified staff to patient abuse (#1), B. monitor a patient with repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (#20), C. implement progressive interventions for repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (#20); and D. failing to report and investigate assaults according to hospital policy for 1 of 1 patients reviewed with known repeated assaultive behaviors (#20). The findings include: A. The hospital failed to ensure a safe environment of care by failing to prevent prevent patient abuse and assure staff immediately reported abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1). Review of hospital policy number VI-A-1 entitled "Abuse/Neglect/Exploitation of Patients, Prohibited" dated 07/21/2008 revealed, "POLICY:...All members of the hospital staff are required to intervene immediately if witnessing abuse, neglect, and/or exploitation of a patient. Where there is physical injury or sexual abuse, the patient is to be provided immediate medical evaluation. (Name of Hospital) further requires that when staff, students or volunteers observe, suspect, or have knowledge of abuse, neglect, and/or exploitation, they must report this information to their immediate supervisor/designee, the Royster Nursing Office (RNO), or the (Name of Hospital) Advocacy Department immediately....Failure to disclose information pertaining to suspected abuse,	A 144		

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neglect and/or exploitation of a patient will result in disciplinary action as determined by the Hospital Director and State Personnel Policy Manual....DEFINITIONS:...Abuse: the infliction of physical or mental pain or injury by other than accidental means....PROCEDURES: I. IMMEDIATE INTERVENTION AND REPORTING REQUIREMENTS A. Adults and Juveniles: Any staff member, student or volunteer who observes, suspects, or receives an allegation of abuse, neglect and/or exploitation of a patient must: 1. Intervene immediately to ensure the safety and well being of the patient. 2. Notify the ward RN (Registered Nurse) of the patient's home ward. 3. Notify their immediate supervisor/designee, RNO, or the (Name of Hospital) Advocacy Department...."

Review of current hospital policy entitled "Disciplinary Action Review" dated 11/07/2006 revealed, "Definition: Active Disciplinary Action is any disciplinary action which was administered...and an eighteen (18) month period from date of issuance has not occurred. In addition, when disciplinary action is in an active status, it may be extended or used toward satisfying the requirement for a suspension without pay, demotion, or dismissal based on job performance...."

Closed record review of Patient #1 revealed a 30 year-old male that was admitted on 07/19/2008 for schizoaffective disorder, bipolar type and borderline intellectual functioning. Review of the Physical Assessment completed upon admission on 07/19/2008 by a Physician Assistant (PA) revealed, "Physical Diagnosis: 1. Mild MR (mental retardation. 2. NAD (no acute distress)." Review of RN #1's progress note documented on

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08/18/2008 at 1330 revealed, "Rec'd (Received) call from U3 groups that (Patient #1) was in an altercation c (with) a peer. Staff intervened et (Patient #1) will be brought back to U2 3E." Review of RN #1's progress note documented at 1340 revealed, "(Patient #1) is back on the ward. When questioned regarding return stated 'Two staff jumped on me' Per staff (Patient #1) threatened a female patient et then a male patient. Staff reports that staff intervened et escorted (Patient #1) back to this ward. Staff will monitor behaviors." Further review revealed no documentation that the nurse notified the physician, nurse supervisor, nursing office (RNO) or Advocacy Department of the patient's allegation that he was abused by two staff members. Record review revealed documentation on 08/22/2008 at 1000 that the patient was discharged to a group home.

Review on 08/29/2008 of an "Abuse, Neglect and/or Exploitation Investigation Report" dated 08/28/2008 revealed documentation of the hospital's investigation into the allegation of the abuse of Patient #1. Report review revealed documentation on 08/18/2008 at 1038 of an interview with Patient #1 conducted by the U2 Unit Nurse Manager and Patient Advocate #1. Review of the interview revealed the patient knew the 2 HCTs that abused him, but didn't know their names. Review of the interview revealed, "'They started beating me down on the ground.' (Patient #1) says that while they were beating him they were saying, 'What are you going to do? What are you going to do?'...(Patient #1) said that after the dude with the red hat left me alone the other dude started choking me on the ground. (Patient #1) was asked how it ended and he said, 'He stopped and let me up.'...(Patient #1) said that he

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told the police and the police said that he would talk to him...." Review of the conclusion of the investigation report revealed, "Investigators find the evidence in this case to be significant, clear and convincing to support the conclusion that (HCT #1) and (HCT#4) physically abused (Patient #1) on 08/18/2008."

Interview on 08/26/2008 at 1715 with Patient Advocate #1 revealed a contracted (non-hospital employee) HCT #2 called her agency on the evening of 08/18/2008 and reported that she had witnessed 2 staff members abusing a patient that afternoon in the breezeway of the U2 treatment mall. Interview revealed the agency supervisor called the nursing office and reported the allegation to the nursing supervisor, who then reported it at 2100 to the Advocacy Department. Interview revealed the Chief Patient Advocate went to the hospital on the night of 08/18/2008 (unsure of time) to begin investigating the allegation. Interview revealed, "We are still investigating. We are in the process of substantiating the abuse." Interview revealed the hospital has a video surveillance system that monitors most patient care areas. Interview revealed there were no cameras located in the breezeways of the units (smoking areas).

Interview on 08/27/2008 at 1350 with HCT #2 (a contracted HCT) revealed the HCT was assigned to monitor female patients from the U2 2W ward when they went to the U3 treatment mall on 08/18/2008 at 1300. Interview revealed the HCT was in the breezeway smoking with 3-5 female patients at approximately 1320. Interview revealed there was also another female HCT present (HCT #3), as well as a male HCT (HCT #1) with several male patients who were also

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A 144	Continued From page 35 smoking. Further interview revealed one by one the patients finished their cigarettes and went inside. Interview revealed when the second to last patient went inside (leaving only Patient #1 in the breezeway with staff members) HCT #4 came out to the breezeway. Interview revealed at that time the only people on the breezeway were HCT #3, HCT #1, HCT #4, Patient #1 and herself. Interview revealed, "I turned to dump ashes and when I turned back I saw (HCT #1) hit (Patient #1) in the stomach. I can't remember if he hit him again before the patient fell, but the patient fell in a fetal position. (HCT #1) and (HCT #4) tag teamed the patient. They took turns hitting him. 2-3 strikes each, then they would change." Interview revealed the two HCTs hit and kicked the patient in the groin, face and legs. Interview revealed, "It looked like he got hit everywhere." Further interview revealed, "After I saw (HCT #4) hit him I went to the door to go inside. As I got to the door they called out 'Wait a minute'. It was like they stopped (hitting the patient) for me to go inside so no one would hear them. (HCT #3) came in right behind me." Interview revealed HCT #2 sat in a chair outside of the bathroom (her assigned post) when she went inside. Interview revealed when Patient #1 came inside (about 5-10 minutes later) he went to the entrance of the dayroom, pointed at the door that goes out to the breezeway and said "These 2 men just jumped me. They beat me". Interview revealed there were staff members present in the dayroom at that time, but the HCT wasn't sure exactly which ones because she was posted at the opposite end of the hall. Interview revealed, "I didn't tell anybody at the hospital about it (the abuse of Patient #1 by the two staff members)....I didn't tell anyone because I was scared. The men were very scary. They said, 'If anyone asks	A 144		

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A 144	Continued From page 36 you, you didn't see anything.'" Interview revealed the HCT felt afraid and intimidated by HCT #1 and HCT #4. Interview revealed, "They kept asking me what was wrong. I told them I had a migraine....They even called my cell phone....I had to change my number." Interview revealed when at home later that evening she decided to report the abuse. Interview revealed the HCT called her agency supervisor at approximately 2000 and reported the abuse (between 6 and 7 hours later). Interview revealed the agency supervisor then called the nursing supervisor at the hospital and reported the abuse. Interview revealed the HCT was out of work for the week following the incident on 08/18/2008, but had returned to work on 08/25/2008 and was reassigned to a different ward. Interview revealed when the HCT escorted a patient past the U3 treatment mall "the other day" she felt intimidated by other staff members, because she could "hear them loudly making comments like 'snitch'". Interview revealed the HCT was on duty at the time of the interview and was assigned to Woodard 1E. Interview revealed, "No one has reviewed the (abuse) policy with me since the incident (9 days before interview)". Telephone interview on 08/27/2008 at 1545 with HCT #3 (an agency HCT) revealed the HCT was assigned to monitor a male patient during a smoke break in the breezeway of the U3 treatment mall on 08/18/2008 at approximately 1315. Interview revealed all of the patients except for Patient #1 had finished smoking and gone inside. Interview revealed, "He (Patient #1) was done smoking and wanted to go back inside. He walked towards the door. (HCT #1) said, 'No, you don't go in.' Me and (HCT #2) were still smoking so we were still out there." Interview	A 144		

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A 144	Continued From page 37 revealed HCT #4 came outside to the breezeway. Interview revealed, "(HCT #1) said something like 'Say something now.' (HCT #4) grabbed him (the patient) from behind and HCT #1 started hitting him." Interview revealed HCT #3 was standing behind HCT #4 and couldn't see the placement of his hands or the the location of the blows that HCT #1 delivered to the patient. Interview revealed the patient started to fight back and was moving his feet trying to get out of the hold. Interview revealed the patient knocked HCT #4's glasses off and HCT #4 let go, picked up his glasses and put them on the window seal. Interview revealed, "When I looked back at the patient, he and (HCT #1) were against the wall. He (the patient) was on the ground in a partial fetal position, with his knees bent and his hands around his face area. (HCT #1) was straddling him and punching him in the side and head and all over." Interview revealed HCT #1 stood up and kicked the patient and the HCT #4 went over and hit the patient again. Interview revealed, "They were hitting him at the same time. (HCT #4) stopped and told (HCT #2) and me to go inside. We went inside." Interview revealed the patient went back inside about 4-5 minutes later and went and talked to a white male nurse. Interview revealed the HCT heard the patient tell the male nurse that he had just gotten attacked outside and he took his shirt off. Interview revealed HCT #3 did not immediately report the abuse of Patient #1 by the two staff members that she witnessed to anyone at the hospital because she was afraid. Interview revealed the HCT denied that she had witnessed the abuse during an interview with the nurse manager and patient advocate on Tuesday 08/19/2008. Interview revealed, "I didn't tell them then because I was told not to tell by (HCT #1) and (HCT #4). They	A 144		

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told me that on Monday, Tuesday and Wednesday....I didn't report it because I was told to keep my mouth shut....They (HCT #1 and HCT #4) told me right after it happened if I told it I'd get my (explicative) beaten. They both called me (on my cellphone) on Tuesday and Wednesday to tell me not to tell it. I got my number changed."

Interview on 08/27/2008 at 1045 with RN #2 revealed the white male nurse was assigned the U2 unit on 08/18/2008 and went with the patients to the U3 treatment mall at 1300. Interview revealed the nurse was standing in the hallway near the group room (dayroom) door when Patient #1 walked up to him. Interview revealed, "He (Patient #1) appeared to be upset. He took his shirt off. I redirected him to put his shirt back on and go into the classroom." Interview revealed the patient went into the dayroom at that time. Interview revealed the nurse denied the patient reported being hit by staff members to him, and therefore did not report abuse.

Interview on 08/27/2008 at 1200 with RN #3 revealed the nurse was assigned to the U2 3W ward on 08/18/2008. Interview revealed the nurse went to the U3 treatment mall at about 1330 to give her husband (who was working in the treatment mall - HCT #6) his lunch. Interview revealed, "(HCT #7) told me that (Patient #1) was upset and needed to go to 3E (his ward). I talked to him (the patient) briefly before I sent him back. He told me he had been beaten up by staff. He had water in his eyes, like he was going to cry because he was so upset. I called his nurse (on U2 3E - RN #1) and told her he had an altercation with another patient and was accusing staff of beating him up and he was very upset." Interview revealed HCT #9 then escorted the patient back

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to the 3E ward. Interview revealed reports of staff to patient abuse should be immediately reported to the nurse supervisor and the advocacy department. Interview revealed, "I'm really not sure who else (allegations of abuse should be reported to). You probably have to do an incident report....I reported it to the ward nurse on 3E (RN #1) and I think I reported it to (RN#2) on my way out." Further interview revealed the nurse did not report Patient #1's allegation of abuse to the nurse supervisor or advocacy department because she "got side tracked".

Interview on 08/27/2008 at 1500 with RN #1 revealed the nurse was the charge nurse on the U2 3E ward on 08/18/2008 during the day shift. Interview revealed the nurse received a phone call from RN #3 at approximately 1330. Interview revealed RN #3 told her that Patient #1 had threatened a female patient and had gotten into an argument with a male patient at the treatment mall. Interview revealed RN #1 told RN #3 to send the patient back to the 3E ward. Interview revealed, "I had a treatment team meeting at 1:30 (PM). When he (Patient #1) came back I said, 'Hey, what's going on?' He came in and sat down at the nurses station and said he was all right. He said, 'Two staff assaulted me. It was about cigarettes.' He got up and walked out and said he didn't want to talk about it anymore....I called the treatment mall and (HCT #6) answered the phone. He said, 'We sent him back because he accused 2 staff members of assaulting him and he threatened a female and got into a verbal confrontation with (a male patient).' He said he didn't witness any of it. I told him to put someone on the phone who did. I don't know who it was on the phone then, it was a male. He said, 'No, I ain't seen anything.' Again I said put someone on

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the phone who did. (HCT #1) got on the phone and said the patient had accused 2 staff of assaulting him, threatened a female and argued with (a male patient). He said he didn't see anything. They then called me to treatment team . I charted all of this while I was on the phone with them." Interview revealed, "I thought the staff on the treatment mall would have reported it (the alleged abuse), so I didn't (report the alleged abuse)."

Interview on 08/27/2008 at 1615 with a Therapeutic Recreation Specialist (TRS #1) revealed the staff member was in the U3 treatment mall on 08/18/2008. Interview revealed, "I heard a couple of bangs against the door from the outside. I heard (Patient #1) yelling outside before the bangs. The door opened and (Patient #1) came in. He was breathing heavily and looked upset. He went to the outside of the group room door and he took his shirt off." Interview revealed the patient either said staff beat him or staff jumped him and he wanted to fight staff. Interview revealed the TRS and a "white male" staff member tried to get the patient to calm down. Interview revealed a hospital police officer came up on the elevator and Patient #1 went up to him and said, "I want to talk to you. They (beat or jumped) me". Interview revealed the police officer told the patient that he had to do something else first and then he would talk to him. Interview revealed, "I did not report the (alleged) abuse (to anyone at the hospital)."

Interview on 08/27/2008 at 1445 with Police Officer #1 revealed the officer went to the U3 treatment mall on 08/18/2008 at "shortly after" 1300 to talk with HCT #6 regarding a patient complaint. Interview revealed, "(Patient #1), but I

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A 144	Continued From page 41 didn't know his name at the time, came up to me and said, 'I need to talk to you.' He said he was assaulted by 2 guys. I told him I had to interview someone, but to stay here and I'd talk to him when I was done. After the interview, I walked out and as I walked past the nurses station I didn't see the patient. I looked in the dayroom. I asked (HCT #1) where the patient was that wanted to talk to me. He said, 'I don't know what you're talking about. I didn't see a patient.' I did not find the patient." Interview revealed the officer identified the patient on 08/19/2008 when he reviewed video surveillance tapes during the investigation of the alleged abuse that occurred on 08/18/2008. Interview on 08/27/2008 at 1645 with HCT #5 revealed the HCT was in the U3 treatment mall on 08/18/2008. Interview revealed the HCT arrived at the treatment mall "sometime after lunch" and "when I got off the elevator I saw a male patient (later identified as Patient #1) standing outside of the nurses station. He was yelling at (HCT #4), who was inside the nurses station. He said, 'If you want to beat my (explicative) come beat it now in front of the cameras.'" Interview revealed HCT #5 did not hear the patient say anyone had hit him. Interview revealed the HCT had not reviewed the abuse policy since 08/18/2008, when Patient #1 alleged being abused by staff. Interview on 08/27/2008 at 0930 with the U2 Unit Nurse Manager revealed the manager went to the nursing office on the morning of 08/19/2008 after she got to work, where the nurse supervisor and chief patient advocate told her there had been a call made by HCT #2 to her agency on the previous night during which she reported an	A 144		

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A 144	Continued From page 42 incident where she witnessed staff attacking a patient on 08/18/2008. Interview revealed HCT #2 had given a time span of the incident and the nurse supervisor and chief patient advocate had been reviewing video surveillance tapes to try to identify the patient as he came in the door from the breezeway into the unit. Interview revealed the video surveillance area did not include the breezeway, but it did include the U3 treatment mall and showed staff and patients that were present. Interview revealed the manager took a picture of the patient to the nursing unit where an HCT identified him as Patient #1. Interview revealed the manager and Patient Advocate #1 began an investigation, which included interviewing the patient and all staff members that had been present in the U3 treatment mall on 08/18/2008. Interview revealed the patient told the manager he and a female patient had argued and HCT #1 told him that he didn't need to talk to females that way. Interview revealed the patient told the manager HCT #1 told him that he could not go inside after he finished his cigarette. Interview revealed the patient told the manager that HCT #4 then came out to the breezeway and hit him in the back. Interview revealed the patient told the manager "they beat me down". Interview revealed the patient told the manager that he reported being hit by HCT #1 and HCT #4 to RN #2, RN #3 and Police Officer #1. Interview revealed as soon as the manager and advocate identified HCT #1 and HCT #4 as being the HCTs that the patient accused of abusing him, they were both called to the nursing office and then were placed on investigatory leave. Interview revealed, "Based on what we've seen during the investigation did, we have substantiated abuse." Interview revealed HCT #1 and HCT #4 were terminated from employment on 08/26/2008.	A 144		

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Interview revealed HCT #1 had been employed at the hospital for approximately 5 years, during which time he "had been involved in a few situations where there had been a couple of substantiations of verbal abuse. He received disciplinary action in 2007, when he was moved from the adolescent unit to adult admissions and he received a written warning. I think he got another one (disciplinary action) on U2 in 2007 and got another written warning." Interview revealed HCT #4's "name has come up with allegations, but never anything that was substantiated. He has not had any disciplinary actions." Interview revealed reports of abuse should be immediately reported to the nursing supervisor, advocacy department, and nursing office. Interview confirmed RN #1, RN #2, RN # 3, HCT # 2, HCT #3 and TRS #1 all were aware of the alleged staff to patient abuse of Patient #1 and none of them immediately reported it to the nursing supervisor, the advocacy department, or the nursing office. Interview revealed hospital staff had not been reeducated to the abuse policy following the abuse of Patient #1 that was not immediately report by staff. Interview revealed there had been no change in hospital policies or procedures since the staff to patient abuse of Patient #1 occurred and was not immediately reported by staff members on 08/18/2008.

Review of hospital documentation of allegations made against HCT #1 from 08/30/2005 through 01/24/2008 revealed 6 allegations of physical abuse of patients had been made during that time period (two and a half years). Review revealed all 6 allegations had been unsubstantiated by the hospital. Review of a sample of two of these investigations revealed:
An allegation that HCT #1 punched Patient #40 in

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A 144	Continued From page 44 the mouth and put his knee into his back on 05/01/2007: Review of the investigative report revealed, "Patient sustained a busted lower lip and skin tear on his chin....Patient also complained of back pain and tooth pain per the nursing assessment...." Review of the documented interview with Patient #40 on 05/02/2007 at 1410 revealed, "they gave me a shot and it knocked me out....He sucker punched hit him in the mouth in the bathroom....I told the social worker....He did the same thing in the adolescent unit. After he hit me, we were in the bathroom....He is crazy....if you push at the worker, he will respond." Further review of the report revealed documentation of an interview with a witness, HCT #17. Review of HCT #17's interview revealed, "(HCT #1) came onto the ward and was trying to assist. The situation ended in the bathroom. The door closed and (HCT #1) and (Patient #40) were in the bathroom. I couldn't get in. When I did get in...(the patient) was already on the floor. There was blood from somewhere....The patient was face down....I did not see him with his knee in his back...." Review of the documented interview with HCT #1 revealed the HCT did not mention the bathroom at all in his interview, but stated, "He started toward the nursing station and (HCT #17) and I grabbed him. I did not have any intent to hurt him. It kind of hurt that he did hit me." Review of the report revealed there were no witnesses to the event in the bathroom. Review of the documented conclusion of the investigation revealed, "The allegation is unsubstantiated for physical abuse. The incident supports the need to avoid bathrooms in excalating and aggressive situations....In summation, while the truth is not known, the incident could well have been a man to man encounter rather than the needed staff	A 144		

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A 144	Continued From page 45 patient therapeutic intervention." Review of the "Investigation Team Recommendations" revealed, "Action to be taken: Appropriate disciplinary action for (HCT #1)." Review of HCT #1's personnel file on 08/27/2008 revealed no documentation of a disciplinary action related to the incident on 05/01/2007. An allegation that HCT #1 hit Patient #41 in the head on 01/24/2008: Review of the investigative report revealed the patient claimed after breakfast he was drinking his coffee slowly in the dining room when "an old black man tried to drink his coffee and he threw the coffee on the man, who then hit him in the head. Review of the documented interview with HCT #1 in the report revealed, "I told him it was time to come upstairs....He got mad, cursed me out and threw coffee on me. He tripped over chair and then we went upstairs....I helped him up and then he went upstairs...." Review of documented interviews with the only two witness, both dining room workers, revealed neither staff member saw how the patient got on the floor, but they both saw the patient get up off the floor by himself while HCT #1 was at the sink washing coffee off. Review of the documented conclusion of the investigation revealed, "The allegation is unsubstantiated as there are no witnesses to any action other than that of a patient falling after throwing coffee on a staff member....Witnesses say that they saw the patient getting up on his own. This creates a problem of credibility with (HCT #1)." Review of the "Investigation Team Recommendations" revealed, "Action to be taken: Action as determined necessary by Nursing Services concerning the issue of truthfulness about helping the patient up in the dining room." Review of HCT #1's personnel file on 08/27/2008 revealed no documentation of a disciplinary action related	A 144		

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to the incident on 01/24/2008.

Interview on 08/29/2008 at 1145 with the U2 Unit Nurse Manager revealed Patient #40 did not have a bloody lip prior to going into the bathroom with HCT #1 on 05/01/2007, but did had a bloody lip afterwards. Interview revealed HCT #1 told the manager, "I don't know what happened to his lip. He hit the floor." Interview revealed the allegation of abuse was unsubstantiated because there had been no witnesses. Interview revealed, "(HCT #1) was cited for using an unapproved restraint technique that resulted in patient injuries." Interview revealed the manager disciplined HCT #1 with a written warning. Interview revealed the manager was unaware that there was no documentation of a written warning related to the incident in the the personnel file. After reviewing her files in her office, the manager produced a copy of a written warning dated 05/15/2007 for HCT #1. Review of the written warning revealed, "By your own admission you utilized an unapproved physical restraint technique which resulted in patient injuries....Follow-Up Conference scheduled for 30 days after issuance...." Interview revealed the manager did not have a follow-up conference with HCT #1 (30) days after the written warning was issued. Interview revealed, "(HCT #1) should have had a 30 day conference with his supervisor." Interview revealed written warnings remain active for 18 months and any other performance issues identified during that time should result in further disciplinary action, which could include another written warning, suspension without pay or dismissal. Further interview revealed the allegation of the abuse of Patient #41 by HCT #1 on 01/24/2008 had been unsubstantiated because there were no witnesses. Interview

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A 144	Continued From page 47 revealed, "(HCT #1) received a supervisory conference related to truthfulness about helping the patient get up in the Dining Room." Interview revealed the manager did not conduct this disciplinary conference, but rather the supervisor (RN #6) did. Interview confirmed HCT #1 was "still under the 18 months written warning" time frame following the written warning received on 05/15/2007 (8 months earlier). Interview revealed there had been no change in the level of supervision of HCT #1, the monitoring of his interactions with patients or his assignments following the allegations of abuse made against him on 05/01/2007 and 01/24/2008. Interview confirmed HCT #1 physically abused Patient #1 on 08/18/2008, less than 16 months after receiving a written warning for using an unapproved physical restraint technique which resulted in patient injuries (during an incident of alleged abuse of Patient #40) and 7 months after he was found to be untruthful during the investigation of the alleged abuse of Patient #41. Interview on 08/29/2008 at 1515 with RN #6 revealed the nurse was the nurse supervisor on the U2 2E and 2W wards. Interview revealed, "I don't do the written warnings and do not have any part of the process, including the 30 day conference (after the written warning). I do supervisory conferences. Once it (performance) progresses to the written warning level, the manager handles it." Interview revealed RN #6 did not do a 30 day conference with HCT #1 following the written warning that he received on 05/15/2008. Interview revealed the supervisor did have a supervisory conference with HCT #1 after the incident of the alleged abuse of Patient #41 on 01/24/2008, but he "couldn't find the documentation of that conference".	A 144		

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A 144	Continued From page 48 B. The hospital failed to ensure a safe environment of care by failing to monitor a patient with repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (pt#20). Review of the hospital's "Precautions and Standard Accountability" policy dated 06/06/2008 revealed, "All patients are regularly monitored with regard to safety and location. Those patients requiring additional safeguards to ensure safety are placed on precautions. Precautions are initiated by a responsible physician or a registered nurse (RN). Any staff member concerned about the safety of a patient is responsible for informing the RN of his/her concerns so that the patient can be assessed and appropriate precautions can be implemented. The RN then communicates with the responsible physician to obtain the order." Review of the hospitals "Restrictive Interventions" policy dated 09/10/2007 revealed, "Staff shall continuously survey the environment to identify patients displaying evidence of increasing agitation and potential for dangerous behaviors directed towards self or others and intervene with therapeutic communication and other de-escalation techniques as early as possible." Closed record review on 08/26/2008 revealed patient (pt) #20 admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several elderly residents and threatened to kill staff working in his previous residential facility. Review of the physician's evaluation for admission dated 06/21/2008 revealed, the patients history of multiple prior admissions for paranoid	A 144		

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A 144	Continued From page 49 schizophrenia, and recommendations that the patient is mentally ill, and is dangerous to others. Review revealed the physician's initial treatment plan for milieu therapy, expand database, and medication to address depression/psychosis/anxiety/mood swings. Review revealed the physician assessed the prognosis as poor. Review of the nursing assessment dated 06/21/2008 revealed, "Precipitating factors to admission Assaulted several elderly residents (and) threatened to kill staff workers." Review revealed the nurse documented "bizarre behavior inappropriate laughing," poor eye contact, flat affect, and preoccupied thought progression. Review revealed the nursing care plan for ineffective individual coping related to assaulting elderly people, threatening to kill staff, and intervention/treatment modalities to redirect as necessary, and set firm limits. Review of the Initial Social Work Entry dated 06/23/2008 revealed the social worker talked with the patients' family and documented "He needs supervision at all times. He's Violent." Review of progress notes revealed the patient with multiple violent/assaultive behaviors during the hospitalization, including: 06/22/2008 0950 "Pt got into a fight (with) another peer"; 06/27/2008 0915 "Involved in altercation (with) (peer)"; 07/01/2008 0830 "Attacked (peer) reported to have been shouting 'stop the voices' and apparently hit (peer) in (left) eyebrow sustaining 1(inch) -1 1/2 (inch) laceration to (left) eyebrow"; 07/04/2008 0830 "Pt attempted to attack the nurse ..."; 07/04/2008 1415 "(peer) trying to attack pt, but	A 144		

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was halted by staff ... about 15 to 20 minutes later, heard another commotion (pt and peer) involved in an altercation, both patients were returned to the ward and ward nurse notified.";
07/16/2008 2145 "within 5 minutes attacked 2 separate peers without any provocation, punching and hitting both peers. He received 8pm meds immediately after the 8:30 attack";
07/29/2008 1315 "Pt became agitated because he is unable to have a cigarette. Pt has been pacing and physically threatening peers and staff. Pt was medicated for psychotic agitation... pt is kept on unit from groups for today, because of his agitation and violence.";
07/30/2008 2300 "(pt) assaulted (peer) during this evening shift.";
08/01/2008 2055 "Pt came uninvited into nurses station ...he exploded in anger, throwing a chair in the nurses station. He continued to make numerous verbal threats about attacking me (HCT#10) and pacing around the nurses station with a threatening affect. Psychiatrist paged and order received";
08/08/2008 1845 "pt came from behind me and pushed me up against smoking door and began rubbing hands all over me and kissing my neck. I pushed pt away and told him to leave me alone. After redirection pt went to his room and closed door"; and
08/10/2008 1815 "At 1800 (pt) reportedly struck (peer) to right side of head causing bleeding and swelling to site. (pt) stated that he struck pt because other pt wanted to use his CD player."

Review on 08/28/2008 at 1200 of hospital digital video record (U2 kitchen 1 & 2 cameras, and U2 1W Hall 3 camera) of the assault that occurred on 08/10/2008 at 1758 in the hallway/vending machine area outside of the dining room

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A 144	Continued From page 51 revealed, approximately 10-12 patients in/out of the hallway/dining room. Review revealed patients gathered in the hallway for 4.5 to 5 minutes. Review revealed during the 4.5 to 5 minutes no staff was present with the patients. Review revealed staff remained in the dining room. Review revealed pt#20 left the dining room, walked into the hallway and kicked the vending machine. Review revealed pt#20 and others then began to dance in the hallway/vending area. Review revealed staff remained in the dining room. Review revealed the patients standing and pacing in the hall/vending area. Review revealed a patient shaking the vending machine. Review revealed pt#20 pacing in the hall/vending area. Review revealed staff remained in the dining room. Review revealed pt#20 suddenly takes off his headset, quickly squats down hits fists/hands to ground, quickly gets up, and walks over to pt#14 and begins hitting pt#14, about 6 blows rapidly to face/head. Review revealed pt#14 was down on the floor. Review revealed 2 staff run from the dining room to the hall/vending area. Review revealed one staff separates the patients, putting pt#20 in a hold against the wall. Review revealed the other staff assisted pt#14 up and into the dining room. Review revealed the other patients remained in the hall/vending area. Review revealed pt#20 was released from the hold, the staff member turned around and walked through the group of patients with pt#20 behind him. Review revealed the patients walked down the hall, followed by the second staff and pt#14. Review revealed pt#14 holding an unidentified object to his head. Record review on 08/26/2008 revealed pt#14 admitted to the hospital on 08/08/2008 with	A 144		

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paranoid schizophrenia, under involuntary commitment, and discharged on 08/27/2008. Review of the initial psychiatric assessment dated 08/08/2008 revealed the patient was calm and cooperative with fair verbal communication, and no recent history of aggressive behavior. Review of nursing progress notes dated 08/10/2008 at 1815 revealed "Pt. (patient) involved in altercation in dining room ... (pt#20) struck (pt#14) to (right) side of head (with) closed fist. Ice pack applied to site. (physician assistant) advised. Bleeding controlled ..." Review revealed the patient had bruising under the left eye, tenderness/difficulties when opening the mouth, contusion to left side of face, pain over the left lower orbital bone area and temporal mandible joint area and tender left jaw area. Review revealed the patient received a pureed diet due to difficulties chewing. Review of the record revealed x-ray and CT scans were obtained and revealed the patient sustained a "comminuted depressed fracture of the left zygomatic arch." Review revealed Maxillary facial surgery consult was obtained and surgical repair scheduled during the admission.

Interview on 08/28/2008 at 1955 with HCT (Health Care Technician) #10 revealed, pt#20 is a "very violent person, snaps very quickly, if he doesn't get things his way he has outbursts, throws things, yells, and punches people. He walks up to patients and punches them in the face with staff standing next to him." Interview revealed the staff member was in the cafeteria the night of 08/10/2008, when pt #20 assaulted pt #14. The interview revealed two HCT's were in the dining room with the patients, the patients finished eating and went out in the hall by the vending machines. The interview revealed the HCT's were in the Dining room, and could not see out

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A 144	Continued From page 53 into the hallway, where the vending machines and patients were. The interview revealed the staff member saw pt#20 threw his headset down, and went charging down to where pt#14 was. The interview revealed the staff then ran out into the hall. The interview revealed pt#20 was punching pt#14. The interview revealed one HCT held pt#20 off of pt#14, and the other HCT assisted pt#14 up, off the ground. The interview revealed pt#14 was bleeding from the right side of his head. The interview revealed the patients were returned to the ward. The interview revealed the nurse provided care to pt#14 and notified the physician of the patient's injuries. Interview on 08/28/2008 at 1400 with the Unit 2 Nurse Manager regarding the incident on 08/10/2008, revealed the manager had reviewed the digital video records of the event. The interview revealed 2 staff HCT's were present in the dining room when pt#20 assaulted pt#14 in the hallway. The interview revealed the patients had finished their meal and congregated in the hall, outside of the dining room. The interview revealed pt#20 was going from patient to patient in the dining room, and then walked in and out of the dining room. The interview revealed pt#20 went out to the hallway/vending machine area, kicked the vending machine, and then started dancing. The interview revealed pt#20 began to pace "back and forth" in the hallway. The interview revealed pt#20, then attacked pt#14. The interview revealed no staff was present in the hall. The interview revealed staff are supposed to keep patients in the dining room until they are ready to go up to the units. If a patient is in the hallway staff should be present in the hall with the patients. The interview revealed from review of the digital video recording, the manager could see	A 144		

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the two staff were in the dining room conversing. The interview revealed the patients were in the hallway for 4.5 to 5 minutes, without staff present. The interview confirmed no staff observed the hallway area for the 5 minutes prior to the assault. The interview revealed if staff had been present in the hallway, they might have been able to prevent the assault. The interview revealed "(pt#20) could have handled CA (constant awareness precautions), I don't know why it wasn't used. If he had been on CA there could have been an intervention before, to prevent the injuries." The interview revealed precautions are not used often. When asked why, the interview revealed "coverage and staffing is a big issue on the campus, volatile behavior is something we see a lot here."

Observation on 08/26/2008 at 1730 of the U2 dining room/hallway/vending area revealed patients in the hallway/vending area, out of sight of staff. Observation revealed no staff present, monitoring the patients for 3 to 5 minutes.

C. The hospital failed to ensure a safe environment by failing to implement precautionary interventions for repeated assaultive behaviors.

Review of the hospital's "Precautions and Standard Accountability" policy dated 06/06/2008 revealed, "All patients are regularly monitored with regard to safety and location. Those patients requiring additional safeguards to ensure safety are placed on precautions. Precautions are initiated by a responsible physician or a registered nurse (RN). Any staff member concerned about the safety of a patient is responsible for informing the RN of his/her concerns so that the patient can be assessed and appropriate precautions can be

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implemented. The RN then communicates with the responsible physician to obtain the order."

Review of executive committee meeting minutes dated 06/20/2006 revealed "upon receipt of a memo from the PI (performance improvement) Department that a patient has had three or more incidents (of any type such as restrictive interventions, falls, or assaults) within a week or six or more incidents (of any type such as restrictive interventions, falls, or assaults) within a calendar month, the treatment team shall initiate a review of the information and the psychiatrist shall document a progress note in the patient's record verifying that the review has been done and any action taken. This review and progress note must be completed within five days of receipt of the memo."

Review of the hospital's "Behavior Plans and Crisis Plans" policy dated 05/05/2008 revealed, "(Hospital name) utilizes a variety of treatment modalities to ensure quality patient care in a safe environment. Some patients have needs which exceed the standard therapeutic capabilities of the ward management system. Such patients require more individualized interventions. Specialized behavior plans or crisis plans are one method to potentially meeting the needs of patients who have behaviors which exceed the therapeutic capabilities of the standard ward management system. Crisis plans are indicated when a patient's behavior presents an imminent danger to self or others and standard ward based interventions have been ineffective in managing, reducing, or eliminating the behavior. A functional analysis of behavior is indicated for any patient that is in need of a thorough assessment of his/her behavior. The functional analysis of

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A 144	Continued From page 56 behavior report includes a description of the patient's challenging behavior and an assessment of the following: the frequency, intensity, and the duration of the challenging behavior; the environmental factors which contribute to the challenging behavior; the triggers and antecedents of the challenging behavior; and the consequences of the challenging behavior. The functional analysis of behavior report also includes recommendations regarding interventions which may reduce, modify, or eliminate the challenging behavior. The functional analysis of behavior report is filed in the patient's medical record. Behavior plans may be indicated when a patient's behavior requires behavioral contingencies and reinforcements unavailable through standard interventions and/or the therapeutic milieu. No specific threshold regarding behaviors has to be exceeded in order to consider a behavior plan. Examples of possible triggers for behavior plans include (but are not limited to): dangerous behaviors towards self or others, behaviors requiring use of forced medication, and non-participation in treatment. If a behavior plan is considered contraindicated, a psychologist completes a behavior consultation report and meet with the treatment team to discuss alternative interventions. A Behavioral Consultation Report is completed when a referral is sent for a Crisis Plan or Behavior Plan and it is determined that a Crisis Plan or Behavior Plan is not clinically indicated. The ward Psychologist or member of the Behavior Management Team meets with the treatment team and reviews recommendations regarding possible strategies to manage the patient's behavior. Behavioral Consultation Reports are filed in the patient's medical record."	A 144		

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A 144	Continued From page 57 Closed record review on 08/26/2008 revealed patient #20 admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several elderly residents and threatened to kill staff working in his previous residential facility. Review of the physician's evaluation for admission dated 06/21/2008 revealed, the patients history of multiple prior admissions for paranoid schizophrenia, and recommendations that the patient is mentally ill, and is dangerous to others. Review revealed the physicians initial treatment plan for milieu therapy, expand database, and medication to address depression/psychosis/anxiety/mood swings. Review revealed the physician assessed the prognosis as poor. Review of the evaluation for admission "Risk Factors for Suicide/Violence, Level of Suicide/Violence Risk, and Behavioral Issues" sections revealed no documentation of physician assessment. Review of the nursing assessment dated 06/21/2008 revealed, "precipitating factors to admission: Assaulted several elderly residents (and) threatened to kill staff workers." Review of the nursing violence risk assessment revealed, no risk factors documented during initial nursing assessment, and the section stating "If patient admission precipitated by homicidal/violent/sexually Inappropriate thoughts/acts then special precautions were discussed with Psychiatrist:" with documentation of "N/A (not applicable)." Review revealed the nurse documented "bizarre behavior inappropriate laughing," poor eye contact, flat affect, and preoccupied thought progression. Review revealed the nursing care plan for ineffective individual coping related to assaulting elderly people, threatening to kill staff,	A 144		

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A 144	Continued From page 58 and intervention/treatment modalities to redirect as necessary, set firm limits. Review failed to reveal the patients risk for violence included in the nursing care plan. Review of the Initial Social Work Entry dated 06/23/2008 revealed the social worker talked with the patients' family and documented "He needs supervision at all times. He's Violent." Review revealed the social worker documented "Trigger: Cigarettes." Review of the initial 72 hour treatment plan dated 06/23/2008 revealed the short term goals: express ideas that are clearly related to one another during interview with staff; display appropriate social behavior in group meetings; participate in treatment/discharge plan; and will demonstrate pleasant, cooperative manner in interactions with staff/patients. Review revealed the long term goals: show observable decrease in symptoms; show observable decrease in dangerous behaviors; manage self destructive or homicidal feelings without acting on them; and demonstration willingness to participate in aftercare plan. Review revealed the plan listed nursing interventions to redirect conversation to reality based subjects, monitor medication regimen, observing for therapeutic effects and side effects, and assist patient in identifying precipitants/stressors that may stimulate hallucinations/delusions/acting out behavior. Review of the plan failed to reveal interventions to decrease the possibility of assaultive behaviors, and failed to reveal the patient was placed on special precautions. Review of progress notes revealed the patient with multiple violent/assaultive behaviors during the hospitalization, including: 06/22/2008 0950 "Pt got into a fight (with) another	A 144		

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A 144	Continued From page 59 peer"; 06/27/2008 0915 "Involved in altercation (with) (peer)"; 07/01/2008 0830 "Attacked (peer) reported to have been shouting 'stop the voices' and apparently hit (peer) in (left) eyebrow sustaining 1(inch) -1 1/2 (inch) laceration to (left) eyebrow"; 07/04/2008 0830 "Pt attempted to attack the nurse..."; 07/04/2008 1415 "(peer) trying to attack pt, but was halted by staff ... about 15 to 20 minutes later, heard another commotion (pt and peer) involved in an altercation, both patients were returned to the ward and ward nurse notified."; 07/16/2008 2145 "within 5 minutes attacked 2 separate peers without any provocation, punching and hitting both peers. He received 8pm meds immediately after the 8:30 attack.; 07/29/2008 1315 "Pt became agitated because he is unable to have a cigarette. Pt has been pacing and physically threatening peers and staff. Pt was medicated for psychotic agitation... pt is kept on unit from groups for today, because of his agitation and violence."; 07/30/2008 2300 "(pt) assaulted (peer) during this evening shift."; 08/01/2008 2055 "Pt came uninvited into nurses station ...he exploded in anger, throwing a chair in the nurses station. He continued to make numerous verbal threats about attacking me and pacing around the nurses station with a threatening affect. Psychiatrist paged and order received"; 08/08/2008 1845 "pt came from behind me and pushed me up against smoking door and began rubbing hands all over me and kissing my neck. I pushed pt away and told him to leave me alone. After redirection pt went to his room and closed door"; and	A 144		

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A 144	Continued From page 60 08/10/2008 1815 "At 1800 (pt) reportedly struck (peer) to right side of head causing bleeding and swelling to site. (pt) stated that he struck pt because other pt wanted to use his CD player." Review of the initial treatment plan dated 07/01/2008 (after 2 - 3 documented assaultive behavior incidents) revealed the long term goal for patient to interact in a calm pleasant manner, and the short term goal for patient to interact for 15 minutes without becoming violent or threatening 3 times a week for 2 weeks. Review revealed the treatment interventions to prescribe and monitor medications, teach the patient ways to manage his agitation instead of becoming violent, ask him to take a time out and return to group when he is calm, and practice positive interactions without violent or threatening behavior, Praise the patient when he is able to interact without violent or threatening behavior. Review revealed the violence risk assessment documenting the patient with aggression/agitation within last 7 days. Review revealed the team documented the patients "Level of Suicide and/or Violence Risk" as "Medium" and documented the interventions to address such risk as "medication." Review revealed no precautions, referrals or other treatment interventions. Review of the treatment plan dated 07/16/2008 (after 5 documented assaultive behavior incidents) revealed, the treatment plan was changed from previous to increase the time spent with the social worker by 5 minutes per week. Review revealed the goal for the patient to interact in a calm pleasant manner was continued. Review revealed no additional interventions, referrals or precautions to address the patient's repeated assaultive behaviors. Review of the treatment plan dated 08/04/2008 (after 9 assaultive	A 144		

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A 144	Continued From page 61 behavior incidents) revealed, the plan documented the patient with 2 additional incidents since the previous plan meeting and a total of 6 incidents in 30 days. Review revealed the treatment team review was documented as a regular review and as a special review due to "6 incidents within 30 days." Review revealed the patient is not meeting his goals. Review revealed the patients long term and short term goals were continued. Review of the treatment plan revealed no additional interventions, referrals or precautions to address the patients repeated assaultive behaviors. Review of the record revealed staff redirected the patient for displays of violence/threats, and assaultive behavior and provided 1:1 contact to de-escalate the patient's behaviors. Review revealed medications were administered, and adjusted during the hospitalization. Review of the record failed to reveal the patient was placed on precautions for repeated assaultive behaviors. Review of the record failed to reveal the Behavior Management Team was consulted for the patient's repeated assaultive behaviors. Interview on 08/28/2008 at 1600 with Psychologist #1 revealed, the psychology department has had "a lot of turn over." The interview revealed the psychologist has been the only psychologist for "quite some time. Generally there are 2 psychologists per unit." The interview revealed the psychologist spends most of his time "getting patients into treatment groups, performing substance abuse assessments, and very little time on the treatment team." The interview revealed treatment teams determine if a Behavior Management Team consult is needed and the Psychiatrist usually makes the referral. The interview revealed "patient needs are	A 144		

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prioritized, basic needs are met, if we had more staff we could do a better job."

Interview on 08/28/2008 at 1715 with the Psychiatrist revealed the physician was aware of the patient's assaultive behaviors. The interview revealed the patient was "very psychotic, unpredictable, but he had certain issues he always addressed, demanding to be discharged locally, and if his requests were not met his behavior got worse at those times." The interview revealed "usually there are some triggers, with (pt#20) if he starts pacing, we know he is escalating, the HCT's know how to intervene. If he is pacing, they know how to talk to him." The interview revealed staff could change precautions to increase monitoring of the patient around those times. The interview revealed staff "used a group approach to watch him, not strictly precautions." The interview revealed the physician did not feel a behavior plan would work with pt#20 due to his ability to understand with his psychosis. The interview revealed the physician's "plan to use the headphones, due to music relaxed him. If (he) behaved, he got the headphones." The interview revealed the hospital was trying to arrange discharge to another facility, and "if we thought he was going to be with us for a long time, then we would have had a behavior plan."

Interview on 08/28/2008 at 1635 with a Behavior Specialist/ Behavior Management Team member, revealed the specialist was unfamiliar with pt#20, and could not find a referral for a Behavior Management consult for pt#20. The interview revealed "anytime we have a referral we go do an assessment. We always try to offer some suggestions if a behavior plan is not going to be helpful." The interview revealed the team will

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A 144	Continued From page 63 offer strategies for staff in dealing with patient behaviors. The interview revealed if the patient has a behavior plan in place while hospitalized, then is discharged, a team member may go out to the home/facility receiving the patient and provide training to the staff/family to continue working on the behavior plan. Interview on 08/27/2008 at 1235 with RN#5 revealed the staff member had worked with pt#20 on numerous occasions. The interview revealed pt#20 was "hyper, always pacing, talking to himself, asking for cigarettes, very labile, the smallest thing would set him off." The interview revealed the patient would become agitated "usually around smoke time or if he felt like he needed to get payback for some other incident. There were times the patient would go several days without an (assaultive) episode. It seemed like when ever he had a treatment planning meeting, or talk about discharge, that would antagonize him." The interview revealed the RN had discussed precautions with the physician, but it was felt to be "not appropriate for the patient. (The patient) saw precautions as staff picking on him, he wanted to be left alone." The interview revealed staff had identified treatment team meetings and smoke time as instigating factors to the patient's behavior. The interview revealed the RN was "unaware of any" precautions/ interventions that were put in place around these identified instigating factors. The interview revealed the RN was not aware of a behavior plan for the patient. The interview revealed staff attempted to keep the patient calm by giving him whatever he wanted. The interview revealed the RN worked on the night of 08/08/2008 when the patient had sexually assaulted a staff member. The interview revealed the patient had not	A 144		

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assaulted anyone in that manner before. The interview revealed this would be considered an escalation in behavior. The interview revealed no changes were made to the plan of care after the assault, "He was at his baseline, with no further outbursts."

Interview on 08/28/2008 at 1955 with HCT#10 revealed, pt#20 is a "very violent person,, snaps very quickly, if he doesn't get things his way he has outbursts, throws things, yells, and punches people. He walks up to patients' and punches them in the face with staff standing next to him." Interview revealed the staff member was in the cafeteria the night of 08/10/2008, when pt #20 assaulted pt #14. The interview revealed pt#14 was bleeding from the right side of his head. The interview revealed the patients' were returned to the ward. The interview revealed the nurse provided care to pt#14 and notified the physician of the patients injuries. The interview revealed pt#20 was not placed on precautions, and no new interventions were implemented. The interview revealed "nothing" happened to pt#20, "he acted like nothing happened, walked around listening to his headphones." The interview revealed the patient has a headset to play music to keep him calm. The interview revealed the headset is not used to reward good behavior; it is used to keep the patient calm and is not taken away from the patient. The interview revealed the staff member was "never told anything" on how to interact with the patient, interventions to use to de-escalate the patient. The interview revealed "there is no way to predict the patients outbursts" the staff "just give him what he wants to keep him quiet."

Interview on 08/27/2008 at 1025 with the DON

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(Director of Nursing) and ADON (Assistant Director of Nursing) revealed, the staff was aware of the patient's assaultive behavior on admission and interventions to redirect and set limits with the patient were initiated. The interview revealed staff can place patients on special precautions for close monitoring of the patient's status, "make sure he is safe, no changes in the patients condition, and monitor for changes in patients mood/agitation level. The interview revealed there was no evidence the patient was placed on precautions at any time during the hospitalization The interview revealed there were no changes made to the treatment plan dated 08/04/2008 (after 9 assaultive incidents). The interview revealed the patient continued to have assaultive behaviors and assaulted a staff member on 08/08/2008. The interview revealed there was no change to the patient's plan of care after the assault on 08/08/2008. The interview revealed the patient assaulted another patient on 08/10/2008, resulting in a serious injury.

Interview on 08/28/2008 at 1400 with the Unit 2 Nurse Manager revealed "(pt#20) could have handled CA (constant awareness precautions), I don't know why it wasn't used. If he had been on CA there could have been an intervention before, to prevent the injuries."

D. The hospital failed to ensure a safe environment of care by failing to report and investigate assaults according to hospital policy.

Review of the hospital's "Incident/Accident Reports" policy dated 11/01/2003 revealed, "PURPOSE: To establish guidelines for systematic reporting of all incidents/accidents which may result in actual or potential injury to

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patients; to establish a mechanism to review circumstances surrounding the incident/accident and make determination for appropriate course of action and follow - up; and to establish a data driven risk assessment system to enable quality of health care, safety management improvement through routine assessment and evaluation. All incidents/accidents resulting in serious or potentially serious injury shall be investigated by the nurse manage/designee. Investigation of major/serious injuries shall be completed within 72 hours of the occurrence with reported findings distributed to the Director of Nursing Services (DON), Clinical Director, and the Performance Improvement Department. Suspected Abuse/Neglect - In cases where abuse, neglect, or exploitation of patients is suspected follow policy on Abuse, Neglect, and Exploitation."

Review of the hospital's "Abuse/Neglect/Exploitation of Patients, Prohibited" policy dated 07/21/2008 revealed, "Neglect: the failure to provide necessary care or services (medical or otherwise) to maintain the mental health, physical health and/or well- being of the patient. Examples of abuse or neglect include ... 10. Failure to provide a required level of supervision."

Review of the hospital's "Criminal Charges Against Patients" policy dated 04/30/2008 revealed, "A. Hospital staff attempt to prevent aggressive behaviors within the hospital. When a patient has a pattern of aggressive or assaultive behaviors, his/her treatment team includes this as a problem with associated goals and interventions in his/her treatment plan. B. Hospital staff immediately attempt to prevent patient disagreements from escalating into potentially

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A 144	Continued From page 67 more serious altercations through techniques such as (but not limited to) redirection, medication, and milieu adjustment. C. In the case of incidents such as physical assault without injury, Hospital staff contact the hospital Police. The Hospital Police inform the alleged victim of his/her rights to file charges. D. Upon discovery or report of an alleged serious crime, Hospital staff immediately contact the Hospital Police and the Hospital Police conduct an investigation to determine whether a crime did occur. 1. In these cases the Hospital Police send the alleged perpetrator's attending psychiatrist/designee the Physician Recommendations form and notifies the Clinical Director's Office that the Physician Recommendations form has been sent. 2. The Core treatment team meets as soon as possible (within 3 working days of receiving the Physician Recommendations Form) to evaluate the incident and determine whether or not charges should be filed. 4. Regardless of whether or not it is recommended that charges be filed, the Hospital Police Department reviews the circumstances of the situation resulting in the possible pursuit of charges with the County District Attorney's office and reaches an agreement as to the appropriateness of filing charges. F. If at any point in the process it is determined that filing charges does not appear appropriate, the alleged victim is notified of such within 3 working days by the Hospital Police and advised of his/her right to file charges with the magistrate upon his/her release." Closed record review on 08/26/2008 revealed patient #20 admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several	A 144		

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A 144	Continued From page 68 elderly residents and threatened to kill staff working in his previous residential facility. Review of the physician's evaluation for admission dated 06/21/2008 revealed, the patients history of multiple prior admissions for paranoid schizophrenia, and recommendations that the patient is mentally ill, and is dangerous to others. Review of progress notes revealed the patient with 8 patient to patient violent/assaultive behaviors and 4 patient to staff violent/assaultive behaviors during the hospitalization. Review of hospital incident reports reveal reports for 10 of 12 violent/assaultive behavior incidents. Review failed to reveal incident reports for the staff assault on	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review, investigative report review and staff interview the hospital failed to: A) prevent staff to patient abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1); and B) ensure adequate monitoring and supervision of patients to prevent patient neglect (#35). The findings include: A) The hospital failed to prevent staff to patient abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1). Review of hospital policy number VI-A-1 entitled "Abuse/Neglect/Exploitation of Patients,	A 145		

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A 145	Continued From page 69 Prohibited" dated 07/21/2008 revealed, "POLICY:...All members of the hospital staff are required to intervene immediately if witnessing abuse, neglect, and/or exploitation of a patient. Where there is physical injury or sexual abuse, the patient is to be provided immediate medical evaluation. (Name of Hospital) further requires that when staff, students or volunteers observe, suspect, or have knowledge of abuse, neglect, and/or exploitation, they must report this information to their immediate supervisor/designee, the Royster Nursing Office (RNO), or the (Name of Hospital) Advocacy Department immediately....Failure to disclose information pertaining to suspected abuse, neglect and/or exploitation of a patient will result in disciplinary action as determined by the Hospital Director and State Personnel Policy Manual....DEFINITIONS:...Abuse: the infliction of physical or mental pain or injury by other than accidental means....PROCEDURES: I. IMMEDIATE INTERVENTION AND REPORTING REQUIREMENTS A. Adults and Juveniles: Any staff member, student or volunteer who observes, suspects, or receives an allegation of abuse, neglect and/or exploitation of a patient must: 1. Intervene immediately to ensure the safety and well being of the patient. 2. Notify the ward RN (Registered Nurse) of the patient's home ward. 3. Notify their immediate supervisor/designee, RNO, or the (Name of Hospital) Advocacy Department....Documentation in the Medical Record: 1. The ward RN shall document the abuse, neglect, and/or exploitation allegation in a progress note in the patient's medical record prior to the end of the shift in which the report is received. Documentation should include: a. a brief statement regarding the allegation; b. the date, time and place of the alleged abuse,	A 145		

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A 145	Continued From page 70 neglect, and/or exploitation; c. the condition of the patient's mental and physical status; and d. the treatment and/or intervention provided...." Closed record review of Patient #1 revealed a 30 year-old male that was admitted on 07/19/2008 for schizoaffective disorder, bipolar type and borderline intellectual functioning. Review of the Physical Assessment completed upon admission on 07/19/2008 by a Physician Assistant (PA) revealed, "Physical Diagnosis: 1. Mild MR (mental retardation. 2. NAD (no acute distress)." Review of RN #1's progress note documented on 08/18/2008 at 1330 revealed, "Rec'd (Received) call from U3 groups that (Patient #1) was in an altercation c (with) a peer. Staff intervened et (Patient #1) will be brought back to U2 3E." Review of RN #1's progress note documented at 1340 revealed, "(Patient #1) is back on the ward. When questioned regarding return stated 'Two staff jumped on me' Per staff (Patient #1) threatened a female patient et then a male patient. Staff reports that staff intervened et escorted (Patient #1) back to this ward. Staff will monitor behaviors." Record review revealed no documentation that the nurse assessed the patient for medical needs or injuries. Further review revealed no documentation that the nurse notified the physician, nurse supervisor, nursing office (RNO) or Advocacy Department of the patient's allegation that he was abused by two staff members. Review of Health Care Technician (HCT) #1's progress note documented on 08/18/2008 at 1345 revealed, "I didn't see what happen between him and (the other patient). When I came from out back (the other patient) told me that he was going to give (Patient #1) what he wanted. And then they send him back to his ward. Before (the other patient)	A 145		

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hit (Patient #1)." Record review revealed the first documentation of a medical examination (after the patient alleged the staff abused him on 08/18/2008) on 08/19/2008 at 1140 (22 hours later). Review of the Physician Assistant's (PA) progress noted dated 08/19/2008 at 1140 revealed, "Pt (Patient) c/o (complains of) pain in 'L (left) side + back of neck' after altercation 1 day ago....Mild ecchymosis or edema (bruising or swelling) on L side of neck....Mild tender on palpation over L lower Ribs...." Record review revealed on 08/19/2008 the patient underwent x-rays of his left rib cage and cervical spine (vertebrae in neck). Record review revealed the results of the x-rays were negative (no fractures). " Review of HCT progress notes documented on 08/19/2008 at 2045 revealed, "...complained of side hurting. Staff reported incident to nurse...." Record review revealed the first documentation that a nurse assessed the patient's pain was on 08/20/2008 at 1548 (19 hours later). Record review revealed the next available documentation of a pain assessment by nursing staff was on 08/21/2008 at 1237, at which time the patient complained of left rib pain. Record review revealed documentation on 08/22/2008 at 1000 that the patient was discharged to a group home.

Review on 08/29/2008 of an "Abuse, Neglect and/or Exploitation Investigation Report" dated 08/28/2008 revealed documentation of the hospital's investigation into the allegation of the abuse of Patient #1. Report review revealed documentation on 08/19/2008 at 1038 of an interview with Patient #1 conducted by the U2 Unit Nurse Manager and Patient Advocate #1. Review of the interview revealed the patient knew the 2 HCTs that abused him, but didn't know their names. Review of the interview revealed, "'They

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started beating me down on the ground.' (Patient #1) says that while they were beating him they were saying, 'What are you going to do? What are you going to do?'...(Patient #1) said that after the dude with the red hat left me alone the other dude started choking me on the ground. (Patient #1) was asked how it ended and he said, 'He stopped and let me up.'...(Patient #1) said that he told the police and the police said that he would talk to him...." Further review of the interview revealed, "Investigators examined (the patient) for any obvious signs of injury and found numerous markings of a suspicious nature. The markings appeared to be recent by their reddish coloration and the markings appeared to be in the same general stages of healing (reddish to slightly purple). The marks were on (the patient's) left upper back (see photo), the left side of the back of his neck (see photo), behind his left ear (see photo), the left front shoulder and neck area (see photo), and some slight markings on his right neck/chest area (see photo)....(Patient #1's) account of this incident and his injuries clearly supports that he was physically abused by (HCT #1) and (HCT #4)." Review of the conclusion of the investigation report revealed, "Investigators find the evidence in this case to be significant, clear and convincing to support the conclusion that (HCT #1) and (HCT#4) physically abused (Patient #1) on 08/18/2008."

Interview on 08/26/2008 at 1715 with Patient Advocate #1 revealed HCT #2 reported called her agency on the evening of 08/18/2008 and reported that she had witnessed 2 staff members abusing a patient that afternoon in the breezeway of the U2 treatment mall. Interview revealed the agency supervisor called the nursing office and reported the allegation to the nursing supervisor,

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A 145	Continued From page 73 who then reported it at 2100 to the Advocacy Department. Interview revealed the Chief Patient Advocate went to the hospital on the night of 08/18/2008 (unsure of time) to begin investigating the allegation. Interview revealed, "We are still investigating. We are in the process of substantiating the abuse." Interview revealed the hospital has a video surveillance system that monitors most patient care areas. Interview revealed there were no cameras located in the breezeways of the units (smoking areas). Interview on 08/27/2008 at 1350 with HCT #2 (an agency HCT) revealed the HCT was assigned to monitor female patients from the U2 2W ward when they went to the U3 treatment mall on 08/18/2008 at 1300. Interview revealed the HCT was in the breezeway smoking with 3-5 female patients at approximately 1320. Interview revealed there was also another female HCT present (HCT #3), as well as a male HCT (HCT #1) with several male patients who were also smoking. Interview revealed one of the female patients asked a male patient (later identified as Patient #1) for some money or cigarettes. Interview revealed Patient #1 became agitated with the female patient and starting yelling at her. Interview revealed the female patient told the HCT "He wants to fight me" and so the HCT told the female patient to stay away from him (Patient #1). Interview revealed, "She finished her cigarette and went inside. Before she went inside I heard (HCT #1) say, 'Go on and fight her and see what happens.' It was like he was egging the patient on." Further interview revealed one by one the patients finished their cigarettes and went inside. Interview revealed when the second to last patient went inside (leaving only Patient #1 in the breezeway with staff members) HCT #4 came	A 145		

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A 145	Continued From page 74 out to the breezeway. Interview revealed at that time the only people on the breezeway were HCT #3, HCT #1, HCT #4, Patient #1 and herself. Interview revealed, "I turned to dump ashes and when I turned back I saw (HCT #1) hit (Patient #1) in the stomach. I can't remember if he hit him again before the patient fell, but the patient fell in a fetal position. (HCT #1) and (HCT #4) tag teamed the patient. They took turns hitting him. 2-3 strikes each, then they would change." Interview revealed the two HCTs hit and kicked the patient in the groin, face and legs. Interview revealed, "It looked like he got hit everywhere." Further interview revealed, "After I saw (HCT #4) hit him I went to the door to go inside. As I got to the door they called out 'Wait a minute'. It was like they stopped (hitting the patient) for me to go inside so no one would hear them. (HCT #3) came in right behind me." Interview revealed HCT #2 sat in a chair outside of the bathroom (her assigned post) when she went inside. Interview revealed when Patient #1 came inside (about 5-10 minutes later) he went to the entrance of the dayroom, pointed at the door that goes out to the breezeway and said "These 2 men just jumped me. They beat me". Interview revealed there were staff members present in the dayroom at that time, but the HCT wasn't sure exactly which ones because she was posted at the opposite end of the hall. Interview revealed the patient took off his jacket as he walked down the hall and then removed his shirt at the entrance to the dayroom "like he was going to fight them". Interview revealed HCT #1 and HCT #4 "nonchalantly" walked past the patient on the way to the nursing station. Interview revealed, "I didn't tell anybody at the hospital about it (the abuse of Patient #1 by the two staff members)....I didn't tell anyone (immediately) because I was	A 145		

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scared. The men were very scary. They said, 'If anyone asks you, you didn't see anything.'" Interview revealed the HCT felt afraid and intimidated by HCT #1 and HCT #4. Interview revealed, "They kept asking me what was wrong. I told them I had a migraine....They even called my cell phone....I had to change my number." Interview revealed when at home later that evening she decided to report the abuse. Interview revealed the HCT called her agency supervisor at approximately 2000 and reported the abuse (between 6 and 7 hours later). Interview revealed the agency supervisor then called the nursing supervisor at the hospital and reported the abuse. Interview revealed the HCT went to the hospital the following day at approximately 1100 for an interview with the nurse manager and patient advocate regarding the abuse that she witnessed. Interview revealed during the interview the nurse manager told her to always report abuse and that the two HCTs had been suspended from work. Interview revealed the HCT was out of work for the week following the incident on 08/18/2008, but had returned to work on 08/25/2008 and was reassigned to a different ward. Interview revealed when the HCT escorted a patient past the U3 treatment mall "the other day" she felt intimidated by other staff members, because she could "hear them loudly making comments like 'snitch'". Interview revealed the HCT was on duty at the time of the interview and was assigned to Woodard 1E. Interview revealed, "No one has reviewed the (abuse) policy with me since the incident (9 days before interview)".

Telephone interview on 08/27/2008 at 1545 with HCT #3 (an agency HCT) revealed the HCT was assigned to monitor a male patient during a

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A 145	Continued From page 76 smoke break in the breezeway of the U3 treatment mall on 08/18/2008 at approximately 1315. Interview revealed, "There were a couple of other patients out there with (HCT #1), (HCT #2) and myself. A male (later identified as Patient #1) and a female patient had a disagreement. I told him he didn't need to talk to a female that way. We moved the female patient where we (the two female HCTs) were to solve the conflict. (HCT #1) told the patient, 'If you are going to do something do it.'" Interview revealed HCT #1 and Patient #1 "exchanged more words." Interview revealed all of the patients except for Patient #1 had finished smoking and gone inside. Interview revealed, "He (Patient #1) was done smoking and wanted to go back inside. He walked towards the door. (HCT #1) said, 'No, you don't go in.' Me and (HCT #2) were still smoking so we were still out there." Interview revealed HCT #4 came outside to the breezeway. Interview revealed, "(HCT #1) said something like 'Say something now.' (HCT #4) grabbed him (the patient) from behind and HCT #1 started hitting him." Interview revealed HCT #3 was standing behind HCT #4 and couldn't see the placement of his hands or the the location of the blows that HCT #1 delivered to the patient. Interview revealed the patient started to fight back and was moving his feet trying to get out of the hold. Interview revealed the patient knocked HCT #4's glasses off and HCT #4 let go, picked up his glasses and put them on the window sill. Interview revealed, "When I looked back at the patient, he and (HCT #1) were against the wall. He (the patient) was on the ground in a partial fetal position, with his knees bent and his hands around his face area. (HCT #1) was straddling him and punching him in the side and head and all over." Interview revealed HCT #1 stood up and kicked the patient	A 145		

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A 145	Continued From page 77 and the HCT #4 went over and hit the patient again. Interview revealed, "They were hitting him at the same time. (HCT #4) stopped and told (HCT #2) and me to go inside. We went inside." Interview revealed the patient went back inside about 4-5 minutes later and went and talked to a white male nurse. Interview revealed the HCT heard the patient tell the male nurse that he had just gotten attacked outside and he took his shirt off. Interview revealed HCT #1 and HCT #4 came back in. Interview revealed the patient went back to his ward about 10 minutes after he came in from the breezeway. Interview revealed the HCT did not see Patient #1 fight with any other patients in the treatment mall on 08/18/2008. Interview revealed HCT #3 did not immediately report the abuse of Patient #1 by the two staff members that she witnessed to anyone at the hospital because she was afraid. Interview revealed the HCT denied that she had witnessed the abuse during an interview with the nurse manager and patient advocate on Tuesday. Interview revealed, "I didn't tell them then because I was told not to tell by (HCT #1) and HCT #4). They told me that on Monday, Tuesday and Wednesday....I didn't report it because I was told to keep my mouth shut....They (HCT #1 and HCT #4) told me right after it happened if I told it I'd get my (explicative) beaten. They both called me (on my cellphone) on Tuesday and Wednesday to tell me not to tell it. I got my number changed." Interview revealed the HCT's agency told her on Wednesday not to go back to work at the hospital. Interview revealed the nurse manager told her on Thursday that she could continue to work at the hospital if she told them what she had seen. Interview revealed the HCT reported the abuse of Patient #1 that she had witnessed on 08/22/2008 during a second	A 145		

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interview with the nurse manager and patient advocate (4 days later). Interview revealed, "They asked me if I would come back to work there if I could. I told them no."

Interview on 08/27/2008 at 1045 with RN #2 revealed the white male nurse was assigned the U2 unit on 08/18/2008 and went with the patients to the U3 treatment mall at 1300. Interview revealed the nurse was standing in the hallway near the group room (dayroom) door when Patient #1 walked up to him. Interview revealed, "He (Patient #1) appeared to be upset. He took his shirt off. I redirected him to put his shirt back on and go into the classroom." Interview revealed the patient went into the dayroom at that time. Interview revealed, "We were at the nurses' station and (Patient #1) came up and said he had gotten into an argument with (a male patient) and earlier with a female patient in a pink shirt. Another RN was on the unit at the time. I think her husband worked there. She asked another staff member to take Patient #1 back to U2." Interview revealed the patient was then escorted back to U2 by HCT #9. Interview revealed the RN didn't hear Patient #1 argue with another patient. Interview revealed the RN remembered seeing HCT #4 eating at the nurses station at about the same time that Patient #1 was sent back to U2. Interview revealed the nurse denied the patient reported being hit by staff members to him, and therefore did not report abuse.

Interview on 08/27/2008 at 1200 with RN #3 revealed the nurse was assigned to the U2 3W ward on 08/18/2008. Interview revealed the nurse went to the U3 treatment mall at about 1330 to give her husband (who was working in the treatment mall - HCT #6) his lunch. Interview

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A 145	Continued From page 79 revealed a hospital police officer arrived at the treatment mall shortly after she did and asked to interview her husband. Interview revealed the nurse decided to wait until the police officer finished talking to her husband before returning to her ward because she was concerned for her husband. Interview revealed HCT #7, HCT #4 (who was eating), HCT #1 and another female staff member (unsure of name) were at the nurses' station. Interview revealed, "(HCT #7) told me that (Patient #1) was upset and needed to go to 3E (his ward). I talked to him (the patient) briefly before I sent him back. He told me he had been beaten up by staff. He had water in his eyes, like he was going to cry because he was so upset. I called his nurse (on U2 3E - RN #1) and told her he had an altercation with another patient and was accusing staff of beating him up and he was very upset." Interview revealed HCT #9 then escorted the patient back to the 3E ward. Interview revealed, "I didn't see an altercation between Patient #1 and another patient. I heard him (Patient #1) and (HCT #4) talk about an incident with a female patient earlier. (HCT #4) told (Patient #1) he shouldn't talk to females like that." Interview revealed the nurse stayed in the U3 treatment mall for about 20 minutes before she returned to her assigned ward. Interview revealed reports of staff to patient abuse should be immediately reported to the nurse supervisor and the advocacy department. Interview revealed, "I'm really not sure who else (allegations of abuse should be reported to). You probably have to do an incident report....I reported it to the ward nurse on 3E (RN #1) and I think I reported it to (RN#2) on my way out." Further interview revealed the nurse did not report Patient #1's allegation of abuse to the nurse supervisor or advocacy department because she "got side	A 145		

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A 145	Continued From page 80 tracked". Interview on 08/27/2008 at 1500 with RN #1 revealed the nurse was the charge nurse on the U2 3E ward on 08/18/2008 during the day shift. Interview revealed the nurse received a phone call from RN #3 at approximately 1330. Interview revealed RN #3 told her that Patient #1 had threatened a female patient and had gotten into an argument with a male patient at the treatment mall. Interview revealed RN #1 told RN #3 to send the patient back to the 3E ward. Interview revealed, "I had a treatment team meeting at 1:30 (PM). When he (Patient #1) came back I said, 'Hey, what's going on?' He came in and sat down at the nurses station and said he was alright. He said, 'Two staff assaulted me. It was about cigarettes.' He got up and walked out and said he didn't want to talk about it anymore....I called the treatment mall and (HCT #6) answered the phone. He said, 'We sent him back because he accused 2 staff members of assaulting him and he threatened a female and got into a verbal confrontation with (a male patient).' He said he didn't witness any of it. I told him to put someone on the phone who did. I don't know who it was on the phone then, it was a male. He said, 'No, I ain't seen anything.' Again I said put someone on the phone who did. (HCT #1) got on the phone and said the patient had accused 2 staff of assaulting him, threatened a female and argued with (a male patient). He said he didn't see anything. They then called me to treatment team . I charted all of this while I was on the phone with them." Interview revealed, "I thought the staff on the treatment mall would have reported it (the alleged abuse), so I didn't (report the alleged abuse)." Interview revealed the patient did not show any "obvious signs" of injury, like "bleeding,	A 145		

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crying or swelling". Interview revealed, "I did not do a head to toe assessment of him (Patient #1)."

Interview on 08/27/2008 at 1615 with a Therapeutic Recreation Specialist (TRS #1) revealed the staff member was in the U3 treatment mall on 08/18/2008. Interview revealed some patients were outside for a smoke break when she arrived. Interview revealed a female patient in the hall said that Patient #1 was threatening her and wanted to fight her. Interview revealed, "I heard a couple of bangs against the door from the outside. I heard (Patient #1) yelling outside before the bangs. The door opened and (Patient #1) came in. He was breathing heavily and looked upset. He went to the outside of the group room door and he took his shirt off." Interview revealed the patient either said staff beat him or staff jumped him and he wanted to fight staff. Interview revealed the TRS and a "white male" staff member tried to get the patient to calm down. Interview revealed the patient then put his shirt on and went into the dayroom. Interview revealed a hospital police officer came up on the elevator and Patient #1 went up to him and said, "I want to talk to you. They (beat or jumped) me". Interview revealed the police officer told the patient that he had to do something else first and then he would talk to him. Interview revealed the TRS then went into the group room and didn't see anything else. Interview revealed, "I did not report the (alleged) abuse (to anyone at the hospital)."

Interview on 08/27/2008 at 1445 with Police Officer #1 revealed the officer went to the U3 treatment mall on 08/18/2008 at "shortly after" 1300 to talk with HCT #6 regarding a patient complaint. Interview revealed, "(Patient #1), but I

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didn't know his name at the time, came up to me and said, 'I need to talk to you.' He said he was assaulted by 2 guys. I told him I had to interview someone, but to stay here and I'd talk to him when I was done. After the interview, I walked out and as I walked past the nurses station I didn't see the patient. I looked in the dayroom. I asked (HCT #1) where the patient was that wanted to talk to me. He said, 'I don't know what you're talking about. I didn't see a patient.' I did not find the patient." Interview revealed the officer identified the patient on 08/19/2008 when he reviewed video surveillance tapes during the investigation of the alleged abuse that occurred on 08/18/2008.

Interview on 08/27/2008 at 1645 with HCT #5 revealed the HCT was was in the U3 treatment mall on 08/18/2008. Interview revealed the HCT arrived at the treatment mall "sometime after lunch" and "when I got off the elevator I saw a male patient (later identified as Patient #1) standing outside of the nurses station. He was yelling at (HCT #4), who was inside the nurses station. He said, 'If you want to beat my (explicative) come beat it now in front of the cameras.'" Interview revealed HCT #5 did not hear the patient say anyone had hit him. Interview revealed the HCT had not reviewed the abuse policy since 08/18/2008, when Patient #1 alleged being abused by staff.

Interview on 08/27/2008 at 0930 with the U2 Unit Nurse Manager revealed the manager received a phone call on 08/19/2008 at 0725 from the night nurse supervisor, who said she needed to talk with the manager. Interview revealed the manager told her she was on the way to work and would be there in ten minutes. Interview revealed

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A 145	Continued From page 83 when the manager got to work she went to the nursing office, where the nurse supervisor and chief patient advocate told her there had been a call made by HCT #2 to her agency on the previous night during which she reported an incident where she witnessed staff attacking a patient on 08/18/2008. Interview revealed HCT #2 had given a time span of the incident and the nurse supervisor and chief patient advocate had been reviewing video surveillance tapes to try to identify the patient as he came in the door from the breezeway into the unit. Interview revealed the video surveillance area did not include the breezeway, but it did include the U3 treatment mall and showed staff and patients that were present. Interview revealed the manager took a picture of the patient to the nursing unit where an HCT identified him as Patient #1. Interview revealed the manager and Patient Advocate #1 began an investigation, which included interviewing the patient and all staff members that had been present in the U3 treatment mall on 08/18/2008. Interview revealed the patient told the manager he and a female patient had argued and HCT #1 told him that he didn't need to talk to females that way. Interview revealed the patient told the manager HCT #1 told him that he could not go inside after he finished his cigarette. Interview revealed the patient told the manager that HCT #4 then came out to the breezeway and hit him in the back. Interview revealed the patient told the manager "they beat me down". Interview revealed the patient told the manager that he reported being hit by HCT #1 and HCT #4 to RN #2, RN #3 and Police Officer #1. Interview revealed as soon as the manager and advocate identified HCT #1 and HCT #4 as being the HCTs that the patient accused of abusing him, they were both called to the nursing office and then	A 145		

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A 145	Continued From page 84 were placed on investigatory leave. Interview revealed, "Based on what we've seen during the investigation did, we have substantiated abuse." Interview revealed HCT #1 and HCT #4 were terminated from employment on 08/26/2008. Interview revealed HCT #1 had been employed at the hospital for approximately 5 years, during which time he "had been involved in a few situations where there had been a couple of substantiations of verbal abuse. He received disciplinary action in 2007, when he was moved from the adolescent unit to adult admissions and he received a written warning. I think he got another one (disciplinary action) on U2 in 2007 and got another written warning." Interview revealed HCT #4's "name has come up with allegations, but never anything that was substantiated. He has not had any disciplinary actions." Interview revealed reports of abuse should be immediately reported to the nursing supervisor, advocacy department, and nursing office. Interview confirmed RN #1, RN #2, RN # 3, HCT # 2, HCT #3 and TRS #1 all were aware of the alleged staff to patient abuse of Patient #1 and none of them immediately reported it to the nursing supervisor, the advocacy department, or the nursing office. Interview revealed RN #2 and RN #3 were terminated from employment and HCT #3 (an agency HCT) would not be employed at the hospital anymore. Interview revealed RN #1 and TRS #1 had received written warnings as disciplinary action. Interview revealed HCT #2 had received no disciplinary action and was currently staffing at the hospital. Interview revealed hospital staff had not been reeducated to the abuse policy following the abuse of Patient #1 that was not immediately report by staff. Interview revealed there had been no change in hospital policies or procedures since the staff to	A 145		

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A 145	Continued From page 85 patient abuse of Patient #1 occurred and was not immediately reported by staff members on 08/18/2008. B) Facility staff failed to ensure adequate monitoring and supervision of patients to prevent patient neglect. Patient #35, a House Bill 95 ("no outside passes") patient with a diagnosis of mild mental retardation and undifferentiated type schizophrenia was observed August 28, 2008 at 9:20AM in the locked stairwell of Building U3 without staff in attendance. Patient #35 was observed at the top of 2 West stairwell attempting to enter a locked door. Interview with Treatment Mall Staff (TMS) #1 revealed the staff member was unable to identify Patient #35. TMS #1 stated Patient # 35 was on his way to a group session in the Treatment Mall. Patient #35 indicated the patient had knocked on the locked door and received no response. Walkthrough observations of the unit revealed the stairwell led down to 1East which egresses to a breezeway directly into the open door of 1West. Further observations revealed facility staff failed to have a system in place to ensure the accountability of patients while transitioning from assigned wards to other facility locations. Observations revealed staff posted at the front of the patient line, directing patients. Staff members were not posted at the rear of patient lines to ensure accountability of patients during movement. Interview with U1 nurse manger and Treatment Mall staff revealed staff had "never been told they needed 1:1 to get patients upstairs".	A 145		
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 171		

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Unless superseded by State law that is more restrictive--
(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:
(A) 4 hours for adults 18 years of age or older;
(B) 2 hours for children and adolescents 9 to 17 years of age; or
(C) 1-hour for children under 9 years of age;

This STANDARD is not met as evidenced by:
Based on review of policy and procedure, medical record and staff interview the physician failed to write behavioral restraint orders per hospital policy for 1 of 9 medical records reviewed (#18).

The findings include:

Review on 08/29/2008 of the hospital policy "Restrictive Interventions" effective 09/10/2007 revealed "3. a. A psychiatrist shall give a verbal, telephone or written order for the use of therapeutic hold, seclusion, or restraint....The order shall be written on the Restrictive Interventions Order Form, ...and shall specify the following:..Time Limit for the seclusion or restraint...Criteria for release..."

Open medical record review revealed patient #18 admitted on 02/21/2008 with mental retardation and schizoaffective disorder. Review of the Restrictive Interventions Order form dated 08/14/2008 at 0728 revealed a physician order for "restraints." Review failed to reveal documented evidence the order had a time limitation and a criteria for release. Review of the Restrictive

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A 171	Continued From page 87 Interventions Order form dated 08/14/2008 at 0832 revealed a physician order for "restraints." Review failed to reveal documented evidence the order had a time limitation and a criteria for release. Interview on 08/28/2008 at 1400 with administrative staff revealed behavioral restraint orders must include documented evidence of a time limitation and a criteria for release in the order. Interview confirmed the physician had failed to write a behavioral restraint order that included a time limitation and criteria for release.	A 171		
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based on review of policy and procedure, medical record and staff interview nursing staff failed to monitor a patient after release from a behavioral restraint per hospital policy for 1 of 9 medical records reviewed (#18). The findings include: Review on 08/29/2008 of the hospital policy "Restrictive Interventions" effective 09/10/2007 revealed "...Releasing the Patient from the Restrictive Intervention: The patient's vital signs (blood pressure, respiration rate, and pulse) shall be obtained 30 minutes following release from restrictive intervention..."	A 175		

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A 175	Continued From page 88 Open medical record review revealed patient #18 admitted on 02/21/2008 with mental retardation and schizoaffective disorder. Review of the Restrictive Interventions Order form dated 08/14/2008 at 0832 revealed a physician order for "restraints." Review revealed patient #18 was released from the restraints at 0945. Review failed to reveal documented evidence nursing staff obtained vital signs 30 minutes after patient #18 was released from restraints. Interview on 08/28/2008 at 1400 with administrative staff revealed nursing staff are to obtain patient's vital signs 30 minutes after release from a restraint. Interview confirmed the medical record failed to reveal documented evidence nursing staff had obtained vital signs after patient #18 was released from restraints.	A 175		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by:	A 263		

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A 263	Continued From page 89 Based on review of facility meeting minutes, quality assessment and performance improvement data, policies and procedures, medical records, investigative reports, and staff interviews, the facility's leadership staff failed to: develop, implement, and maintain a system to aggregate and analyze patient incident data in order to prioritize organization-wide performance improvement activities related to patients' rights and safety and ensure systems were in place to assure completion of incident reports according to policy and procedure for 2 of 12 reportable incidents reviewed for a patient with a pattern of aggression and violent tendencies (#20). Findings include: A. The facility's leadership staff failed to: A. develop a system to aggregate and analyze patient abuse, neglect and exploitation of patients and B. develop a system to aggregate and analyze incidents of patient aggression and violence. ~cross refer to 482.21(e)(2) Executive Responsibilities - Tag A0313 B. The facility's leadership staff failed to ensure systems were in place to assure completion of incident reports according to policy and procedure for 2 of 12 reportable incidents reviewed for a patient with a pattern of aggression and violent tendencies (#20). ~cross refer to 482.21(a)(2) QAPI Quality Indicators - Tag A0267	A 263		
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track	A 267		

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quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations.

This STANDARD is not met as evidenced by:
Based on review of facility policies and procedures, medical records, investigative reports and staff interviews staff failed to complete an incident report according to policy and procedure for 2 of 12 reportable incidents reviewed for a patient with a pattern of aggression and violent tendencies (#20).

Findings include:

Review of the hospital's "Incident/Accident Reports" policy dated 11/01/2003 revealed, "PURPOSE: To establish guidelines for systematic reporting of all incidents/accidents which may result in actual or potential injury to patients; to establish a mechanism to review circumstances surrounding the incident/accident and make determination for appropriate course of action and follow-up; and to establish a data driven risk assessment system to enable quality of health care, safety management improvement through routine assessment and evaluation. All incidents/accidents resulting in serious or potentially serious injury shall be investigated by the nurse manager/designee. Investigation of major/serious injuries shall be completed within 72 hours of the occurrence with reported findings distributed to the Director of Nursing Services (DON), Clinical Director, and the Performance Improvement Department. Suspected Abuse/Neglect - In cases where abuse, neglect, or exploitation of patients is suspected follow policy on Abuse, Neglect, and Exploitation."

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A 267	Continued From page 91 Closed record review on 08/26/2008 revealed patient #20 admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several elderly residents and threatened to kill staff working in his previous residential facility. Review of the physician's evaluation for admission dated 06/21/2008 revealed, the patients history of multiple prior admissions for paranoid schizophrenia, and recommendations that the patient is mentally ill, and is dangerous to others. Review of progress notes revealed 8 patient to patient violent/assaultive behaviors and 4 patient to staff violent/assaultive behaviors involving patient #20 during the hospitalization. Review of hospital incident reports revealed reports for 10 of 12 violent/assaultive behavior incidents for Patient #20. Review failed to reveal incident reports for a staff assaulted on 08/08/2008, and aggression by patient #20 on 07/29/2008.	A 267		
A 313	482.21(e)(2) EXECUTIVE RESPONSIBILITIES [That the hospital-wide quality assessment and performance improvement efforts address priorities for improved] and patient safety [and that all improvement actions are evaluated.] This STANDARD is not met as evidenced by: Based on review of facility meeting minutes, quality assessment and performance improvement data, and staff interviews, the facility's leadership staff failed to: A. develop a system to aggregate and analyze patient abuse, neglect and exploitation of patients and B. develop a system to aggregate and analyze	A 313		

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A 313	Continued From page 92 incidents of patient aggression and violence. Findings include: Review of facility policy "Continuous Quality Improvement (CQI) Plan" dated 04/29/2008 revealed "Definition of CQI- Continuous Quality Improvement (CQI) is an organizational wide approach which actively involves all employees in a central focus to improve processes within the hospital ....Scope of the CQI Plan...The hospital leaders (Executive Committee) have the ultimate responsibility for strategic planning and determining the quality improvement priorities for the organization. ...All areas, departments, programs, and committees participate in the CQI Process. ...Establishing CQI Priorities - CQI Priorities are based upon: ...Comparative Data, ...Regulatory Requirements ...CQI Plan: Roles and Responsibilities - Executive Committee ensures that the CQI program is defined, implemented and maintained. ...Department Managers will select and monitor two service indicators for their area...". Review of the facility policy CCP Number-VI-A-1, "Abuse/Neglect/Exploitation of Patients, Prohibited", revised 07/21/2008 and 08/20/2008 revealed no process for analyzing, aggregating and reporting the incidents of patient abuse, neglect and exploitation to the performance improvement department. Review of the facility policy CCP Number VI-I-1, "Incident/Accident Reports", effective 11/01/2003, revealed "...VII. ...Monitoring: A statistical database will be maintained on all reported cases of patient incidents/accidents by the Performance Improvement Department ...".	A 313		

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A. The facility's leadership staff failed to develop a system to analyze and track patient abuse, neglect and exploitation of patients.

Interview with the facility's compliance officer on 08/28/2008 at 1610 revealed "PI (Performance Improvement) does not track abuse, neglect and exploitation of patients. That is done by advocacy. We only get the cases where incident reports are completed. The process needs to be better defined". The interview further revealed "there are no checks and balances in our system. There is no advocacy data (abuse/neglect/exploitation of patients) in our PI data. We are not tracking or analyzing allegations of abuse/assault unless we get an incident report". Interview further revealed "the PI indicators are not unit specific. We've told our departments they must choose 2 indicators to track".

Interview with the Nurse Manager of U2-2West, an acute psychiatric 22 bed unit, on 08/26/2008 at 1100 revealed the unit had not conducted any unit specific quality improvement activity.

Interview with the Charge Nurse of Woodard 1East, a 24 bed chronic psychiatric rehabilitation unit, on 08/28/2008 at 1440 revealed the unit had not conducted any unit specific quality improvement activity.
B. The facility's leadership staff failed to develop a system to aggregate and analyze incidents of patient aggression and violence.

Interview with the facility's compliance officer on 8/29/2008 at 1015 revealed the Risk Management department receives the incident reports regarding any episode of patient

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A 313	Continued From page 94 aggression or violence. Interview revealed the Risk Management Department will notify the Unit Nurse Manager for any 3 episodes of aggression or violence reported on the incident reports for follow-up at the treatment team meetings. Interview failed to reveal the episodes of aggression and violence collected through incident reports by the Risk Management Department were aggregated and analyzed through the Quality Improvement process of the hospital. Interview with the facility's compliance officer on 8/31/2008 at 1945 revealed the facility had aggregated and analyzed data back to the year 2006 on 8/30/2008 (the day prior). Further interview revealed the findings indicated a Performance Improvement team would be formed to further study the increase in violent and aggressive incidents of the patient population. Interview confirmed the facility's Quality Improvement Department had failed to aggregate and analyze incidents of patient aggression and violence in order to set priorities for patient safety in the organization.	A 313		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on review of policy and procedures, medical records, digital videos, incident reports, observations during tour, and staff interviews, the hospital's failed to provide an organized nursing service by failing to: A. Facility staff failed to ensure adequate monitoring and supervision of	A 385		

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patients to prevent patient neglect (#35). The facility failed to have a system in place to promote patient and staff safety while patients transitioned from assigned wards to other facility locations. B. prevent and report staff to patient abuse and assess a patient following an alleged incident of abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1), C. monitor a patient with repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (pt#20), D. implement progressive interventions for repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (pt#20), E. provide safe and effective administration of medication for 7 of 8 medication passes observed (#42, #52, #53, #54, #55, #56, #57); and, F. supervise, and monitor the delivery of care to ensure basic needs (nutrition and hydration) were provided for 1 of 19 inpatient open records reviewed (#21).

Findings include:

A. Facility staff failed to ensure adequate monitoring and supervision of patients to prevent patient neglect. The facility failed to have a system in place to promote patient and staff safety while patients transitioned from assigned wards to other facility locations.

Patient #35, a House Bill 95 ("no outside passes") patient with a diagnosis of mild mental retardation and undifferentiated type schizophrenia was observed August 28, 2008 at 9:20AM in the locked stairwell of Building U3 without staff in attendance. Patient #35 was observed at the top of 2 West stairwell attempting to enter a locked door. Interview with Treatment

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A 385	Continued From page 96 Mall Staff (TMS) #1 revealed the staff member was unable to identify Patient #35. TMS #1 stated Patient #35 was on his way to a group session in the Treatment Mall. Patient #35 indicated the patient had knocked on the locked door and received no response. Walkthrough observations of the unit revealed the stairwell led down to 1East which egresses to a breezeway directly into the open door of 1West. Further observations revealed facility staff failed to have a system in place to ensure the accountability of patients while transitioning from assigned wards to other facility locations. Observations revealed staff posted at the front of the patient line, directing patients. Staff members were not posted at the rear of patient lines to ensure accountability of patients while patients transitioned from assigned wards to other facility locations. Interview with U1 nurse manger and Treatment Mall staff revealed staff had "never been told they needed 1:1 to get patients upstairs". ~cross refer to 482.23(b) RN Staffing and Delivery of Care Tag A0392 B. The hospital failed to provide nursing supervision of patients by failing to prevent and report staff to patient abuse and assess a patient following an alleged incident of abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1). ~cross refer to 482.23(b)(3) RN Supervision of Nursing Care Tag A0395 C. The hospital failed to provide nursing supervision of patients by failing to monitor a patient with repeated assaultive behaviors for 1 of	A 385		

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A 385	Continued From page 97 1 patients reviewed with known repeated assaultive behaviors (pt#20). ~cross refer to 482.23(b)(3) RN Supervision of Nursing Care Tag A0395 D. The hospital failed to provide nursing supervision of patients by failing to implement progressive interventions for repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (pt#20). ~cross refer to 482.23(b)(3) RN Supervision of Nursing Care Tag A0395 E. The hospital failed to provide nursing supervision of patients by failing to provide safe and effective administration of medication for 7 of 8 medication passes observed (#42, #52, #53, #54, #55, #56, #57). ~cross refer to 482.23(c) Administration of Durgs Tag A0404 F. The hospital failed to provide nursing supervision of patients by failing to supervise, and monitor the delivery of care to ensure basic needs (nutrition and hydration) were provided for 1 of 19 inpatient open records reviewed (#21). ~cross refer to 482.23(b)(3) Supervision of Nursing Care Tag A0395	A 385		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed.	A 392		

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There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:
Based on review of policies and procedures, medical records and investigative reports, staff interviews, review of personnel files, digital videos, meeting minutes, incident reports, observation and police reports, the hospital's nursing staff failed to provide care in such as way as to ensure that patient needs were met by failing to: A. ensure adequate monitoring and supervision of patients to prevent patient neglect. The facility failed to have a system in place to promote patient and staff safety while patients transitioned from assigned wards to other facility locations. (#35) B. prevent and report staff to patient abuse and assess a patient following an alleged incident of abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1) and C. monitor a patient with repeated assaultive behaviors for 1 of 1 patients reverie with known repeated assaultive behaviors (#20).

The findings include:

A. Facility staff failed to ensure adequate monitoring and supervision of patients to prevent patient neglect. The facility failed to have a system in place to promote patient and staff safety while patients transitioned from assigned wards to other facility locations.

Patient #35, a House Bill 95 ("no outside passes") patient with a diagnosis of mild mental retardation and undifferentiated type

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A 392	Continued From page 99 schizophrenia was observed August 28, 2008 at 9:20AM in the locked stairwell of Building U3 without staff in attendance. Patient #35 was observed at the top of 2 West stairwell attempting to enter a locked door. Interview with Treatment Mall Staff (TMS) #1 revealed the staff member was unable to identify Patient #35. TMS #1 stated Patient # 35 was on his way to a group session in the Treatment Mall. Patient #35 indicated the patient had knocked on the locked door and received no response. Walkthrough observations of the unit revealed the stairwell led down to 1East which egresses to a breezeway directly into the open door of 1West. Further observations revealed facility staff failed to have a system in place to ensure the accountability of patients patients while transitioning from assigned wards to other facility locations. Observations revealed staff posted at the front of the patient line, directing patients. Staff members were not posted at the rear of patient lines to ensure accountability of patients during movement. Interview with U1 nurse manger and Treatment Mall staff revealed staff had "never been told they needed 1:1 to get patients upstairs". B. The hospital's nursing staff failed to provide care in such as way as to ensure that patient needs were met by failing to prevent and report staff to patient abuse and assess a patient following an alleged incident of abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1). Review of hospital policy number VI-A-1 entitled "Abuse/Neglect/Exploitation of Patients, Prohibited" dated 07/21/2008 revealed, "DEFINITIONS:...Abuse: the infliction of physical or mental pain or injury by other than accidental	A 392		

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A 392	Continued From page 100 means....PROCEDURES: I. IMMEDIATE INTERVENTION AND REPORTING REQUIREMENTS A. Adults and Juveniles: Any staff member, student or volunteer who observes, suspects, or receives an allegation of abuse, neglect and/or exploitation of a patient must: 1. Intervene immediately to ensure the safety and well being of the patient. 2. Notify the ward RN (Registered Nurse) of the patient's home ward. 3. Notify their immediate supervisor/designee, RNO, or the (Name of Hospital) Advocacy Department....D. Assessment and Treatment: 1. Upon notification of possible abuse, neglect and/or exploitation of a patient, the ward RN shall assess the patient immediately for any medical needs or injuries. 2. If medical needs or injuries are noted and assessment by the Medical Physician is deemed immediately necessary, the ward RN shall contact the assigned Medical Physician/designee. If medical needs or injuries are not noted or immediate medical assessment is not deemed necessary, the ward RN shall place the patient's name in the sick call book for assessment by the assigned Medical Physician/designee within 24 hours....4. The ward RN shall notify the Nurse Supervisor/designee of all allegations of abuse, neglect, and/or exploitation....E. Documentation in the Medical Record: 1. The ward RN shall document the abuse, neglect, and/or exploitation allegation in a progress note in the patient's medical record prior to the end of the shift in which the report is received. Documentation should include: a. a brief statement regarding the allegation; b. the date, time and place of the alleged abuse, neglect, and/or exploitation; c. the condition of the patient's mental and physical status; and d. the treatment and/or intervention provided...."	A 392		

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A 392	Continued From page 101 Closed record review of Patient #1 revealed a 30 year-old male that was admitted on 07/19/2008 for schizoaffective disorder, bipolar type and borderline intellectual functioning. Review of the Physical Assessment completed upon admission on 07/19/2008 by a Physician Assistant (PA) revealed, "Physical Diagnosis: 1. Mild MR (mental retardation. 2. NAD (no acute distress)." Review of RN #1's progress note documented on 08/18/2008 at 1330 revealed, "Rec'd (Received) call from U3 groups that (Patient #1) was in an altercation c (with) a peer. Staff intervened et (Patient #1) will be brought back to U2 3E." Review of RN #1's progress note documented at 1340 revealed, "(Patient #1) is back on the ward. When questioned regarding return stated 'Two staff jumped on me' Per staff (Patient #)1 threatened a female patient et then a male patient. Staff reports that staff intervened et escorted (Patient #1) back to this ward. Staff will monitor behaviors." Record review revealed no documentation that the nurse assessed the patient for medical needs or injuries. Further review revealed no documentation that the nurse notified the physician, nurse supervisor, nursing office (RNO) or Advocacy Department of the patient's allegation that he was abused by two staff members. Review of Health Care Technician (HCT) #1's progress note documented on 08/18/2008 at 1345 revealed, "I didn't see what happen between him and (the other patient). When I came from out back (the other patient) told me that he was going to give (Patient #1) what he wanted. And then they send him back to his ward. Before (the other patient) hit (Patient #1)." Record review revealed the first documentation of a medical examination (after the patient alleged the staff abused him on	A 392		

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A 392	Continued From page 102 08/18/2008) on 08/19/2008 at 1140 (22 hours later). Review of the Physician Assistant's (PA) progress noted dated 08/19/2008 at 1140 revealed, "Pt (Patient) c/o (complains of) pain in 'L (left) side + back of neck' after altercation 1 day ago....Mild ecchymosis or edema (bruising or swelling) on L side of neck....Mild tender on palpation over L lower Ribs...." Record review revealed on 08/19/2008 the patient underwent x-rays of his left rib cage and cervical spine (vertebrae in neck). Record review revealed the results of the x-rays were negative (no fractures). Review of HCT progress notes documented on 08/19/2008 at 2045 revealed, "...complained of side hurting. Staff reported incident to nurse...." Record review revealed the first documentation that a nurse assessed the patient's pain was on 08/20/2008 at 1548 (19 hours later). Record review revealed the next available documentation of a pain assessment by nursing staff was on 08/21/2008 at 1237, at which time the patient complained of left rib pain. Record review revealed documentation on 08/22/2008 at 1000 that the patient was discharged to a group home. Interview on 08/27/2008 at 1350 with HCT #2 (an agency HCT) revealed the HCT was assigned to monitor female patients from the U2 2W ward when they went to the U3 treatment mall on 08/18/2008 at 1300. Interview revealed the HCT was in the breezeway smoking with 3-5 female patients at approximately 1320. Interview revealed there was also another female HCT present (HCT #3), as well as a male HCT (HCT #1) with several male patients who were also smoking. Further interview revealed one by one the patients finished their cigarettes and went inside. Interview revealed when the second to last patient went inside (leaving only Patient #1 in	A 392		

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A 392	Continued From page 103 the breezeway with staff members) HCT #4 came out to the breezeway. Interview revealed at that time the only people on the breezeway were HCT #3, HCT #1, HCT #4, Patient #1 and herself. Interview revealed, "I turned to dump ashes and when I turned back I saw (HCT #1) hit (Patient #1) in the stomach. I can't remember if he hit him again before the patient fell, but the patient fell in a fetal position. (HCT #1) and (HCT #4) tag teamed the patient. They took turns hitting him. 2-3 strikes each, then they would change." Interview revealed the two HCTs hit and kicked the patient in the groin, face and legs. Interview revealed, "It looked like he got hit everywhere." Further interview revealed, "After I saw (HCT #4) hit him I went to the door to go inside. As I got to the door they called out 'Wait a minute'. It was like they stopped (hitting the patient) for me to go inside so no one would hear them. (HCT #3) came in right behind me." Interview revealed HCT #2 sat in a chair outside of the bathroom (her assigned post) when she went inside. Interview revealed when Patient #1 came inside (about 5-10 minutes later) he went to the entrance of the dayroom, pointed at the door that goes out to the breezeway and said "These 2 men just jumped me. They beat me". Interview revealed there were staff members present in the dayroom at that time, but the HCT wasn't sure exactly which ones because she was posted at the opposite end of the hall. Interview revealed the patient took off his jacket as he walked down the hall and then removed his shirt at the entrance to the dayroom "like he was going to fight them". Interview revealed HCT #1 and HCT #4 "nonchalantly" walked past the patient on the way to the nursing station. Interview revealed, "I didn't tell anybody at the hospital about it (the abuse of Patient #1 by the two staff members)....I	A 392		

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didn't tell anyone (immediately) because I was scared. The men were very scary. They said, 'If anyone asks you, you didn't see anything.'" Interview revealed the HCT felt afraid and intimidated by HCT #1 and HCT #4. Interview revealed, "They kept asking me what was wrong. I told them I had a migraine....They even called my cell phone....I had to change my number." Interview revealed when at home later that evening she decided to report the abuse. Interview revealed the HCT called her agency supervisor at approximately 2000 and reported the abuse (between 6 and 7 hours later). Interview revealed the agency supervisor then called the nursing supervisor at the hospital and reported the abuse. Interview revealed, "No one has reviewed the (abuse) policy with me since the incident (9 days before interview)".

Telephone interview on 08/27/2008 at 1545 with HCT #3 (an agency HCT) revealed the HCT was outside in the breezeway of the U3 treatment mall when she witnessed HCT #1 and HCT #4 physically abuse Patient #1. Interview revealed after the event of abuse the HCT saw the patient go back inside and talk to a white male nurse. Interview revealed the HCT heard the patient tell the male nurse that he had just gotten attacked outside and he took his shirt off.

Interview on 08/27/2008 at 1045 with RN #2 revealed the white male nurse was assigned the U2 unit on 08/18/2008 and went with the patients to the U3 treatment mall at 1300. Interview revealed the nurse was standing in the hallway near the group room (dayroom) door when Patient #1 walked up to him. Interview revealed, "He (Patient #1) appeared to be upset. He took his shirt off. I redirected him to put his shirt back

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on and go into the classroom." Interview revealed the patient went into the dayroom at that time. Interview revealed the nurse denied the patient reported being hit by staff members to him, and therefore did not report abuse or assess the patient.

Interview on 08/27/2008 at 1200 with RN #3 revealed the nurse was assigned to the U2 3W ward on 08/18/2008. Interview revealed the nurse went to the U3 treatment mall at about 1330 to give her husband (who was working in the treatment mall - HCT #6) his lunch. Interview revealed, "(HCT #7) told me that (Patient #1) was upset and needed to go to 3E (his ward). I talked to him (the patient) briefly before I sent him back. He told me he had been beaten up by staff. He had water in his eyes, like he was going to cry because he was so upset. I called his nurse (on U2 3E - RN #1) and told her he had an altercation with another patient and was accusing staff of beating him up and he was very upset." Interview revealed HCT #9 then escorted the patient back to the 3E ward. Interview revealed reports of staff to patient abuse should be immediately reported to the nurse supervisor and the advocacy department. Interview revealed, "I'm really not sure who else (allegations of abuse should be reported to). You probably have to do an incident report....I reported it to the ward nurse on 3E (RN #1) and I think I reported it to (RN#2) on my way out." Further interview revealed the nurse did not report Patient #1's allegation of abuse to the nurse supervisor or advocacy department because she "got side tracked". Further interview revealed the nurse did not assess the patient for signs of injury after the patient told her he had been beaten up by staff.

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A 392	Continued From page 106 Interview on 08/27/2008 at 1500 with RN #1 revealed the nurse was the charge nurse on the U2 3E ward on 08/18/2008 during the day shift. Interview revealed the nurse received a phone call from RN #3 at approximately 1330. Interview revealed RN #3 told her that Patient #1 had threatened a female patient and had gotten into an argument with a male patient at the treatment mall. Interview revealed RN #1 told RN #3 to send the patient back to the 3E ward. Interview revealed, "I had a treatment team meeting at 1:30 (PM). When he (Patient #1) came back I said, 'Hey, what's going on?' He came in and sat down at the nurses station and said he was all right. He said, 'Two staff assaulted me. It was about cigarettes.' He got up and walked out and said he didn't want to talk about it anymore....I called the treatment mall and (HCT #6) answered the phone. He said, 'We sent him back because he accused 2 staff members of assaulting him and he threatened a female and got into a verbal confrontation with (a male patient).' He said he didn't witness any of it....They then called me to treatment team . I charted all of this while I was on the phone with them." Interview revealed, "I thought the staff on the treatment mall would have reported it (the alleged abuse), so I didn't (report the alleged abuse)." Interview revealed the patient did not show any "obvious signs" of injury, like "bleeding, crying or swelling". Interview revealed, "I did not do a head to toe assessment of him (Patient #1)." Interview on 08/27/2008 at 0930 with the U2 Unit Nurse Manager revealed on the morning of 08/19/2008 the patient told the manager that he had reported being hit by HCT #1 and HCT #4 to RN #2 and RN #3. Interview confirmed HCT #2, HCT #3, RN #1, RN #2 and RN # 3 were aware of	A 392		

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A 392	Continued From page 107 the alleged staff to patient abuse of Patient #1 and none of them immediately reported it to the nursing supervisor, the advocacy department, or the nursing office. Further interview confirmed there was no documentation that any of the RNs assessed the patient for injuries following the allegation that 2 staff members had abused him. Interview revealed there had been no education or training provided to the hospital nursing staff regarding the hospital's abuse policy following the abuse of Patient #1 on 08/18/2008. C. The hospital's nursing staff failed to provide care in such as way as to ensure that patient needs were met by failing to monitor a patient with repeated assaultive behaviors for 1 of 1 patients reveiewed with known repeated assaultive behaviors (#20). Review of the hospital's "Precautions and Standard Accountability" policy dated 06/06/2008 revealed, "All patients are regularly monitored with regard to safety and location." Review of the hospitals "Restrictive Interventions" policy dated 09/10/2007 revealed, "Staff shall continuously survey the environment to identify patients displaying evidence of increasing agitation and potential for dangerous behaviors directed towards self or others and intervene with therapeutic communication and other de-escalation techniques as early as possible." Closed record review on 08/26/2008 revealed patient #20 admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several elderly residents and threatened to kill staff working in his previous residential facility. Review	A 392		

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of the physician's evaluation for admission dated 06/21/2008 revealed, the patients history of multiple prior admissions for paranoid schizophrenia, and recommendations that the patient is mentally ill, and is dangerous to others. Review of progress notes revealed the patient with 8 patient to patient violent/assaultive behaviors and 4 patient to staff violent/assaultive behaviors during the hospitalization.

Record review on 08/26/2008 revealed pt#14 admitted to the hospital on 08/08/2008 with paranoid schizophrenia, under involuntary commitment, and discharged on 08/27/2008. Review of nursing progress notes dated 08/10/2008 at 1815 revealed "Pt. (patient) involved in altercation in dining room ... (pt#20) struck (pt#14) to (right) side of head (with) closed fist. Ice pack applied to site. (physician assistant) advised. Bleeding controlled ..." Review of the record revealed x-ray and CT scans were obtained and revealed the patient sustained a "comminuted depressed fracture of the left zygomatic arch." Review revealed Maxillary facial surgery consult was obtained and surgical repair scheduled during the admission.

Review on 08/28/2008 at 1200 of hospital digital video record (U2 kitchen 1 & 2 cameras, and U2 1W Hall 3 camera) of the assault that occurred on 08/10/2008 at 1758 in the hallway/vending machine area outside of the dining room revealed, approximately 10-12 patients in/out of the hallway/dining room. Review revealed patients gathered in the hallway for 4.5 to 5 minutes. Review revealed during the 4.5 to 5 minutes no staff was present with the patients. Review revealed staff remained in the dining room. Review revealed pt#20 left the dining

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A 392	Continued From page 109 room, walked into the hallway and kicked the vending machine. Review revealed pt#20 and others then began to dance in the hallway/vending area. Review revealed staff remained in the dining room. Review revealed the patients standing and pacing in the hall/vending area. Review revealed a patient shaking the vending machine. Review revealed pt#20 pacing in the hall/vending area. Review revealed staff remained in the dining room. Review revealed pt#20 suddenly takes off his headset, quickly squats down hits fists/hands to ground, quickly gets up, and walks over to pt#14 and begins hitting pt#14, about 6 blows rapidly to face/head. Review revealed pt#14 was down on the floor. Review revealed 2 staff run from the dining room to the hall/vending area. Review revealed one staff separates the patients, putting pt#20 in a hold against the wall. Review revealed the other staff assisted pt#14 up and into the dining room. Interview on 08/28/2008 at 1955 with HCT (Health Care Technician) #10 revealed, pt#20 is a "very violent person, snaps very quickly, if he doesn't get things his way he has outbursts, throws things, yells, and punches people. He walks up to patients and punches them in the face with staff standing next to him." Interview revealed the staff member was in the cafeteria the night of 08/10/2008, when pt #20 assaulted pt #14. The interview revealed two HCT's were in the dining room with the patients, the patients finished eating and went out in the hall by the vending machines. The interview revealed the HCT's were in the Dining room, and could not see out into the hallway, where the vending machines and patients were.	A 392		

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A 392	Continued From page 110 Interview on 08/28/2008 at 1400 with the Unit 2 Nurse Manager revealed staff are supposed to keep patients in the dining room until they are ready to go up to the units. If a patient is in the hallway staff should be present in the hall with the patients. The interview revealed from review of the digital video recording, the manager could see the two staff were in the dining room conversing. The interview revealed the patients were in the hallway for 4.5 to 5 minutes, without staff present. The interview confirmed no staff observed the hallway area for the 5 minutes prior to the assault. The interview revealed if staff had been present in the hallway, they might have been able to prevent the assault. The interview revealed "(pt#20) could have handled CA (constant awareness precautions), I don't know why it wasn't used. If he had been on CA there could have been an intervention before, to prevent the injuries." The interview revealed precautions are not used often. When asked why, the interview revealed "coverage and staffing is a big issue on the campus, volatile behavior is something we see a lot here." Observation on 08/26/2008 at 1730 of the U2 dining room/hallway/vending area revealed patients in the hallway/vending area, out of sight of staff. Observation revealed no staff present, monitoring the patients for 3 to 5 minutes.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of policy and procedures, medical records, digital videos, incident reports,	A 395		

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A 395	Continued From page 111 observations during tour, and staff interviews, the hospital's nursing staff failed to provide supervision of patient care by failing to: A. prevent and report staff to patient abuse and assess a patient following an alleged incident of abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1), B. monitor a patient with repeated assaultive behaviors for 1 of 1 patients reveiewed with known repeated assaultive behaviors (#20), C. implement progressive interventions for repeated assaultive behaviors for 1 of 1 patients reveiewed with known repeated assaultive behaviors (#20), D. supervise, and monitor the delivery of care to ensure basic needs (nutrition and hydration) were provided for 1 of 19 inpatient open records reviewed (#21). The findings include: A. The hospital's nursing staff failed to provide supervision of patient care by failing to prevent and report staff to patient abuse and assess a patient following an alleged incident of abuse for 1 of 1 sampled patients with substantiated staff to patient abuse (#1). Review of hospital policy number VI-A-1 entitled "Abuse/Neglect/Exploitation of Patients, Prohibited" dated 07/21/2008 revealed, "POLICY:...All members of the hospital staff are required to intervene immediately if witnessing abuse, neglect, and/or exploitation of a patient. Where there is physical injury or sexual abuse, the patient is to be provided immediate medical evaluation. (Name of Hospital) further requires that when staff, students or volunteers observe, suspect, or have knowledge of abuse, neglect, and/or exploitation, they must report this information to their immediate	A 395		

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A 395	Continued From page 112 supervisor/designee, the Royster Nursing Office (RNO), or the (Name of Hospital) Advocacy Department immediately.... DEFINITIONS:... Abuse: the infliction of physical or mental pain or injury by other than accidental means.... PROCEDURES: I. IMMEDIATE INTERVENTION AND REPORTING REQUIREMENTS A. Adults and Juveniles: Any staff member, student or volunteer who observes, suspects, or receives an allegation of abuse, neglect and/or exploitation of a patient must: 1. Intervene immediately to ensure the safety and well being of the patient. 2. Notify the ward RN (Registered Nurse) of the patient's home ward. 3. Notify their immediate supervisor/designee, RNO, or the (Name of Hospital) Advocacy Department....D. Assessment and Treatment: 1. Upon notification of possible abuse, neglect and/or exploitation of a patient, the ward RN shall assess the patient immediately for any medical needs or injuries. 2. If medical needs or injuries are noted and assessment by the Medical Physician is deemed immediately necessary, the ward RN shall contact the assigned Medical Physician/designee. If medical needs or injuries are not noted or immediate medical assessment is not deemed necessary, the ward RN shall place the patient's name in the sick call book for assessment by the assigned Medical Physician/designee within 24 hours....4. The ward RN shall notify the Nurse Supervisor/designee of all allegations of abuse, neglect, and/or exploitation....E. Documentation in the Medical Record: 1. The ward RN shall document the abuse, neglect, and/or exploitation allegation in a progress note in the patient's medical record prior to the end of the shift in which the report is received. Documentation should include: a. a brief statement regarding the	A 395		

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allegation; b. the date, time and place of the alleged abuse, neglect, and/or exploitation; c. the condition of the patient's mental and physical status; and d. the treatment and/or intervention provided...."

Closed record review of Patient #1 revealed a 30 year-old male that was admitted on 07/19/2008 for schizoaffective disorder, bipolar type and borderline intellectual functioning. Review of the Physical Assessment completed upon admission on 07/19/2008 by a Physician Assistant (PA) revealed, "Physical Diagnosis: 1. Mild MR (mental retardation. 2. NAD (no acute distress)." Review of RN #1's progress note documented on 08/18/2008 at 1330 revealed, "Rec'd (Received) call from U3 groups that (Patient #1) was in an altercation c (with) a peer. Staff intervened et (Patient #1) will be brought back to U2 3E." Review of RN #1's progress note documented at 1340 revealed, "(Patient #1) is back on the ward. When questioned regarding return stated 'Two staff jumped on me' Per staff (Patient #)1 threatened a female patient et then a male patient. Staff reports that staff intervened et escorted (Patient #1) back to this ward. Staff will monitor behaviors." Record review revealed no documentation that the nurse assessed the patient for medical needs or injuries. Further review revealed no documentation that the nurse notified the physician, nurse supervisor, nursing office (RNO) or Advocacy Department of the patient's allegation that he was abused by two staff members. Review of Health Care Technician (HCT) #1's progress note documented on 08/18/2008 at 1345 revealed, "I didn't see what happen between him and (the other patient). When I came from out back (the other patient) told me that he was going to give

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A 395	Continued From page 114 (Patient #1) what he wanted. And then they send him back to his ward. Before (the other patient) hit (Patient #1)." Record review revealed the first documentation of a medical examination (after the patient alleged the staff abused him on 08/18/2008) on 08/19/2008 at 1140 (22 hours later). Review of the Physician Assistant's (PA) progress noted dated 08/19/2008 at 1140 revealed, "Pt (Patient) c/o (complains of) pain in 'L (left) side + back of neck' after altercation 1 day ago....Mild ecchymosis or edema (bruising or swelling) on L side of neck....Mild tender on palpation over L lower Ribs...." Record review revealed on 08/19/2008 the patient underwent x-rays of his left rib cage and cervical spine (vertebrae in neck). Record review revealed the results of the x-rays were negative (no fractures). " Review of HCT progress notes documented on 08/19/2008 at 2045 revealed, "...complained of side hurting. Staff reported incident to nurse...." Record review revealed the first documentation that a nurse assessed the patient's pain was on 08/20/2008 at 1548 (19 hours later). Record review revealed the next available documentation of a pain assessment by nursing staff was on 08/21/2008 at 1237, at which time the patient complained of left rib pain. Record review revealed documentation on 08/22/2008 at 1000 that the patient was discharged to a group home. Telephone interview on 08/27/2008 at 1545 with HCT #3 (an agency HCT) revealed the HCT was outside in the breezeway of the U3 treatment mall when she witnessed HCT #1 and HCT #4 physically abuse Patient #1. Interview revealed after the event of abuse the HCT saw the patient go back inside and talk to a white male nurse. Interview revealed the HCT heard the patient tell the male nurse that he had just gotten attacked	A 395		

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A 395	Continued From page 115 outside and he took his shirt off. Interview on 08/27/2008 at 1045 with RN #2 revealed the white male nurse was assigned the U2 unit on 08/18/2008 and went with the patients to the U3 treatment mall at 1300. Interview revealed the nurse was standing in the hallway near the group room (dayroom) door when Patient #1 walked up to him. Interview revealed, "He (Patient #1) appeared to be upset. He took his shirt off. I redirected him to put his shirt back on and go into the classroom." Interview revealed the patient went into the dayroom at that time. Interview revealed the nurse denied the patient reported being hit by staff members to him, and therefore did not report abuse or assess the patient. Interview on 08/27/2008 at 1200 with RN #3 revealed the nurse was assigned to the U2 3W ward on 08/18/2008. Interview revealed the nurse went to the U3 treatment mall at about 1330 to give her husband (who was working in the treatment mall - HCT #6) his lunch. Interview revealed, "(HCT #7) told me that (Patient #1) was upset and needed to go to 3E (his ward). I talked to him (the patient) briefly before I sent him back. He told me he had been beaten up by staff. He had water in his eyes, like he was going to cry because he was so upset. I called his nurse (on U2 3E - RN #1) and told her he had an altercation with another patient and was accusing staff of beating him up and he was very upset." Interview revealed HCT #9 then escorted the patient back to the 3E ward. Interview revealed reports of staff to patient abuse should be immediately reported to the nurse supervisor and the advocacy department. Interview revealed, "I'm really not sure who else (allegations of abuse should be	A 395		

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reported to). You probably have to do an incident report....I reported it to the ward nurse on 3E (RN #1) and I think I reported it to (RN#2) on my way out." Further interview revealed the nurse did not report Patient #1's allegation of abuse to the nurse supervisor or advocacy department because she "got side tracked". Further interview revealed the nurse did not assess the patient for signs of injury after the patient told her he had been beaten up by staff.

Interview on 08/27/2008 at 1500 with RN #1 revealed the nurse was the charge nurse on the U2 3E ward on 08/18/2008 during the day shift. Interview revealed the nurse received a phone call from RN #3 at approximately 1330. Interview revealed RN #3 told her that Patient #1 had threatened a female patient and had gotten into an argument with a male patient at the treatment mall. Interview revealed RN #1 told RN #3 to send the patient back to the 3E ward. Interview revealed, "I had a treatment team meeting at 1:30 (PM). When he (Patient #1) came back I said, 'Hey, what's going on?' He came in and sat down at the nurses station and said he was alright. He said, 'Two staff assaulted me. It was about cigarettes.' He got up and walked out and said he didn't want to talk about it anymore....I called the treatment mall and (HCT #6) answered the phone. He said, 'We sent him back because he accused 2 staff members of assaulting him and he threatened a female and got into a verbal confrontation with (a male patient).' He said he didn't witness any of it....They then called me to treatment team. I charted all of this while I was on the phone with them." Interview revealed, "I thought the staff on the treatment mall would have reported it (the alleged abuse), so I didn't (report the alleged abuse)." Interview revealed

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the patient did not show any "obvious signs" of injury, like "bleeding, crying or swelling". Interview revealed, "I did not do a head to toe assessment of him (Patient #1)."

Interview on 08/27/2008 at 0930 with the U2 Unit Nurse Manager revealed on the morning of 08/19/2008 the patient told the manager that he had reported being hit by HCT #1 and HCT #4 to RN #2 and RN #3. Interview confirmed RN #1, RN #2 and RN #3 were aware of the alleged staff to patient abuse of Patient #1 and none of them immediately reported it to the nursing supervisor, the advocacy department, or the nursing office. Further interview confirmed there was no documentation that any of the RNs assessed the patient for injuries following the allegation that 2 staff members had abused him. Interview revealed there had been no education or training provided to the hospital nursing staff regarding the hospital's abuse policy following the abuse of Patient #1 on 08/18/2008.
B. The hospital's nursing staff failed to provide supervision of patient care by failing to monitor a patient with repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (pt#20).

Review of the hospital's "Precautions and Standard Accountability" policy dated 06/06/2008 revealed, "All patients are regularly monitored with regard to safety and location. Those patients requiring additional safeguards to ensure safety are placed on precautions. Precautions are initiated by a responsible physician or a registered nurse (RN). Any staff member concerned about the safety of a patient is responsible for informing the RN of his/her concerns so that the patient can be assessed and appropriate precautions can be

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implemented. The RN then communicates with the responsible physician to obtain the order."

Review of the hospitals "Restrictive Interventions" policy dated 09/10/2007 revealed, "Staff shall continuously survey the environment to identify patients displaying evidence of increasing agitation and potential for dangerous behaviors directed towards self or others and intervene with therapeutic communication and other de-escalation techniques as early as possible."

Closed record review on 08/26/2008 revealed patient #20 admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several elderly residents and threatened to kill staff working in his previous residential facility. Review of the physician's evaluation for admission dated 06/21/2008 revealed, the patients history of multiple prior admissions for paranoid schizophrenia, and recommendations that the patient is mentally ill, and is dangerous to others. Review revealed the physicians initial treatment plan for milieu therapy, expand database, and medication to address depression/psychosis/anxiety/mood swings. Review revealed the physician assessed the prognosis as poor. Review of the nursing assessment dated 06/21/2008 revealed, "Precipitating factors to admission Assaulted several elderly residents (and) threatened to kill staff workers." Review revealed the nurse documented "bizarre behavior Inappropriate laughing," poor eye contact, flat affect, and preoccupied thought progression. Review revealed the nursing care plan for Ineffective individual coping related to assaulting elderly

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people, threatening to kill staff, and intervention/treatment modalities to redirect as necessary, and set firm limits. Review of the Initial Social Work Entry dated 06/23/2008 revealed the social worker talked with the patients' family and documented "He needs supervision at all times. He's Violent."

Review of progress notes revealed the patient with multiple violent/assaultive behaviors during the hospitalization, including:
06/22/2008 0950 "Pt got into a fight (with) another peer";
06/27/2008 0915 "Involved in altercation (with) (peer)";
07/01/2008 0830 "Attacked (peer) reported to have been shouting 'stop the voices' and apparently hit (peer) in (left) eyebrow sustaining 1(inch) -1 1/2 (inch) laceration to (left) eyebrow";
07/04/2008 0830 "Pt attempted to attack the nurse ...";
07/04/2008 1415 "(peer) trying to attack pt, but was halted by staff ... about 15 to 20 minutes later, heard another commotion (pt and peer) involved in an altercation, both patients were returned to the ward and ward nurse notified.";
07/16/2008 2145 "within 5 minutes attacked 2 separate peers without any provocation, punching and hitting both peers. He received 8pm meds immediately after the 8:30 attack";
07/29/2008 1315 "Pt became agitated because he is unable to have a cigarette. Pt has been pacing and physically threatening peers and staff. Pt was medicated for psychotic agitation... pt is kept on unit from groups for today, because of his agitation and violence.";
07/30/2008 2300 "(pt) assaulted (peer) during this evening shift.";
08/01/2008 2055 "Pt came uninvited into nurses

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A 395	Continued From page 120 station ...he exploded in anger, throwing a chair in the nurses station. He continued to make numerous verbal threats about attacking me (HCT#10) and pacing around the nurses station with a threatening affect. Psychiatrist paged and order received"; 08/08/2008 1845 "pt came from behind me and pushed me up against smoking door and began rubbing hands all over me and kissing my neck. I pushed pt away and told him to leave me alone. After redirection pt went to his room and closed door"; and 08/10/2008 1815 "At 1800 (pt) reportedly struck (peer) to right side of head causing bleeding and swelling to site. (pt) stated that he struck pt because other pt wanted to use his CD player." Review on 08/28/2008 at 1200 of hospital digital video record (U2 kitchen 1 & 2 cameras, and U2 1W Hall 3 camera) of the assault that occurred on 08/10/2008 at 1758 in the hallway/vending machine area outside of the dining room revealed, approximately 10-12 patients in/out of the hallway/dining room. Review revealed patients gathered in the hallway for 4.5 to 5 minutes. Review revealed during the 4.5 to 5 minutes no staff was present with the patients. Review revealed staff remained in the dining room. Review revealed pt#20 left the dining room, walked into the hallway and kicked the vending machine. Review revealed pt#20 and others then began to dance in the hallway/vending area. Review revealed staff remained in the dining room. Review revealed the patients standing and pacing in the hall/vending area. Review revealed a patient shaking the vending machine. Review revealed pt#20 pacing in the hall/vending area. Review revealed staff remained in the dining room.	A 395		

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A 395	Continued From page 121 Review revealed pt#20 suddenly takes off his headset, quickly squats down hits fists/hands to ground, quickly gets up, and walks over to pt#14 and begins hitting pt#14, about 6 blows rapidly to face/head. Review revealed pt#14 was down on the floor. Review revealed 2 staff run from the dining room to the hall/vending area. Review revealed one staff separates the patients, putting pt#20 in a hold against the wall. Review revealed the other staff assisted pt#14 up and into the dining room. Review revealed the other patients remained in the hall/vending area. Review revealed pt#20 was released from the hold, the staff member turned around and walked through the group of patients with pt#20 behind him. Review revealed the patients walked down the hall, followed by the second staff and pt#14. Review revealed pt#14 holding an unidentified object to his head. Record review on 08/26/2008 revealed pt#14 admitted to the hospital on 08/08/2008 with paranoid schizophrenia, under involuntary commitment, and discharged on 08/27/2008. Review of the initial psychiatric assessment dated 08/08/2008 revealed the patient was calm and cooperative with fair verbal communication, and no recent history of aggressive behavior. Review of nursing progress notes dated 08/10/2008 at 1815 revealed "Pt. (patient) involved in altercation in dining room ... (pt#20) pt struck (pt#14) to (right) side of head (with) closed fist. Ice pack applied to site. (physician assistant) advised. Bleeding controlled ..." Review revealed the patient had bruising under the left eye, tenderness/difficulties when opening the mouth, contusion to left side of face, pain over the left lower orbital bone area and temporal mandible joint area and tender left jaw area. Review	A 395		

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revealed the patient received a pureed diet due to difficulties chewing. Review of the record revealed x-ray and CT scans were obtained and revealed the patient sustained a "comminuted depressed fracture of the left zygomatic arch." Review revealed Maxillary facial surgery consult was obtained and surgical repair scheduled during the admission.

Interview on 08/28/2008 at 1955 with HCT#10 revealed, pt#20 is a "very violent person, snaps very quickly, if he doesn't get things his way he has outbursts, throws things, yells, and punches people. He walks up to patients and punches them in the face with staff standing next to him." Interview revealed the staff member was in the cafeteria the night of 08/10/2008, when pt #20 assaulted pt #14. The interview revealed two HCT's were in the dining room with the patients', the patients finished eating and went out in the hall by the vending machines. The interview revealed the HCT's were in the Dining room, and could not see out into the hallway, where the vending machines and patients were. The interview revealed the staff member saw pt#20 threw his headset down, and went charging down to where pt#14 was. The interview revealed the staff then ran out into the hall. The interview revealed pt#20 was punching pt#14. The interview revealed one HCT held pt#20 off of pt#14, and the other HCT assisted pt#14 up, off the ground. The interview revealed pt#14 was bleeding from the right side of his head. The interview revealed the patients were returned to the ward. The interview revealed the nurse provided care to pt#14 and notified the physician of the patient's injuries.

Interview on 08/28/2008 at 1400 with the Unit 2

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A 395	Continued From page 123 Nurse Manager regarding the incident on 08/10/2008, revealed the manager had reviewed the digital video records of the event. The interview revealed 2 staff HCT's were present in the dining room when pt#20 assaulted pt#14 in the hallway. The interview revealed the patients had finished their meal and congregated in the hall, outside of the dining room. The interview revealed pt#20 was going from patient to patient in the dining room, and then walked in and out of the dining room. The interview revealed pt#20 went out to the hallway/vending machine area, kicked the vending machine, and then started dancing. The interview revealed pt#20 began to pace "back and forth" in the hallway. The interview revealed pt#20, then attacked pt#14. The interview revealed no staff was present in the hall. The interview revealed staff are supposed to keep patients in the dining room until they are ready to go up to the units. If a patient is in the hallway staff should be present in the hall with the patients. The interview revealed from review of the digital video recording, the manager could see the two staff were in the dining room conversing. The interview revealed the patients were in the hallway for 4.5 to 5 minutes, without staff present. The interview confirmed no staff observed the hallway area for the 5 minutes prior to the assault. The interview revealed if staff had been present in the hallway, they might have been able to prevent the assault. The interview revealed "(pt#20) could have handled CA (constant awareness precautions), I don't know why it wasn't used. If he had been on CA there could have been an intervention before, to prevent the injuries." The interview revealed precautions are not used often. When asked why, the interview revealed "coverage and staffing is a big issue on the campus, volatile behavior is something we see a	A 395		

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lot here."

Observation on 08/26/2008 at 1730 of the U2 dining room/hallway/vending area revealed patients in the hallway/vending area, out of sight of staff. Observation revealed no staff present, monitoring the patients for 3 to 5 minutes.

C. The hospital's nursing staff failed to provide supervision of patient care by failing to implement progressive interventions for repeated assaultive behaviors for 1 of 1 patients reviewed with known repeated assaultive behaviors (pt#20).

Review of the hospital's "Precautions and Standard Accountability" policy dated 06/06/2008 revealed, "All patients are regularly monitored with regard to safety and location. Those patients requiring additional safeguards to ensure safety are placed on precautions. Precautions are initiated by a responsible physician or a registered nurse (RN). Any staff member concerned about the safety of a patient is responsible for informing the RN of his/her concerns so that the patient can be assessed and appropriate precautions can be implemented. The RN then communicates with the responsible physician to obtain the order."

Review of executive committee meeting minutes dated 06/20/2006 revealed "upon receipt of a memo from the PI (performance improvement) Department that a patient has had three or more incidents (of any type such as restrictive interventions, falls, or assaults) within a week or six or more incidents (of any type such as restrictive interventions, falls, or assaults) within a calendar month, the treatment team shall initiate a review of the information and the psychiatrist shall document a progress note in the patient's

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record verifying that the review has been done and any action taken. This review and progress note must be completed within five days of receipt of the memo."

Review of the hospital's "Behavior Plans and Crisis Plans" policy dated 05/05/2008 revealed, "(Hospital name) utilizes a variety of treatment modalities to ensure quality patient care in a safe environment. Some patients have needs which exceed the standard therapeutic capabilities of the ward management system. Such patients require more individualized interventions. Specialized behavior plans or crisis plans are one method to potentially meeting the needs of patients who have behaviors which exceed the therapeutic capabilities of the standard ward management system. Crisis plans are indicated when a patient's behavior presents an imminent danger to self or others and standard ward based interventions have been ineffective in managing, reducing, or eliminating the behavior. A functional analysis of behavior is indicated for any patient that is in need of a thorough assessment of his/her behavior. The functional analysis of behavior report includes a description of the patient's challenging behavior and an assessment of the following: the frequency, intensity, and the duration of the challenging behavior; the environmental factors which contribute to the challenging behavior; the triggers and antecedents of the challenging behavior; and the consequences of the challenging behavior. The functional analysis of behavior report also includes recommendations regarding interventions which may reduce, modify, or eliminate the challenging behavior. The functional analysis of behavior report is filed in the patient's medical record. Behavior plans may be

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A 395	Continued From page 126 indicated when a patient's behavior requires behavioral contingencies and reinforcements unavailable through standard interventions and/or the therapeutic milieu. No specific threshold regarding behaviors has to be exceeded in order to consider a behavior plan. Examples of possible triggers for behavior plans include (but are not limited to): dangerous behaviors towards self or others, behaviors requiring use of forced medication, and non-participation in treatment. If a behavior plan is considered contraindicated, a psychologist completes a behavior consultation report and meet with the treatment team to discuss alternative interventions. A Behavioral Consultation Report is completed when a referral is sent for a Crisis Plan or Behavior Plan and it is determined that a Crisis Plan or Behavior Plan is not clinically indicated. The ward Psychologist or member of the Behavior Management Team meets with the treatment team and reviews recommendations regarding possible strategies to manage the patient's behavior. Behavioral Consultation Reports are filed in the patient's medical record." Closed record review on 08/26/2008 revealed patient #20 admitted to the hospital on 06/21/2008 with paranoid schizophrenia under involuntary commitment due to violent aggressive and homicidal behavior having assaulted several elderly residents and threatened to kill staff working in his previous residential facility. Review of the physician's evaluation for admission dated 06/21/2008 revealed, the patients history of multiple prior admissions for paranoid schizophrenia, and recommendations that the patient is mentally ill, and is dangerous to others. Review revealed the physicians initial treatment plan for milieu therapy, expand database, and	A 395		

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A 395	Continued From page 127 medication to address depression/psychosis/anxiety/mood swings. Review revealed the physician assessed the prognosis as poor. Review of the evaluation for admission "Risk Factors for Suicide/Violence, Level of Suicide/Violence Risk, and Behavioral Issues" sections revealed no documentation of physician assessment. Review of the nursing assessment dated 06/21/2008 revealed, "precipitating factors to admission: Assaulted several elderly residents (and) threatened to kill staff workers." Review of the nursing violence risk assessment revealed, no risk factors documented during initial nursing assessment, and the section stating "If patient admission precipitated by homicidal/violent/sexually Inappropriate thoughts/acts then special precautions were discussed with Psychiatrist:" with documentation of "N/A (not applicable)." Review revealed the nurse documented "bizarre behavior inappropriate laughing," poor eye contact, flat affect, and preoccupied thought progression. Review revealed the nursing care plan for ineffective individual coping related to assaulting elderly people, threatening to kill staff, and intervention/treatment modalities to redirect as necessary, set firm limits. Review failed to reveal the patients risk for violence included in the nursing care plan. Review of the Initial Social Work Entry dated 06/23/2008 revealed the social worker talked with the patients' family and documented "He needs supervision at all times. He's Violent." Review revealed the social worker documented "Trigger: Cigarettes." Review of the initial 72 hour treatment plan dated 06/23/2008 revealed the short term goals: express ideas that are clearly related to one another during interview with staff; display	A 395		

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A 395	Continued From page 128 appropriate social behavior in group meetings; participate in treatment/discharge plan; and will demonstrate pleasant, cooperative manner in interactions with staff/patients. Review revealed the long term goals: show observable decrease in symptoms; show observable decrease in dangerous behaviors; manage self destructive or homicidal feelings without acting on them; and demonstration willingness to participate in aftercare plan. Review revealed the plan listed nursing interventions to redirect conversation to reality based subjects, monitor medication regimen, observing for therapeutic effects and side effects, and assist patient in identifying precipitants/stressors that may stimulate hallucinations/delusions/acting out behavior. Review of the plan failed to reveal interventions to decrease the possibility of assaultive behaviors, and failed to reveal the patient was placed on special precautions. Review of progress notes revealed the patient with multiple violent/assaultive behaviors during the hospitalization, including: 06/22/2008 0950 "Pt got into a fight (with) another peer"; 06/27/2008 0915 "Involved in altercation (with) (peer)"; 07/01/2008 0830 "Attacked (peer) reported to have been shouting 'stop the voices' and apparently hit (peer) in (left) eyebrow sustaining 1(inch) -1 1/2 (inch) laceration to (left) eyebrow"; 07/04/2008 0830 "Pt attempted to attack the nurse..."; 07/04/2008 1415 "(peer) trying to attack pt, but was halted by staff ... about 15 to 20 minutes later, heard another commotion (pt and peer) involved in an altercation, both patients were returned to the ward and ward nurse notified.";	A 395		

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07/16/2008 2145 "within 5 minutes attacked 2 separate peers without any provocation, punching and hitting both peers. He received 8pm meds immediately after the 8:30 attack.;
07/29/2008 1315 "Pt became agitated because he is unable to have a cigarette. Pt has been pacing and physically threatening peers and staff. Pt was medicated for psychotic agitation... pt is kept on unit from groups for today, because of his agitation and violence.";
07/30/2008 2300 "(pt) assaulted (peer) during this evening shift.";
08/01/2008 2055 "Pt came uninvited into nurses station ...he exploded in anger, throwing a chair in the nurses station. He continued to make numerous verbal threats about attacking me and pacing around the nurses station with a threatening affect. Psychiatrist paged and order received";
08/08/2008 1845 "pt came from behind me and pushed me up against smoking door and began rubbing hands all over me and kissing my neck. I pushed pt away and told him to leave me alone. After redirection pt went to his room and closed door"; and
08/10/2008 1815 "At 1800 (pt) reportedly struck (peer) to right side of head causing bleeding and swelling to site. (pt) stated that he struck pt because other pt wanted to use his CD player."

Review of the initial treatment plan dated 07/01/2008 (after 2 - 3 documented assaultive behavior incidents) revealed the long term goal for patient to interact in a calm pleasant manner, and the short term goal for patient to interact for 15 minutes without becoming violent or threatening 3 times a week for 2 weeks. Review revealed the treatment interventions to prescribe and monitor medications, teach the patient ways

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A 395	Continued From page 130 to manage his agitation instead of becoming violent, ask him to take a time out and return to group when he is calm, and practice positive interactions without violent or threatening behavior, Praise the patient when he is able to interact without violent or threatening behavior. Review revealed the violence risk assessment documenting the patient with aggression/agitation within last 7 days. Review revealed the team documented the patients "Level of Suicide and/or Violence Risk" as "Medium" and documented the interventions to address such risk as "medication." Review revealed no precautions, referrals or other treatment interventions. Review of the treatment plan dated 07/16/2008 (after 5 documented assaultive behavior incidents) revealed, the treatment plan was changed from previous to increase the time spent with the social worker by 5 minutes per week. Review revealed the goal for the patient to interact in a calm pleasant manner was continued. Review revealed no additional interventions, referrals or precautions to address the patient's repeated assaultive behaviors. Review of the treatment plan dated 08/04/2008 (after 9 assaultive behavior incidents) revealed, the plan documented the patient with 2 additional incidents since the previous plan meeting and a total of 6 incidents in 30 days. Review revealed the treatment team review was documented as a regular review and as a special review due to "6 incidents within 30 days." Review revealed the patient is not meeting his goals. Review revealed the patients long term and short term goals were continued. Review of the treatment plan revealed no additional interventions, referrals or precautions to address the patients repeated assaultive behaviors. Review of the record revealed staff redirected the patient for displays of	A 395		

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A 395	Continued From page 131 violence/threats, and assaultive behavior and provided 1:1 contact to de-escalate the patient's behaviors. Review revealed medications were administered, and adjusted during the hospitalization. Review of the record failed to reveal the patient was placed on precautions for repeated assaultive behaviors. Review of the record failed to reveal the Behavior Management Team was consulted for the patient's repeated assaultive behaviors. Interview on 08/28/2008 at 1715 with the Psychiatrist revealed the physician was aware of the patient's assaultive behaviors. The interview revealed the patient was "very psychotic, unpredictable, but he had certain issues he always addressed, demanding to be discharged locally, and if his requests were not met his behavior got worse at those times." The interview revealed "usually there are some triggers, with (pt#20) if he starts pacing, we know he is escalating, the HCT's know how to intervene. If he is pacing, they know how to talk to him." The interview revealed staff could change precautions to increase monitoring of the patient around those times. The interview revealed staff "used a group approach to watch him, not strictly precautions." The interview revealed the physician did not feel a behavior plan would work with pt#20 due to his ability to understand with his psychosis. The interview revealed the physician's "plan to use the headphones, due to music relaxed him. If (he) behaved, he got the headphones." Interview on 08/28/2008 at 1635 with a Behavior Specialist/ Behavior Management Team member, revealed the specialist was unfamiliar with pt#20, and could not find a referral for a Behavior Management consult for pt#20. The interview	A 395		

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revealed "anytime we have a referral we go do an assessment. We always try to offer some suggestions if a behavior plan is not going to be helpful." The interview revealed the team will offer strategies for staff in dealing with patient behaviors.

Interview on 08/27/2008 at 1235 with RN#5 revealed the staff member had worked with pt#20 on numerous occasions. The interview revealed pt#20 was "hyper, always pacing, talking to himself, asking for cigarettes, very labile, the smallest thing would set him off." The interview revealed the patient would become agitated "usually around smoke time or if he felt like he needed to get payback for some other incident. There were times the patient would go several days without an (assaultive) episode. It seemed like when ever he had a treatment planning meeting, or talk about discharge, that would antagonize him." The interview revealed the RN had discussed precautions with the physician, but it was felt to be "not appropriate for the patient. (The patient) saw precautions as staff picking on him, he wanted to be left alone." The interview revealed staff had identified treatment team meetings and smoke time as instigating factors to the patients behavior. The interview revealed the RN was "unaware of any" precautions/ interventions that were put in place around these identified instigating factors. The interview revealed the RN was not aware of a behavior plan for the patient. The interview revealed staff attempted to keep the patient calm by giving him whatever he wanted. The interview revealed the RN worked on the night of 08/08/2008 when the patient had sexually assaulted a staff member. The interview revealed the patient had not assaulted anyone in that manner before. The

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A 395	Continued From page 133 interview revealed this would be considered an escalation in behavior. The interview revealed no changes were made to the plan of care after the assault, "He was at his baseline, with no further outbursts." Interview on 08/28/2008 at 1955 with HCT#10 revealed, pt#20 is a "very violent person,, snaps very quickly, if he doesn't get things his way he has outbursts, throws things, yells, and punches people. He walks up to patients' and punches them in the face with staff standing next to him." Interview revealed the staff member was in the cafeteria the night of 08/10/2008, when pt #20 assaulted pt #14. The interview revealed pt#14 was bleeding from the right side of his head. The interview revealed the patients' were returned to the ward. The interview revealed the nurse provided care to pt#14 and notified the physician of the patients injuries. The interview revealed pt#20 was not placed on precautions, and no new interventions were implemented. The interview revealed "nothing" happened to pt#20, "he acted like nothing happened, walked around listening to his headphones." The interview revealed the patient has a headset to play music to keep him calm. The interview revealed the headset is not used to reward good behavior; it is used to keep the patient calm and is not taken away from the patient. The interview revealed the staff member was "never told anything" on how to interact with the patient, interventions to use to de-escalate the patient. The interview revealed "there is no way to predict the patients outbursts" the staff "just give him what he wants to keep him quiet." Interview on 08/27/2008 at 1025 with the DON (Director of Nursing) and ADON (Assistant	A 395		

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Director of Nursing) revealed, the staff was aware of the patient's assaultive behavior on admission and interventions to redirect and set limits with the patient were initiated. The interview revealed staff can place patients on special precautions for close monitoring of the patient's status, "make sure he is safe, no changes in the patients condition, and monitor for changes in patients mood/agitation level. The interview revealed there was no evidence the patient was placed on precautions at any time during the hospitalization The interview revealed there were no changes made to the treatment plan dated 08/04/2008 (after 9 assaultive incidents). The interview revealed the patient continued to have assaultive behaviors and assaulted a staff member on 08/08/2008. The interview revealed there was no change to the patient's plan of care after the assault on 08/08/2008. The interview revealed the patient assaulted another patient on 08/10/2008, resulting in a serious injury.

Interview on 08/28/2008 at 1400 with the Unit 2 Nurse Manager revealed "(pt#20) could have handled CA (constant awareness precautions), I don't know why it wasn't used. If he had been on CA there could have been an intervention before, to prevent the injuries."
D. The hospital's nursing staff failed to provide supervision of patient care by failing to supervise, and monitor the delivery of care to ensure basic needs (nutrition and hydration) were provided for 1 of 19 inpatient open records reviewed (#21).

Review of hospital policy "Intake and Output (I&O)" effective: 08/20/2008 revealed the purpose is "to ensure proper monitoring of nutrition, hydration, urinary and bowel function...Registered Nurses, Licensed Practical nurses, and health

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A 395	Continued From page 135 care technicians are responsible for collecting I&O data and recording on the I&O worksheet...the registered nurse is responsible for assessing intake and output daily and documenting at the end of the evening shift..." Review of hospital policy "Multi-purpose Flow Sheet" effective 08/20/2008 revealed "Meals: Record prescribed type of diet in the space provided. A licensed nurse observes the patient at meal time and documents the amount eaten as indicated on flow sheet...Nurse Monitor: Auditing the flow sheet is done by the Registered Nurse every shift." Open record review on August 26, 2008 revealed Patient #21 a 24 year old male admitted to the U1 3 East unit on 06/16/2008 with a diagnosis of Schizophrenia verses Post Traumatic Stress Disorder, Personality Issues, Moderate Obesity, and non-compliance with meds. The nursing physical assessment on 06/16/2008 noted the patient was 5 feet and 4 inches in height and weighed 237 pounds. Review of the physician's progress note on 07/03/2008 revealed the patient was started on Risperdal, and Cogentin (behavior medications). Review revealed the following diagnosis being currently treated medically: hypertension, chronic constipation, and diabetes mellitus Review of physician's orders written 07/07/08 revealed an order for the patient to "receive Glucerna 1 can p.o. (orally) tid (three times daily) with meals, offer it if the pt (patient) eats less than 50% of meal." Review of the patient's multi-purpose flow sheet for 7/2008 and 08/2008 revealed the patient ate	A 395		

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A 395	Continued From page 136 less than 50% of his meal on the following dates: · Breakfast: 07/09, 07/10, 07/12, 07/17, 07/18, 07/21, 07/23, 07/24, 07/27, 07/28, 08/01, 08/05, 08/08, 08/11, 08/13, 08/15, 08/19, 08/20, 08/21; and, · Lunch: 07/15, 07/16, 07/19, 07/26, 07/27, 08/01, 08/06, 08/15, 08/18, 08/20, 08/14, 08/25, 08/26, 08/27; and, · Dinner: 07/17, 07/20, 07/23, 07/29, 08/04, 08/05, 08/06, 08/09, 08/16, 08/27. Record review revealed no documentation on the multi-purpose flow sheet, I&O flow sheet, or MAR(Medication Administration Record) for 7/2008 and 08/2008, to indicate if the patient was offered the supplement Glucerna tid when he ate less than 50% of meals. Interview on 08/26/2008 at 1045 with the assigned medication nurse, a LPN #3 (Licensed Practical Nurse), confirmed the current physician order was "if the patent did not eat 50 % of his meal, he was to be offered a can of Glucerna supplement." The interview confirmed it was not documented if the Glucerna was offered when the patient ate less than 50% of meals. Interview on 08/26/2008 at 1150 with the charge RN#4 (Registered Nurse) revealed the order was not on the patient's July or August MAR. Further interview with the RN indicated there was no documentation on the multipurpose flow sheet or I&O flow sheet indicating the patient was offered Glucerna when he ate less than 50% of meals. Interview on 08/27/2008 at 1115 with the Director of Nursing indicated "first I find the actions of my staff appalling" it is the policy and expectation of the nursing staff to initiate and follow care plans	A 395		

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and for RN's to supervise the LPN's. It is the policy for the LPNs to observe meals eaten documenting them on the multipurpose flow sheet. Interview confirmed nursing staff failed to provide the supplement nutrition as ordered by the physician.

A 404 482.23(c) ADMINISTRATION OF DRUGS — A 404

Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.

This STANDARD is not met as evidenced by:
Based on review of policy and procedures, open record reviews, patient and staff interviews, and unit tours, the nursing staff failed to provide safe and effective administration of medication for 7 of 8 medication passes observed (#42, #52, #53, #54, #55, #56, #57).

Findings include:

Review of the Policy "Medication Administration" effective 05/05/2008 revealed "Registered Nurses and Licensed Practical Nurses administer medication to patients as ordered by licensed prescribers . . . medications are administered 30 minutes before or 30 minutes after the ordered time . . . patients are identified by using two identifiers. . . Routinely name and picture . . . self administration of medications is only allowed with a physician's order and approval of the patient's treatment team.

1. Open record review on 08/28/2008 of patient #42 revealed a 42 year old male admitted on

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05/05/2008 to the facility requiring medication for behaviors. The patient's daily medication included Risperidone oral solution twice daily, scheduled for 0800 and 2000.

Observation of the U3 treatment mall on 08/27/2008 at 1100 revealed, LPN#1 (Licensed Practical Nurse) in the medication room preparing to dispense medications. Observation revealed Patient #42 approached LPN#1 and requested Risperidone that was not given to him on the 0800 morning pill pass. Further observation revealed LPN#1 refused to medicate the patient and directed him to LPN #2 who was in the dining room. Observation revealed Patient #42 returned to LPN#1 stating he was instructed to return and be medicated. Observation revealed LPN#1 refused to medicate the patient and sent him away, stating she would talk to LPN#2. Further observation revealed Patient #42 was not medicated and LPN#1 continued to pass medication to other patients.

Review of the MAR (medication administration record) for Patient #42 revealed the nurse signed off that the Risperidone was given at 0800 on 8/27/2008 (three hours prior to the observation). Further record review revealed documentation the Risperidone was given at 1300 (5 hours late) on 8/27/2008.

Interview on 08/27/2008 at 1135 with LPN#1 revealed some medications were missing this morning and "I don't know what it was." LPN#1 indicated it is the responsibility of the RN or LPN to notify the physician and obtain an order for late medication administration. Interview revealed LPN#1 did not notify the physician when she learned the patient's morning dose of Risperidone

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was not available.

Interview on 08/27/2008 at 1215 with LPN#2 revealed "medications were missing this morning for 6-7 patients." Further interview revealed it was "cart day." Interview revealed carts are filled one time a week, and it is not unusual for medications to be found missing. LPN#2 indicated she would notify the physician of the late administration of Risperidone to patient #42 and obtain an order. Further interview revealed the LPN did not notify the physician but stated she gave a list of the patients with missing medications to the charge nurse RN#1.

Interview on 08/27/2008 at 1230 with RN#1 confirmed that LPN#2 communicated the need to obtain an order to give Risperidone to client #42 after its prescribed time. Further interview with RN#1 indicated that she was to contact the physician for an order to give the medication between the times of 0800-1000. Further interview confirmed that the physician had not been notified and RN#1 was on a different unit, in a different building, and planned to contact the physician later. RN#1 stated she had not received a list of patients with missing medications from LPN#2.

Interview on 08/27/2008 at 1245 with LPN#2 confirmed she did not make a list of the patients missing medications during the 0800 medication pass and could not recall who the patients were that did not receive their 0800 medications.

2. Observation of the U3 treatment mall medication pass on 08/27/2008 at 1100 revealed Patient #52, a 42 year old male, approached LPN#1 for Simethicone medication (anti-gas)

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after his meal. Observation revealed the medication was removed from the patient drawer, and given to the patient in his hand. Further observation revealed the patient was allowed to walk away from the medication room with the medication in his hand, he was not observed by LPN#1 taking his medication, and was not identified using two patient identifiers.

Interview on 08/27/2008 at 1135 with LPN#1 confirmed she did not use 2 forms of identification for the patient during the medication pass.

Interview on 08/28/2008 at 1130 with the Director of Nursing confirmed it is the policy and expectation of the facility that patients receive their medication on time in a safe manner. "I am appalled and have started disciplinary action with the staff involved. I believe some of the actions you witnessed were sabotage to this facility. It is unbelievable that many errors could occur in one medication pass."

3. Observation of the U3 treatment mall medication pass on 08/27/2008 at 1100 revealed Patient # 53, a 42 year old female, complained of a headache. Observation revealed LPN#1 did not identify the patient using two identifiers prior to administering a PRN (ordered as needed) for the patient's headache. Observation revealed the patient was not wearing an identification arm bracelet. Further observation revealed the patient's picture was not on the MAR.

Interview on 08/27/2008 at 1135 with LPN#1 confirmed she did not use 2 forms of identification for the patient during the medication pass.

Interview on 08/28/2008 at 1130 with the Director

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of Nursing confirmed it is the policy and expectation of the facility that patients receive their medication on time in a safe manner. "I am appalled and have started disciplinary action with the staff involved. I believe some of the actions you witnessed were sabotage to this facility. It is unbelievable that many errors could occur in one medication pass."

4. Observation of the U3 treatment mall medication pass on 08/27/2008 at 1100 revealed Patient #54, a 62 year old male, was medicated with his scheduled 1200 medication by the medication nurse. Observation revealed LPN#1 administered the patient's medications and failed to identify the patient using two patient identifiers.

Interview on 08/27/2008 at 1135 with LPN#1 confirmed she did not use 2 forms of identification for the patient during the medication pass.

Interview on 08/28/2008 at 1130 with the Director of Nursing confirmed it is the policy and expectation of the facility that patients receive their medication on time in a safe manner. "I am appalled and have started disciplinary action with the staff involved. I believe some of the actions you witnessed were sabotage to this facility. It is unbelievable that many errors could occur in one medication pass."

5. Observation of the U3 treatment mall medication pass on 08/27/2008 at 1100 revealed Patient # 55, a 40 year old male, was medicated with his scheduled 1200 medication. Observation revealed LPN#1 failed to identify the patient using two patient identifiers.

Interview on 08/27/2008 at 1135 with LPN#1

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confirmed she did not use 2 forms of identification for the patient during the medication pass.

Interview on 08/28/2008 at 1130 with the Director of Nursing confirmed it is the policy and expectation of the facility that patients receive their medication on time in a safe manner. "I am appalled and have started disciplinary action with the staff involved. I believe some of the actions you witnessed were sabotage to this facility. It is unbelievable that many errors could occur in one medication pass."

6. Observation of the U3 treatment mall medication pass on 08/27/2008 at 1100 revealed Patient #56, a 58 year old male, was medicated with his scheduled 1200 medication. Observation revealed LPN#1 failed to identify the patient using two patient identifiers.

Interview on 08/27/2008 at 1135 with LPN#1 confirmed she did not use 2 forms of identification for the patient during the medication pass.

Interview on 08/28/2008 at 1130 with the Director of Nursing confirmed it is the policy and expectation of the facility that patients receive their medication on time in a safe manner. "I am appalled and have started disciplinary action with the staff involved. I believe some of the actions you witnessed were sabotage to this facility. It is unbelievable that many errors could occur in one medication pass."

7. Observation of the U3 treatment mall medication pass on 08/27/2008 at 1100 revealed Patient #57, a 46 old male, was medicated with his scheduled 1200 medication. Observation revealed LPN#1 failed to identify the patient using

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A 404	Continued From page 143 two patient identifiers. Interview on 08/27/2008 at 1135 with LPN#1 confirmed she did not use 2 forms of identification for the patient during the medication pass. Interview on 08/28/2008 at 1130 with the Director of Nursing confirmed it is the policy and expectation of the facility that patients receive their medication on time in a safe manner. "I am appalled and have started disciplinary action with the staff involved. I believe some of the actions you witnessed were sabotage to this facility. It is unbelievable that many errors could occur in one medication pass."	A 404		
A 503	482.25(b)(2)(ii) CONTROLLED DRUGS KEPT LOCKED Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area. This STANDARD is not met as evidenced by: Based on review of the facility's policy, staff interviews, open record review, and observation during tour, the facility's staff failed to maintain narcotic medications according to the standards of practice and law. Findings include: Review of the policy "Controlled Substances" effective 12/15/2000 revealed, ". . . All controlled substances will be kept under double lock and key. . ." Observations during tour of the U3 treatment mall medication room on 08/27/2008 at 1030 with the	A 503		

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A 503	Continued From page 144 medication LPN #1 (Licensed Practical Nurse) revealed the medication room door was locked. Observation revealed the narcotic medication cabinet located in the medication room was found to be opened and unlocked. Observation revealed the narcotic medications were only under a single lock (the medication room door). Interview on 08/27/2008 at 1030 with LPN #1 revealed narcotic medication is stored in the medication room and is to be secured under two locks at all times. The staff nurse confirmed the only lock securing the narcotics was the door to the medication room. Interview on 08/28/2008 at 1100 with the Director of Nursing confirmed it is the facility's expectation and policy that medication is maintained in a secure environment and controlled substances are kept under two locks at all times. Interview confirmed the medication nurse failed to secure the narcotic medications according to facility policy.	A 503		
A 618	482.28 FOOD AND DIETETIC SERVICES The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.	A 618		

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A 618	Continued From page 145 This CONDITION is not met as evidenced by: Based on review of dietary policies and procedures, medical records, dietary staff interviews, patient interviews and observations the hospital failed to ensure dietary services were supervised and services provided in an organized manner. The findings include: A. The Dietary Director failed to ensure the Dietary Department had current policies and procedures for dietary staff and accessible for nursing services. Review of dietary policies on August 27, 2008 consisted of a binder with documents which included strike through and handwritten notes without dates. ~cross refer to 482.28(a) Organization - Tag A0619 ~cross refer to 482.28(b)(3) Diets - Tag A0631 B. The Dietary Director failed to provide oversight to have a system or process in place to ensure the hot foods were served hot and cold foods were served cold. Observation on August 28, 2008 revealed meal trays are prepared in the main kitchen. Trays are stacked on open transport carts, pulled onto a closed truck and driven to respective buildings for patient distribution. Dietary staff obtain and record temperatures of trays upon receipt in the dining area. Temperatures of the lunch meal test tray on August 27, 2008 revealed the following temperatures: Coleslaw 53 degrees at 11:35AM	A 618		

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A 618	Continued From page 146 Breakfast test tray: Sausage 80 degrees at 8:30AM Pancakes 100 degrees at 8:30AM Areview of temperature logs of temperatures upon receipt of trays in distinct dining rooms revealed the following examples of temperatures: August 26, 2008 Community living: Eggs 97 degrees at 8:07AM Vegetables 105 degrees at 6:10PM Gelatin 60 degrees at 6:10PM August 26, 2008 U2: Scrambled Eggs 100 degrees at 7:44AM California vegetables 105 degrees at 5:01PM August 26, 2008 U4 (Adolescent): Eggs 102 degrees Rice 104 degrees August 26, 2008 Woodard: Eggs 90 degrees Rice & Tomatoes 100 degrees California vegetables 100 degrees August 27, 2008 U2: Sausage 80 degrees Pancakes 100 degrees August 27, 2008 U4 (Adolescent): Sausage 100 degrees Pancakes 105 degrees August 27, 2008 Woodard: Sausage 80 degrees	A 618		

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Pancakes 92 degrees

August 28, 2008 U4 (Adolescent): Eggs 105 degrees
French Fries 100 degrees at 11:45AM
Fried chicken 100 degrees at 5:35PM

August 28, 2008 Woodard: Chipped beef 100 degrees at 7:30AM

Based on review of dining room shift reports, dietary staff consistently reported "meal service is fine". There is no identification or mention of food temperatures or patient complaints. There was no policy or evidence to indicate the Dietary Director reviewed the daily logs or implemented a performance indicator to improve the meal delivery system.

Interview with RD #1 August 29, 2008 at 2:20PM revealed clients in U4 complain of food being cold. On U4 the boys eat later than the girls. Interview confirmed meal trays may sit for thirty minutes prior to distribution to patients in dining area. Interview with the Dietary Director August 29, 2008 confirmed the hospital does not have a system to maintain temperatures or ensure hot food is served hot and cold foods are served cold upon patient receipt.

C. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure Dietary Department staff were knowledgeable in the operations of scales. Staff inability to operate scales to verify serving portions results in staff serving diets contrary to the menu pattern and physician orders.

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Review of the lunch menu for August 28, 2008 revealed:
Beef patty on bun:
1500 calorie diet 2.0 ounce / 1 each
French fries 4.0 ounces
2200 calorie diet 2.0 ounce / 1 each
French fries 4.0 ounces
2500 calorie diet 3.0 ounce / 1 each
French fries 8.0 ounces
3000 calorie diet 3.0 ounce / 1 each
French fries 8.0 ounces

Observations on August 28, 2008 at 11:20AM revealed food scales were not easily accessible for use in the kitchen. Based on observations, the Dietary Director was unable to calibrate the food scales to determine the ounces of beef patty served. Additional observations revealed the Dietary Director was not knowledgeable of operating the digital food scales. Based on these observations, the portion of beef patty could not be verified to determine the portion size to ensure compliance with the menu pattern and the physician prescribed diet order. Interview with the Dietary Manager on August 29, 2008 at 2:30PM revealed the hospital did not have a system in place to ensure servings of french fries were served in accordance with the menu pattern and compliance with the physician prescribed diet.

~cross refer to 482.28(b)(2) Diets - Tag A0630

D. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure Dietary Department served meals that were palatable and appropriate for the patient population served.

Observation of the evening meal in the U4

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(adolescent unit) dining room on 08/26/2008 revealed Patients # 5 and 10 received a 3000 calorie diet with double portions of white rice. Observation revealed the patients adding multiple packs of hot sauce to the rice. Patient #5 said, "I'm adding the hot sauce to give it some taste. Interview with Patient #5 revealed "I'm still hungry after meals."

Interview with dietician #4 on 08/26/2008 at 1745 revealed "a dietary consult was ordered. We have 72 hours to complete the consult". Interview further revealed "they should have received double portions of meat, not rice. I'll make sure they get food they like."

E. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure Dietary Department acknowledged patient dislikes and served meals with substitutions as were appropriate for the patient population served

Observation during a tour of 2 East Unit revealed a monthly menu on the wall. Observation revealed each meal only had one choice listed.

Observation during a tour of the cafeteria in the U2 building on 08/26/2008 at 1730 revealed 2 East patients eating their supper. Observation revealed LPN #4 (licensed practical nurse) and a mental health technician from 2 East monitoring the patients. Observation revealed registered dietician (RD) #2 observing the patients eating their supper. Further observation revealed patient #11 brought his supper tray to the cart. Observation revealed patient #11 had not consumed any food off the tray. Observation revealed patient #11 left the cafeteria, went to the vending machine and returned eating a chocolate

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A 618	Continued From page 150 bar. Observation revealed the RD and the LPN did not offer any type of food substitution to patient #11 when he did not consume his supper. Interview on 08/26/2008 at 1745 with patient #11 revealed "I did not like the fish that was for supper, so I went and got a chocolate bar." Interview on 08/26/2008 at 1750 with LPN #4 revealed "We are to monitor patients' intake at supper. I guess patient #11 is still hungry. The chocolate bar is very nutritional. A lot of our patients do not like the food so they eat the food from the vending machine." Interview revealed LPN #4 was monitoring only the solids the patients consumed. Interview revealed LPN #4 did not know how much fluid the glasses held. Interview revealed the fluid intake is not monitored at mealtime unless a physician orders a patient be placed on intake and output. Further interview revealed LPN #4 was not aware if substitutions could be offered to patients who did not eat the food on the supper trays. Interview revealed "The patients are given a snack before bedtime." Interview revealed the snack consisted of a sandwich, a piece of fruit and a beverage. Interview on 08/26/2008 at 1800 with RD #2 revealed the RD monitors the supper hour twice a week. Interview revealed the RD checks if the diet cards on the trays are correct and if the patients eat 75 % of the meal. Interview revealed "patient #11 did not eat his supper because he didn't like the fish." Interview revealed they did not have another hot meal to substitute a patient's meal if he did not like the food that was served. Interview revealed "the nurses should have referred patient #11 to let us know he doesn't like fish."	A 618		

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Observation on 08/26/2008 at 1810 failed to reveal RD #2 attempted to offer patient #11 a substitution for supper. Observation revealed the RD went and obtained a sandwich 5 minutes later. Observation revealed the RD offered the sandwich to another patient until the LPN told her it was patient #11 who had not eaten his supper. Observation revealed other patients came and asked for a sandwich also. Observation revealed the dietician did not address these requests.

Interview on 08/26/2008 at 1815 with two other patients in the cafeteria who had requested sandwiches revealed they are usually hungry even after eating the food given to them on the supper tray. Interview revealed they had not seen sandwiches offered before today.
Interview on 08/27/2008 at 1100 with administrative staff who had been in attendance in the cafeteria during the above event revealed "The dietician only went and got a sandwich as a substitution after she was questioned about the hospital's practice of meal substitutions."

~cross refer to 482.28(b)(2) Organization - Tag A0630

F. Nursing staff failed to supervise and evaluate the diet delivery process to ensure that each patient receives the correct diet as prescribed by the physician and failed to enforce the care nurses full accountability for each patient receiving the correct diet. Nursing administration and dietary administration failed to coordinate and ensure that the diet delivery process was effective in (1) meeting the dietary needs of all patients, (2) delivering the physician's prescribed diets for all patients and (3) receiving and resolving dietary

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problems in order to prevent reoccurrence.

Observation on 08/28/2008 at 1725 on U2 2West, revealed 2 patients remaining on the ward for dinner. Observation revealed staff monitoring the patients. Observation revealed staff completed meal monitoring prior to both patients having finished eating. Observation revealed one patient obtained a carton of milk from another patient, and there was no staff monitoring meals at the time.

Interview on 08/26/2008 at 1725 with HCT#18 revealed the HCT was not monitoring the patients' meal/fluid consumption. The interview revealed the nurse was responsible for monitoring meals. The interview revealed the HCT was unsure who was monitoring meal consumption. The interview confirmed there was no staff monitoring meal consumption at that time.

Interview on 08/26/2008 at 1735 with the Registered Nurse (RN#7) revealed, the nurse had not witnessed the patient obtain milk from another patient. The interview revealed the RN had not documented the patients' meal consumption accurately. The interview revealed RN#7 corrected the patients' records.

Observation on 08/26/2008 at 1640 in the U2 dining room revealed 10 patients eating the evening meal. Observation revealed an LPN assigned to the dining room to record percent of meals eaten. Observation revealed, prior to leaving the dining room, the patient returns his tray to a cart. Observation revealed the LPN would ask the patient to lift the lid of the tray so the LPN can view and record percentage of meal eaten. Observation revealed there was no way of

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A 618	Continued From page 153 verifying that items missing from the food tray were indeed eaten by the patient. The LPN stated, "we keep an eye on them" as being the method used by staff to verify that missing food items were eaten by the patient. ~cross refer to 482.28(b)(2) Diets - Tag A0630 G. The facility's leadership staff failed to provide oversight to ensure dietary services was provided in a safe environment for staff. Observation on August 28, 2008 at 11:55AM revealed a dietary employee filling the "plate soak tub". Observations revealed the sink had a major leak. Water was leaking from left side sink. Interview with the dietary tech revealed he/she was assigned in the plate soak area on August 27, 2008 and the left sink was leaking. Interview at 12:00NOON with the Dietary Director revealed the left sink was "always leaking. Maintenance could not fix. Sometimes we can adjust and it will not leak". Further interview revealed the Dietary Director failed to inform the Vice President whom he/she reported.	A 618		
A 619	482.28(a) ORGANIZATION Organization This STANDARD is not met as evidenced by: Based on review of dietary policies and procedures, medical records, dietary staff interviews, patient interviews and observations the hospital failed to ensure dietary services were supervised and services provided in an organized manner. The findings include:	A 619		

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A 619	Continued From page 154 A. The Dietary Director failed to ensure the Dietary Department had current policies and procedures for dietary staff and accessible for nursing services. Review of dietary policies on August 27, 2008 consisted of a binder with documents which included strike throughs and handwritten notes without dates. The manual lacked a current table of contents and reference list. Interview August 27, 2008 at 3:00PM with the Dietary Director revealed there were no other policies available for staff use. The Dietary Director was unable to verify who made the handwritten notations and dates the notations were made. Further interview revealed it would take one year to have a current and organized policy and procedure manual available for dietary staff and accessible for other departmental use. B. The Dietary Director failed to provide oversight to have a system or process in place to ensure the hot foods were served hot and cold foods were served cold. Observation on August 28, 2008 revealed meal trays are prepared in the main kitchen. Trays are stacked on open transport carts, pulled onto a closed truck and driven to respective buildings for patient distribution. Dietary staff obtain and record temperatures of trays upon receipt in the dining area. Temperatures of the lunch meal test tray on August 27, 2008 revealed the following temperatures: Coleslaw 53 degrees at 11:35AM Breakfast test tray: Sausage 80 degrees at 8:30AM Pancakes 100 degrees at 8:30AM A review of temperature logs of temperatures	A 619		

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A 619	Continued From page 155 upon receipt of trays in distinct dining rooms revealed the following examples of temperatures: August 26, 2008 Community living: Eggs 97 degrees at 8:07AM Vegetables 105 degrees at 6:10PM Gelatin 60 degrees at 6:10PM August 26, 2008 U2 : Scrambled Eggs 100 degrees at 7:44AM California vegetables 105 degrees at 5:01PM August 26, 2008 U4 (Adolescent) Eggs 102 degrees Rice 104 degrees August 26, 2008 Woodard Eggs 90 degrees Rice & Tomatoes 100 degrees California vegetables 100 degrees August 27, 2008 U2 Sausage 80 degrees Pancakes 100 degrees August 27, 2008 U4 (Adolescent) Sausage 100 degrees Pancakes 105 degrees August 27, 2008 Woodard Sausage 80 degrees Pancakes 92 degrees August 28, 2008 U4 (Adolescent) Eggs 105 degrees French Fries 100 degrees at	A 619		

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Continued From page 156
11:45AM
Fried chicken 100 degrees at 5:35PM

August 28, 2008 Woodard Chipped beef 100 degrees at 7:30AM

Based on review of dining room shift reports, dietary staff consistently reported "meal service is fine". There is no identification or mention of food temperatures or patient complaints. There was no policy or evidence to indicate the Dietary Director reviewed the daily logs or implemented a performance indicator to improve the meal delivery system.

Interview with RD #1 August 29, 2008 at 2:20PM revealed clients in U4 complain of food being cold. On U4 the boys eat later than the girls. Interview confirmed meal trays may sit for thirty minutes prior to distribution to patients in dining area. Interview with the Dietary Director August 29, 2008 confirmed the hospital does not have a system to maintain temperatures or ensure hot food is served hot and cold foods are served cold upon patient receipt.

C. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure Dietary Department staff were knowledgeable in the operations of scales. Staff inability to operate scales to verify serving portions may result in the serving of diets contrary to physician orders.
Review of the lunch menu for August 28, 2008 revealed:
Beef patty on bun:
1500 calorie diet 2.0 ounce / 1 each

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French fries 4.0 ounces
2200 calorie diet 2.0 ounce / 1 each
French fries 4.0 ounces
2500 calorie diet 3.0 ounce / 1 each
French fries 8.0 ounces
3000 calorie diet 3.0 ounce / 1 each
French fries 8.0 ounces

Observations on August 28, 2008 at 11:20AM revealed food scales were not easily accessible for use in the kitchen. Based on observations, the Dietary Director was unable to calibrate the food scales to determine the ounces of beef patty served. Additional observations revealed the Dietary Director was not knowledgeable of operating the digital food scales. Based on these observations, the portion of beef patty could not be verified to determine the portion size to ensure compliance with the menu pattern and the physician prescribed diet order. Interview with the Dietary Manager on August 29, 2008 at 2:30PM revealed the hospital did not have a system in place to ensure servings of french fries were served in accordance with the menu pattern and compliance with the physician prescribed diet.

D. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure Dietary Department served meals that were palatable and appropriate for the patient population served.

Observation of the evening meal in the U4 (adolescent unit) dining room on 08/26/2008 revealed Patients # 5 and 10 received a 3000 calorie diet with double portions of white rice. Observation revealed the patients adding multiple packs of hot sauce to the rice. Patient #5 said, "I'm adding the hot sauce to give it some taste.

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A 619	Continued From page 158 Interview with Patient #5 revealed "I'm still hungry after meals." Interview with dietician #4 on 08/26/2008 at 1745 revealed "a dietary consult was ordered. We have 72 hours to complete the consult". Interview further revealed "they should have received double portions of meat, not rice. I'll make sure they get food they like." Observation on 08/28/2008 at 1725 on U2 2West, revealed 2 patients remaining on the ward for dinner. Observation revealed staff monitoring the patients. Observation revealed staff completed meal monitoring prior to both patients having finished eating. Further observation revealed one patient obtained a carton of milk from another patient, and no staff were in attendance or monitoring the meal to observe this exchange of milk products. Interview on 08/26/2008 at 1725 with HCT#18 revealed the HCT was not monitoring the patients' meal/fluid consumption. The interview revealed the nurse was responsible for monitoring meals. The interview revealed the HCT was unsure who was monitoring meal consumption. The interview confirmed there was no staff monitoring meal consumption at that time. Interview on 08/26/2008 at 1735 with the Registered Nurse (RN#7) revealed, the nurse had not witnessed the patient obtain milk from another patient. The interview revealed the RN had not documented the patients' meal consumption accurately. The interview revealed RN#7 corrected the patients' records.	A 619		

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Observation on 08/26/2008 at 1640 in the U2 dining room revealed 10 patients eating the evening meal. Observation revealed an LPN assigned to the dining room to record percent of meals eaten. Observation revealed, prior to leaving the dining room, the patient returns his tray to a cart. Observation revealed the LPN would ask the patient to lift the lid of the tray so the LPN can view and record percentage of meal eaten. Observation revealed there was no way of verifying that items missing from the food tray were indeed eaten by the patient. The LPN stated, "we keep an eye on them" as being the method used by staff to verify that missing food items were eaten by the patient.

Observation on 08/28/08 at 1100 on U2 3East revealed 2 patients, pt#2 and pt#3 remaining on the ward for the lunch meal. Pt#3 was prescribed a regular 2500 calorie diet and pt#2 was prescribed a 2500 calorie 2gm (gram) sodium AHA/ADA (American Heart Association/American Dietetic Association) diet. Observation revealed both patients received identical food trays which included hamburger on bun, lettuce, tomato, french fries, and two chocolate chip cookies. Observation revealed the patients were served orange punch (which was floor stock). Observation revealed no mechanism for assuring patients received food items acceptable for the diets prescribed.

A 630 — 482.28(b)(2) DIETS — A 630

Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients.

This STANDARD is not met as evidenced by:

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Based on record review, menu pattern review, meal tray cards, patient interview and staff interview, the Dietary Director failed to ensure diets were served in accordance with the menu pattern and as prescribed by the physician. Nursing staff failed to supervise and evaluate the diet delivery process to ensure that each patient receives the correct diet as prescribed by the physician and failed to enforce the care nurses full accountability for each patient receiving the correct diet.

The findings include:

A. The facility's leadership staff failed to ensure oversight to have a system or process in place to ensure Dietary Department staff were knowledgeable in the operations of scales. Staff inability to operate scales to verify serving portions results in staff serving diets contrary to the menu pattern and physician orders.
Review of the lunch menu for August 28, 2008 revealed:
Beef patty on bun:
1500 calorie diet 2.0 ounce / 1 each
French fries 4.0 ounces
2200 calorie diet 2.0 ounce / 1 each
French fries 4.0 ounces
2500 calorie diet 3.0 ounce / 1 each
French fries 8.0 ounces
3000 calorie diet 3.0 ounce / 1 each
French fries 8.0 ounces

Observations on August 28, 2008 at 11:20AM revealed food scales were not easily accessible for use in the kitchen. Based on observations, the Dietary Director was unable to calibrate the food scales to determine the ounces of beef patty served. Additional observations revealed the

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Dietary Director was not knowledgeable of operating the digital food scales. Based on these observations, the portion of beef patty could not be verified to determine the portion size to ensure compliance with the menu pattern and the physician prescribed diet order. Interview with the Dietary Manager on August 29, 2008 at 2:30PM revealed the hospital did not have a system in place to ensure servings of french fries were served in accordance with the menu pattern and compliance with the physician prescribed diet.

B. Observation of the evening meal in the U4 (adolescent unit) dining room on 08/26/2008 revealed Patients # 5 and 10 received a 3000 calorie diet with double portions of white rice. Observation revealed the patients adding multiple packs of hot sauce to the rice. Patient #5 said, "I'm adding the hot sauce to give it some taste. Interview with Patient #5 revealed "I'm still hungry after meals."

Interview with dietician #4 on 08/26/2008 at 1745 revealed "a dietary consult was ordered. We have 72 hours to complete the consult". Interview further revealed "they should have received double portions of meat, not rice. I'll make sure they get food they like."

C. Based on record review and meal tray card, Patient # 2 had physician orders to receive a 2500 calorie ADA/AHA - 2 gm NA diet. August 26, 2008, during the dinner meal at 5:00PM, Patient #2 received the meal without salt packets on the tray. A HCT was observed to offer Patient #2 the condiment tray. Patient # 2 removed two packets of salt and four packets of hot sauce from the condiment tray. The dietary tech intervened and removed the two salt packets.

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Patient #2 consumed the four packets of hot sauce on the fish.

Observation of the lunch meal on August 27, 2008 in the U2 dining room revealed a meal of a roast beef wrap, coleslaw and water melon delivered to Patient #2. Patient #2 refused the meal and stated "it looked like food from Japan".

Observation on 08/28/08 at 1100 on U2 3East revealed 2 patients, pt#2 and pt#3 remaining on the ward for the lunch meal. Pt#3 was prescribed a regular 2500 calorie diet and pt#2 was prescribed a 2500 calorie 2gm (gram) sodium AHA/ADA (American Heart Association/American Dietetic Association) diet. Observation revealed both patients received identical food trays which included hamburger on bun, lettuce, tomato, french fries, and two chocolate chip cookies. Observation revealed the patients were served orange punch (which was floor stock). Observation revealed no mechanism for assuring patients received food items acceptable for the diets prescribed.

D. Review of the menu pattern and observations of the dinner meal on August 26, 2008 revealed hospital wide, all diets were served "sugar free lime gelatin". Facility staff failed to provide regular gelatin as a substitute for regular diets and diets without restricted sugar intake. Interview with the Dietary Director on August 27, 2008 at 2:40PM stated sugar free gelatin was served to "watch calories". Further interview with the Dietary Director indicated, the facility cannot make everyone happy and for staff ease, substitutions are limited. The facility failed to have a policy to define the serving of non-sweetened items for regular and other diets

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without sugar restrictions.

E. Nursing staff failed to supervise and evaluate the diet delivery process to ensure that each patient receives the correct diet as prescribed by the physician and failed to enforce the care nurses full accountability for each patient receiving the correct diet. Nursing administration and dietary administration failed to coordinate and ensure that the diet delivery process was effective in (1) meeting the dietary needs of all patients, (2) delivering the physician's prescribed diets for all patients and (3) receiving and resolving dietary problems in order to prevent reoccurrence.

Observation on 08/28/2008 at 1725 on U2 2West, revealed 2 patients remaining on the ward for dinner. Observation revealed staff monitoring the patients. Observation revealed staff completed meal monitoring prior to both patients having finished eating. Observation revealed one patient obtained a carton of milk from another patient, and there was no staff monitoring meals at the time.

Interview on 08/26/2008 at 1725 with HCT#18 revealed the HCT was not monitoring the patients' meal/fluid consumption. The interview revealed the nurse was responsible for monitoring meals. The interview revealed the HCT was unsure who was monitoring meal consumption. The interview confirmed there was no staff monitoring meal consumption at that time.

Interview on 08/26/2008 at 1735 with the Registered Nurse (RN#7) revealed, the nurse had not witnessed the patient obtain milk from another patient. The interview revealed the RN had not documented the patients' meal consumption

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A 630	Continued From page 164 accurately. The interview revealed RN#7 corrected the patients' records. Observation on 08/26/2008 at 1640 in the U2 dining room revealed 10 patients eating the evening meal. Observation revealed an LPN assigned to the dining room to record percent of meals eaten. Observation revealed, prior to leaving the dining room, the patient returns his tray to a cart. Observation revealed the LPN would ask the patient to lift the lid of the tray so the LPN can view and record percentage of meal eaten. Observation revealed there was no way of verifying that items missing from the food tray were indeed eaten by the patient. The LPN stated, "we keep an eye on them" as being the method used by staff to verify that missing food items were eaten by the patient.	A 630		
A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on a review of menu pattern, dietary manuals, and staff interviews the Dietary Director failed to ensure the Dietary Department had current policies and procedures for dietary staff and accessible for nursing services. The findings include: Review of dietary policies on August 27, 2008 consisted of a binder with documents which included strike throughs and handwritten notes without dates. The manual lacked a current table of contents and reference list. Interview August	A 631		

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A 631	Continued From page 165 27, 2008 at 3:00PM with the Dietary Director revealed there were no other policies available for staff use. The Dietary Director was unable to verify who made the handwritten notations and dates the notations were made. Further interview revealed it would take one year to have a current and organized policy and procedure manual available for dietary staff and accessible for other departmental use. Medical Director and Clinical Director interviews on August 28, 2008 at 4:00PM revealed the two physicians were not aware all diets were served non-sweetened gelatin and fat free milk for all diets except the AHA diet. The facility failed to have a policy defining the use of non-sweetened gelatin and other products for patients without physician orders for restricted sugar diets.	A 631		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations during tour, as referenced in the Life Safety survey completed 08/28/2008, and dietary observations, the hospital failed to maintain the environment ensuring the safety and well being of patients and staff. The findings include: 1. During tour of Buildings: V-1, V-2, V-4, Woodard, and the Therapeutic Center on	A 701		

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A 701	Continued From page 166 8/28/2008 observation revealed exit doors throughout the facilities need to be placed on a Preventative Maintenance (PM) program so that all keys (grand master, master, staff keys, etc.) will work properly. Several locks would only work after the door was opened with another type of key (i.e. grand master key would only work after the door was unlocked using a master key). ~cross refer to NFPA 101 Life Safety Code Standard Tag K038 2. During tour of the facility on 8/28/2008, observation revealed the main fire alarm control panel located in the Royster Building did not get a trouble signal (audible or visual) when the dialer for the fire system was taken off line. ~cross refer to NFPA 101 Life Safety Code Standard Tag K051 3. During tour of Buildings: V-1, V-2, and V-3 on 8/28/2008, observation revealed straight chairs blocking the emergency egress path in the corridor of 2 West in the V-1 Building. Observation revealed the emergency egress path was reduced below the required minimum with vending machines in the exit corridor of 1 West in the V-2 Building. Observation revealed the emergency egress path of the 2 West, 2 East and 3 East corridors of the V-3 building were blocked by straight chairs. ~cross refer to NFPA 101 Life Safety Code Standard Tag K072 4. During tour of Buildings: V-1, V-2, V-3, Woodard, and the Therapeutic Center on 8/28/2008, observation revealed oxygen cylinders	A 701		

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A 701	Continued From page 167 mounted on crash-carts throughout the building without the proper oxygen in use warning signage. ~cross refer to NFPA 101 Life Safety Code Standard Tag K076 5. During tour of Buildings: V-2, V-4 and the Therapeutic Center on 8/28/2008 observation revealed unapproved ashtrays in the exterior exit stairwell from the West wing of the U-2 Building. Observation revealed unapproved ashtrays in the exterior exit stairwell from the 2 East wing of the V-4 building. Observation revealed unapproved ashtrays in the exterior exit stairwell from the West wing of the Therapeutic Center. ~cross refer to NFPA 101 Life Safety Code Standard Tag K066 6. During tour of the V-3 Building on 8/28/2008 observation revealed the exit discharge from the tunnel connecting the two wing's stairwells was missing the required hard surface path to the public way (this is part of the required exit discharge). ~cross refer to NFPA 101 Life Safety Code Standard Tag K038 7. During tour of the Dayroom canteen of 2 West in the V-1 Building on 8/28/2008 observation revealed coffee pots plugged into receptacles next to the sink that were not GFI (Ground-fault Interrupter) receptacles and the receptacles were not listed as protected by GFCI (Ground-fault Circuit Interrupter) breakers. During tour of the 1st floor breakroom of the V-4 Building on 8/28/2008 observation revealed an unapproved	A 701		

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A 701	Continued From page 168 surge protector in use. ~cross refer to NFPA 101 Life Safety Code Standard Tag K0147 8. During tour of the Woodard Building on 8/28/2008 observation revealed a pipe/duct chase on 2 center near room #236 equipped with a door that was not a minimum of a 45 minute fire-rated door. During tour of the Dining area of the V-1 Building on 8/28/2008 observation revealed a door hold-open device in two doors of the dining room storage area. ~cross refer to NFPA 101 Life Safety Code Standard Tag K029 9. During tour of the V-1 Building on 8/28/2008 observation revealed holes in the smoke partition on the 2 East corridor (caulking was missing at location where wires were passing through the wall). Observation during tour of the V-4 Building on 8/28/2008 revealed holes found in the smoke partition on the 2 West corridor (caulking was missing at location where wires were passing through the wall). ~cross refer to NFPA 101 Life Safety Code Standard Tag K025 10. Observations during tour on 8/28/2008 revealed the ducts passing through the smoke partitions on the 1 West and 2 West wings of the V2 Building and Room 148 of the V-3 Building have flanges around the duct work that is screwed to the partition and the duct (Flange is to be screwed to the duct work only). ~cross refer to NFPA 101 Life Safety Code	A 701		

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A 701	Continued From page 169 Standard Tag K067 11. The facility's leadership staff failed to provide oversight to ensure dietary services was provided in a safe environment for staff. Observation on August 28, 2008 at 11:55AM revealed a dietary employee filling the "plate soak tub". Observations revealed the sink had a major leak. Water was leaking from left side sink. Interview with the dietary tech revealed he/she was assigned in the plate soak area on August 27, 2008 and the left sink was leaking. Interview at 12:00NOON with the Dietary Director revealed the left sink was "always leaking". Maintenace could not fix. Sometimes we can adjust and it will not leak". Further interview revealed the Dietary Director failed to inform the Vice President whom he/she reported. ~cross refer to 482.28 Dietary Services - Tag A0618 NC00049247 NC00049083	A 701		