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

PRINTED: 02/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	344001		C 01/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOROTHEA DIX HOSP	820 S BOYLAN AVE RALEIGH, NC 27603

(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
B 118	482.61(c)(1) TREATMENT PLAN Each patient must have an individual comprehensive treatment plan. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, medical record review and staff interview facility staff failed to update a patient's treatment plan according to facility policy for 1 of 4 treatment plans reviewed (#1) Findings include: Review of facility policy "Patient Management Standards: Adult, Child and Adolescent, Forensic, Treatment and Geriatric Psychiatric Services" effective 02-2007 revealed "b. Continuing Care Treatment Planning . . 7. . The treatment team shall review and document the patient's progress towards each goal in the treatment plan and shall revise the plan as needed based on the patient's clinical condition, but no less often than weekly for the first month, monthly for the next two (2) months..." Open record review for patient #1 revealed a 51 year old female admitted to the facility on 10-28-2007 for psychotic disorder. Review revealed the patient is currently on the Adult Long-Term Female ward. Review of the "Continuing Care Treatment Plan" revealed the last date of Treatment Plan review for patient #1 was 11-29-2007 (49 days from date of record review). Interview with a Registered Nurse responsible for treatment team planning for Patient #1 on 01-17-2008 at 1535 revealed the psychiatrist in	B 118	**Dorothea Dix Hospital has a procedure to ensure that a patient's treatment plan is reviewed and updated according to the Hospital policy** The Treatment Plan review form has been simplified to encourage improved documentation for both regularly scheduled team meetings as well as treatment plan reviews conducted for clinical reasons (see attached). A memorandum from the Clinical Director was distributed to all treatment teams reminding the teams of the minimum frequency of treatment team reviews by Hospital Policy (see attached). A designated person on each treatment team has been assigned the responsibility for tracking when the treatment plan for each patient is due for review to ensure timeliness of reviews.	3/1/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia L. Christie	CEO	2/29/08

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B 118	Continued From page 1 charge of the treatment teams had resigned from the medical staff effective December 2007 and had taken two weeks off prior to the date of resignation. Interview revealed there has been no physician available to run the treatment teams for the Adult Long Term Female ward since December 2007. Interview revealed the patient's Treatment Plan was overdue for review by 19 days. Interview revealed patient #1 would require an update to the Treatment Plan in regards to assistance with Activities of Daily Living to include assistance at mealtimes. Interview confirmed facility staff had not reviewed the Treatment Plan for patient #1 per facility policy. NC00042476, NC00043075	B 118	The Social Work Qualitative Audit has been modified to include the completion of treatment plan reviews according to Hospital policy, "Patient Management Standards: Adult Child and Adolescent, Forensic Treatment and Geriatric Psychiatric Services" (see attached). All treatment plan reviews for a patient from each treatment team will be audited each month by the Social Work Supervisors. The completed audits will be reviewed and analyzed for trends by the Director of Social Work Services and presented to the Clinical Director and Clinical Management Team. Treatment plans will be a standing agenda item at the monthly Clinical Management Meeting which is chaired by the Clinical Director and includes the Hospital Director or designee, Assistant Clinical Director, Service Chiefs, Clinical Discipline Heads, Risk Manager, and Standards Director. Issues/concerns related to patient care including treatment plans are presented at this meeting for input regarding possible causes and solutions.	

TREATMENT PLAN REVIEWS

Instructions: Treatment plans must be reviewed and revised as indicated during each scheduled treatment plan meeting. For regularly scheduled team reviews, document that all areas of the plan were reviewed and indicate which aspects were revised. Treatment Plan revisions may be implemented any time during the course of treatment should also be documented on this form.

Review Date: _____ **Team Members Present** (including patient, family and community): _____

_____

Summary of review and changes to plan:

_____

_____

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_____

_____

_____

Signatures: _____

_____

Review Date: _____ **Team Members Present** (including patient, family and community): _____

_____

Summary of review and changes to plan:

_____

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_____

_____

Signatures: _____

_____

SOCIAL WORK QUALITATIVE AUDIT

Review Date_____ Assigned Social Worker_____

Patient: _____ Record Number:_____ Unit/ Division: _____

Auditor: _____ Admit Date:_____ or Transfer (in) Date:_____

I. PSYCHOSOCIAL HISTORY AND ASSESSMENT		Yes	No	N/A	COMMENTS
A. Psychosocial Assessment Completed on Time:					
▪ **Initial Bio-Psychosocial Assessment** is completed within 2 working days and placed in chart.	4				
▪ **Comprehensive Bio-Psychosocial Assessment** is completed and in chart by 8th day after admission	4				
▪ **Annual Bio-Psychosocial Assessment** is completed within 30 days prior to treatment plan re-write.	4				
Substance Abuse Assessment is fully completed.	3				
NOTE: Audit comprehensive, addendum, interim and annual assessments for the items below with focus on the past year's psychosocial functioning.					
B. Contact Person/Informant(s) are documented. (Must include a collateral contact.)	2				
C. MR/DD caregiver form completed as applicable.	2				
D. Reason for Admission/Readmission/Continued hospitalization is addressed.	2				
E. Living arrangement and options are addressed.	2				
F. The diagnostic impression includes a description of past and present bio-psychosocial functioning, education level, economic status, insight, motivation, mental status, high risk factors, and barriers to treatment/discharge. ***	5				
G. Pertinent spiritual and cultural factors are addressed.	2				
H. Family/other relationships/current support system and dynamics are assessed.	2				
I. Tentative discharge readiness impression, access to needed community resources and plan are addressed.	5				
J. High risk factors indicated in section VIII	2				

II. TREATMENT PLAN		Yes	No	N/A	COMMENTS
A. There is documentation of patient/ family/ guardian/ LME/Community provider input and recommendations for treatment and discharge planning.	5				
B. SW interventions are well-written, specific, and related to patient problems/needs as identified in the bio-psychosocial assessment. ***	5				
C. **Treatment Plan Review is completed as follows: 1)weekly for first 30 days after admission 2)monthly for 2 months after 1st month of admission 3)quarterly after 3 months of admission					This item for tracking purposes only. No score given.

III. Community Collaboration/Social Work Consents					
A. Patient /guardian consent is obtained and current for LME, Community Providers, aftercare referrals, and all Social Work services provided.	4				
B. Initial Social Work note documents that the LME/Area Program was notified within one business day of patient's admission/transfer to the unit. If patient has a substance abuse diagnosis, a consent form must be obtained before notification of LME or community svc. providers. ***	4				

SOCIAL WORK QUALITATIVE AUDIT – Page 2

Patient Chart Number_____ Assigned Social Worker_____

C. IM from Medicare letter is given to patient or person of interest within 2 days prior to discharge. This includes documentation in progress note of notice sent to person of interest. ##	2				
IV. PROGRESS NOTES		**Yes**	**No**	**N/A**	**COMMENTS**
A. Addresses patient response to treatment and documents other interventions by problem,,goal, or name of service in progress note. ***	5				
B. Social Work notes reflect community contacts, current status of discharge planning, evaluation of the patient/family response to psychosocial treatment and interventions.	5				
C. Notes are of good quality: reflect ongoing clinical social work services that are consistent with treatment plan interventions and are completed in a timely manner (minimum of 1 note/week).	3				
D. Notes and signature are legible.	2				
E. Transfer note & Intra Hospital Transfer form completed prior to transfer to another psychiatric unit.	2				
V. AFTERCARE PLAN		**Yes**	**No**	**N/A**	**COMMENTS**
A. Olmstead Review completed 60 days after admission and yearly thereafter on anniversary of admission. ##	3				
B. Discharge type, living arrangement, code, and release plans are noted, and sufficient for the level of care being recommended. ***	2				
C. Anticipated problems and social work needs / interventions are identified and explained.	5				
D. Follow up plans are identified for each service recommended as applicable	5				
D. Plan and related documentation indicate joint planning with patient, family, treatment team, LME, and other providers. (Input must be explained /specified).	5				
E. If a patient has no means to pay for their medications, the issue is addressed prior to discharge.	2				
F. Plan is signed by patient and parent/guardian if available.	2				

RATING: Each audit must meet the minimal standard of a 90% compliance rating. Only work performed by the assigned social worker (name on top of audit) will be assessed. Staff will not be held responsible for documentation of a prior social worker(s) (auditors: use "n/a" for items documented by other social workers). Please complete section below if the chart receives less than a 90% rating and note the plan of correction measures.

Rating: _____ of 100 . Percent Average _____

SUMMARY/COMMENTS/RECOMMENDATIONS:

_____

_____

_____

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_____

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A 288	482.21(c)(2) QAPI FEEDBACK AND LEARNING Performance improvement activities must track medical errors and adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospital This STANDARD is not met as evidenced by: Based on review of facility documents and staff interview, the facility's leadership failed to analyze causes and implement preventative actions for a patient elopement episode (#4) Findings include: Review of facility policy "Occurrence Reporting" effective 5-2004 revealed "Policy - The purpose of reporting occurrences and medical errors is to improve the safety of patients ...and to reduce additional risk through analysis of systems for necessary improvements." Review of facility policy "Patient Safety Plan 2007" revealed "Scope of Program...The types of errors, occurrences, or other safety issues may range from no harm "near misses" to Sentinel Events. This may include, but is not limited to ... elopements..." Further review revealed "Remedial actions for staff may be necessary in some cases, but are done so only to assist, no punish the employee." Review of a memo "Fresh Air Break / PSR	A 288	**A 288 - 482.21(c)(2) QAPI Feedback** **Occurrences and medical errors are reported and analyzed per facility policy** The following procedure was implemented on 1/21/08 to ensure that occurrences and medical errors are reported and analyzed: • The appropriate Unit Nurse Director during business hours and the House Supervisor after business hours, weekends and holidays contacts the Risk Manager for certain high risk events when they occur. These events include: - Unauthorized absences - Medical malfunctioning of equipment while in use with a patient - e.g., IV pump, ventilator - Fire setting by a patient - Confirmed sexual attack/rape - Assault with serious injury or weapon - Unexpected deaths - Suicide attempt confirmed by a physician or suicide.	1/21/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia L. Christian	CEO	2/29/08

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A 288	Continued From page 1 Transport / Off Unit Rules" dated 8-24-2006 revealed "1 One staff member in front of group (in front of all patients) 2 One staff member in rear of group (behind all patients) 3 One staff member every 6th patient. " Open medical record review for patient #4 revealed a 50 year old female admitted to the facility on 10-20-2007 for psychosis with bipolar disorder and currently a patient on the Adult Long-Term Female ward. Review of nursing documentation on 12-14-2007 at 1600 revealed "Pt (patient) went out on smoke break c (with) staff and walked away from the group. Within 5 min (minutes) of the incident pt was found missing. Two of unit staff went and found pt walking on the grounds..." Interview with Registered Nursing (RN) staff on 01-17-2008 at 1520 revealed the RN was the charge nurse on 12-14-2007 on the shift patient #4 was missing and was the RN who documented the note on 12-14-2007 at 1600. Interview revealed the memo regarding the Fresh Air Breaks also applies to the Smoke Breaks. Interview revealed the patients are taken as a group by the HCT (Healthcare Technician) staff from the ward, down the main elevator to the Main Lobby level, then to the right down the corridor to the enclosed courtyard. Interview revealed the RN was first made aware the patient was missing from the group when a nurse just coming on the next shift approached the charge nurse and asked if patient #4 was on a pass because she saw her in the front lobby speaking with the front desk staff. Interview revealed the charge nurse asked the oncoming nurse to go back to the lobby with HCT staff to bring the patient back to the ward since patient #4 was	A 288	The Risk Manager made up cards which were given to the Unit Nurse Managers and House Supervisors which include the serious events listed above for which she needs to be notified; phone numbers for her at work, home, and pager; and who else to notify. • The Risk Manager maintains a log on all events for which she is notified. Information included on the log includes date, event, time event occurred, name of person who called, and actions taken. When deemed necessary, the Risk Manager, Director of Nursing Services, and the Administrative On-Call Officer will come back to Dorothea Dix Hospital to coordinate further actions that need to be taken at that time. • The Risk Manager receives the House Supervisor's Daily Report which lists events that may require further investigation and/or analysis. This report includes the census, episodes of restrictive interventions, etc.	

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A 288	Continued From page 2 supposed to be with a group on smoke break and not on a pass. Interview revealed that once the staff got back to the front lobby of the facility, the patient had left the lobby and was seen from the front steps of the facility walking away from the facility, but still on the grounds. Interview revealed staff recovered the patient and brought her back to the ward. Interview revealed the patient was missing for approximately five to ten minutes. Further interview revealed that most unauthorized absences occur during transport of patients. Further interview revealed that when patients are being transported, since the main lobby elevators are right at the front lobby entrance to the hospital, patients will go to the left towards the lobby instead of to the right down the corridor. Interview revealed the charge nurse could not recall how many patients or staff went with the patients on the fresh air break on 12-14-2007 around 1600. Interview revealed the HCT staff are responsible for organizing the patients who can go on the fresh air breaks. Further interview revealed there should be a HCT in the front and back of the patient group to prevent unauthorized absences during transport of patients. Interview revealed the RN did complete an incident report regarding the incident prior to leaving her shift that day. Interview revealed there has been no administrative follow-up with the RN regarding the incident. Interview with HCT staff on 01-17-2008 at 1440 revealed the staff member was leading the group for a fresh air break on 12-14-2007 when patient #4 was discovered as missing. Interview revealed the HCT staff stated what was recorded in the record was incorrect. Interview revealed patient #4 was allowed to leave the ward by nursing staff on a pass by mistake. Interview	A 288	• All Occurrence Reports are sent to the Risk Manager. • The Risk Manager assesses the Log, House Supervisor's Daily Report and the Occurrence Report to determine the need for further investigation. Unit Event Analysis or Review and corrective actions including changing procedures and/or training. • The Risk Manager presents any serious events that require a Unit Event Analysis (e.g., medication errors) or Unit Event Review (e.g., patient abuse) at the monthly Patient Safety Committee. Review of cited incident by the Risk Manager found that this patient had not gone out on smoke break but instead had been mistakenly let out on a pass for which she was not eligible. A new procedure was initiated which includes steps to take before a patient is allowed off the unit - see A 395.	

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A 288	Continued From page 3 revealed the staff member stated patient #4 was not with the group on fresh air break. Interview revealed there has been no administrative follow-up with the HCT regarding the incident. Interview with the Nurse Manager for Adult Long-Term Female ward on 01-17-2008 at 1455 revealed the manager received notification of the incident regarding the unauthorized absence of patient #4 on 12-18-2007 (four days after the incident). Interview revealed the manager informed the Risk Management Department of the incident that same day. Interview confirmed the manager did not follow up with the staff involved with the incident (four weeks and six days since the incident). Interview revealed the memo "Fresh Air Break/PSR Transport/Off Unit Rules" dated 8-24-2006 is the unit policy on patient transports. Interview confirmed the management staff was unaware as to whether staff transported patients on 12-14-2007 when patient #4 was found to be missing according to the memo. Interview revealed there has been no documented monitoring of the group transport process to evaluate whether or not staff transported patients as outlined in the memo dated 8-24-2006.	A 288		
A 386	482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.	A 386	The Director of Nursing (DON) reviews all reported occurrences in conjunction with the Risk Manager. The DON maintains a log of incidents and the action involved.	2/1/08

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A 386	Continued From page 4 This STANDARD is not met as evidenced by: Based on review of facility Personnel policies and procedures, review of facility investigation reports, personnel files and staff interview, the facility's nursing leadership staff failed to ensure disciplinary actions were taken with an employee regarding a substantiated allegation of Patient Abuse for 1 of 4 personnel files reviewed (#6). Findings include: Review of facility policy "Disciplinary Action Suspension and Dismissal" effective 10-1995 revealed "B. Written Warning - Contents of a Warning - All Warnings Shall Be in writing..." Review of an investigative report dated 9-18-2007 at 1450 revealed an incident on 9-13-2007 at 1310 involving patient #9 and employee #6. Review revealed "Allegation type Patient Abuse". Further review revealed "Summary of incident. Pt (patient) alleges HCT (Health Care Technician) made threatening comments, 'go ahead and hit me, I'll lay you out' & pushed him in the shoulder after pt went into his bedroom". Further review revealed "1. Review of findings: Concern c (with) findings, 2. Actions Taken/Recommended written warning". Review of personnel file for employee #6	A 386	A further cross-check of incidents occurs each month at the time of the Human Rights Committee meeting. All patient incidents involving the Hospital Advocates are noted and reviewed. These incidents are cross-checked with the DON's action log. In addition, the DON reviews each 24-hour report from the House Supervisor for incidents requiring follow-up.	

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A 386	Continued From page 5 revealed the employee is a HCT. Review of the file revealed no documentation of a written warning regarding the incident with patient #9. Interview with employee #6 on 01-16-2008 at 1420 revealed the employee has been a HCT Child and Adolescent Acute Unit for three years. Interview revealed the HCT did recall the incident between the HCT (employee #6) and patient #9. Interview confirmed there had been no follow-up since the incident was unsubstantiated. Interview confirmed employee #6 did not receive a written warning regarding a substantiated allegation of patient abuse involving patient #9. Interview with nursing administrative staff on 01-16-2007 at 1500 revealed the allegation of patient abuse with employee #6 regarding an incident with patient #9 on 9-15-2007 was substantiated. Interview confirmed the personnel file for employee #6 did not contain a written warning for the incident involving patient #9. Interview further confirmed there was no follow-up or documented written warning issued to employee #6 regarding the incident. Interview revealed the administrative staff did not know why there was no follow-up with the employee or written warning issued. Interview confirmed the nursing leadership staff did not follow facility disciplinary policy regarding disciplinary action follow-up and documentation of written warnings.	A 386		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient	A 395	**Monitoring a Patient During Transport**	3/17/08

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A 395	Continued From page 6 This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, medical record review and staff interview, the facility's nursing staff failed to: A. monitor a patient during transport in a group outside of the locked ward in order to prevent an unauthorized absence of the patient (#4); B. obtain pulse oximetry readings as ordered by the physician for 1 of 1 patients with pulse oximetry readings ordered (#1) and C. ensure the accuracy of patient weights ordered by the physician for 1 of 1 patients sampled on a physician prescribed weight management plan (#4) Findings include: A. The facility's nursing staff failed to monitor a patient during transport in a group outside of the locked ward in order to prevent an unauthorized absence of the patient (#4) Review of a memo "Fresh Air Break / PSR Transport / Off Unit Rules" dated 8-24-2006 revealed "1. One staff member in front of group (in front of all patients). 2. One staff member in rear of group (behind all patients) 3. One staff member every 6th patient..." Open medical record review on 01-16-2008 for patient #4 revealed a 50 year old female admitted to the facility on 10-20-2007 for psychosis with bipolar disorder and currently a patient on the Adult Long-Term Female ward. Review of nursing documentation on 12-14-2007 at 1600 revealed "Pt (patient) went out on smoke break c (with) staff and walked away from the group. Within 5 min (minutes) of the incident pt was	A 395	The issue of properly transporting/ escorting patients and preventing elopements was reviewed with the Unit Nurse Managers (UNM) in their Nurse Managers meeting on February 25, 2008. The UNM's will be provided with training sheets for Nursing Staff on the proper method of transporting patients to use in re-educating their nursing staff members (RN's, LPN's, and HCT's). (see attached) After re-education, each nursing staff member will sign a sheet stating that he/she understands the proper method of transporting patients and agrees to adhere with the protocol. Each individual nursing staff member's signed sheet will be filed in his/her file maintained by the appropriate UNM. All nursing staff members are to be re-educated and have signed the acknowledgement sheet by March 17, 2008. Each UNM is to notify the Director of Nursing (DON) in writing when re-education is complete and all nursing staff members have signed the acknowledgement sheet.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	344001		C 01/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOROTHEA DIX HOSP	820 S BOYLAN AVE RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	Continued From page 7 found missing. Two of unit staff went and found pt walking on the grounds..." Interview with Registered Nursing staff on 01-17-2008 at 1520 revealed the RN was the charge nurse on 12-14-2007 on the shift patient #4 was missing and was the RN who documented the note on 12-14-2007 at 1600. Interview revealed the memo regarding the Fresh Air Breaks also applies to the Smoke Breaks. Interview revealed the patients are taken as a group by the HCT (Health Care Technician) staff from the ward, down the main elevator to the Main Lobby level, then to the right down the corridor to the enclosed courtyard. Interview revealed the RN was first made aware the patient was missing from the group when a nurse just coming on the next shift approached the charge nurse and asked if patient #4 was on a pass because she saw her in the front lobby speaking with the front desk staff. Interview revealed the charge nurse asked the oncoming nurse to go back to the lobby with HCT staff to bring the patient back to the ward since patient #4 was supposed to be with a group on smoke break and not on a pass. Interview revealed that once the staff got back to the front lobby of the facility, the patient had left the lobby and was seen from the front steps of the facility walking away from the facility, but still on the grounds. Interview revealed staff recovered the patient and brought her back to the ward. Further interview revealed that most unauthorized absences occur during transport of patients. Further interview revealed that when patients are being transported, since the main lobby elevators are right at the front lobby entrance to the hospital, patients will go to the left towards the lobby instead of to the right down the corridor. Interview revealed the charge	A 395	Each UNM will audit two (2) patient transports per month on his/her unit(s) for three (3) months starting April 1, 2008. (see attached audit form.) Results of the audits will be sent to the DON in writing and shared with the Director of Standards. When the Risk Manager reviewed this episode, it was determined that the patient was not in the smoke break group but rather had been allowed off the ward on a pass for which she was not eligible. A protocol has been put in place which specifies that nursing staff must notify the charge nurse to verify privilege level before taking a patient off the unit and that the charge nurse is accountable for knowing the number of patients off the unit at all times. These requirements were added to the training sheet on Patient Transportation and the audit sheet on Transportation/ Elopement Procedure Audit cited above.	

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A 395	Continued From page 8 nurse could not recall how many patients or staff went with the patients on the fresh air break on 12-14-2007 around 1600. Interview revealed the HCT staff are responsible for organizing the patients who can go on the fresh air breaks. Further interview revealed there should be a HCT in the front and back of the patient group to prevent unauthorized absences during transport of patients Interview with HCT staff on 01-17-2008 at 1440 revealed the staff member was leading the group for a fresh air break on 12-14-2007 when patient #4 was discovered as missing. Interview revealed the HCT staff stated what was recorded in the record was incorrect. Interview revealed patient #4 was allowed to leave the ward by nursing staff on a pass by mistake. Interview revealed the staff member stated patient #4 was not with the group on fresh air break. Interview with the Nurse Manager for Adult Long-Term Female ward on 01-17-2008 at 1455 revealed the manager received notification of the incident regarding the unauthorized absence of patient #4 on 12-18-2007 (four days after the incident). Interview revealed the manager informed the Risk Management Department of the incident that same day. Interview confirmed the manager did not follow up with the staff involved with the incident (four weeks and six days since the incident). Interview revealed the memo "Fresh Air Break/PSR Transport/Off Unit Rules" dated 8-24-2006 is the unit policy on patient transports. Interview confirmed the management staff was unaware as to whether staff transported patients on 12-14-2007 when patient #4 was found to be missing according to the memo.	A 395		

Nursing Staff: HCT & LPN Patient Transportation

- You **MUST** notify the Charge Nurse EVERYTIME you take a patient off the unit.
- When escorting a patient, the patient must walk ahead or next to the staff member- **NEVER** will the patient be behind the staff member.
- The ratio of staff to patients during escort should be based on the RN's assessment of the patient's acuity and level of observation.
- When escorting patients to/from unit activities that require absence from the unit- **ALWAYS** perform a head count before and after.

Please view policy SCPM T-4 or your unit policy manual if more clarification is required.

Nursing Staff: RN Patient Transportation

- All staff should notify the Charge Nurse when taking a patient off the unit- **FOR ANY REASON**
- When escorting a patient, the patient must walk ahead or next to the staff member- **NEVER** will the patient be behind the staff member.
- The ratio of staff to patients during escort should be based on the RN's assessment of the patient's acuity and level of observation.
- When escorting patients to/from unit activities that require absence from the unit- **ALWAYS** perform a head count before and after.
- The Charge Nurse should **ALWAYS** be able to account for the number of patients participating in off unit activities (example: smoke/ fresh air break).

Please view policy SCPM T-4 or your unit policy manual if more clarification is required.

Transportation / Elopement Procedure Audit

Review Date: _____ Auditor(s): _____

Title	Yes	No	N/A	Employee Involved
Charge Nurse				
▪ Able to identify which staff member was responsible for transportation.				
▪ Able to account for which patient(s) participated in off-unit activity.				
▪ Able to identify privilege level of all patients who participated in off-unit activity.				
HCT/LPN				
▪ Communicated with Charge Nurse which patient's would be participating in off-unit activity.				
▪ Verified privilege level of all patients participating in off-unit activity.				
▪ Head count was performed before leaving the unit and before returning from activity.				
▪ Flow sheet reflects accurate patient activity.				
▪ Staff walked behind or next to the patients at all times.				

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A 395	Continued From page 9 B. The facility's nursing staff failed to obtain pulse oximetry readings as ordered by the physician for 1 of 1 patients with pulse oximetry readings ordered (#1) Review of facility policy "Vital Signs: Documentation and Reporting" reviewed 10-2006 on 01-17-2008 revealed "Definition: ...Oxygen Saturation...". Further review revealed "Procedure ...3. The licensed nurse is responsible for the following ... Transcribing vital signs onto the patient vital sign graphic record..." Open record review for patient #1 on 01-17-2008 revealed a 51 year old female admitted to the Adult Long-Term Female ward of the facility on 10-28-2007 for psychotic disorder. Review of physician progress notes on 12-18-2007 at 1325 revealed "Baseline resp (respiratory) alkalosis (low levels of carbon dioxide in the blood) likely 2°/2 (secondary to) obesity and probable OSA (obstructive sleep apnea)..." Review of physician's orders written on 12-19-2007 at 1600 revealed "Pulse Oximetry (measures oxygen levels in the blood) q a.m. (every morning) & q hs (every evening) & record". Record review revealed from 12-19-2007 at 1800 through 01-17-2008 at 0630 19 of 58 pulse oximetry readings ordered (33%) were recorded on the "Graphic Record". Review of the Medication Administration Record (MAR) revealed an entry on 12-19-2007 scheduled for 0700 each day "Please check pulse ox q a.m. - record on graphic section" and scheduled at 2200 each day "Check O2sats when asleep q hs and record in graphics". Further review of the MAR revealed pulse oximetry readings recorded on the MAR at 0700 except on the following dates: 12-24-2007.	A 395	**Transcription of Vital Signs including Pulse Oximetry Readings on the Graphic Sheet** The issue of having to chart vital signs including pulse oximetry readings on the graphic sheet was reviewed with the Unit Nurse Managers (UNM) in the February 25, 2008 Nurse Managers Meeting. The UNM's will be provided with training sheets on the proper method of charting all vital signs on the graphic sheet and what needs to be reported to use for educating all nursing staff. (RN's, LPN's, and HCT's). (see attached) After re-education, each nursing staff member will sign a sheet stating that he/she understands the procedure for recording all vital signs on the graphic sheet and what needs to be reported and agrees to adhere with the protocol. Each individual nursing staff member's signed sheet will be filed his/her file maintained by the appropriate UNM. All nursing staff members are to be re-educated and have signed the acknowledgement sheet by March 17, 2008.	3/17/08

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A 395	Continued From page 10 12-26-2007, 12-27-2007, 12-29-2007, 12-30-2007, 12-31-2007 and 01-09-2008. Further review of the MAR revealed pulse oximetry readings recorded on the MAR at 2200 except on the day 12-20-2007. Review revealed that 50 of 58 pulse oximetry readings were recorded on the MAR (86%) Interview with nursing management staff on 01-17-2008 at 1600 revealed the manager was not aware of any policy to record pulse oximetry checks on the graphics record. Interview revealed if the physician cannot find the pulse oximetry readings on the graphics record they will go to the MAR to look for the readings. Interview confirmed the pulse oximetry readings not reflected on the MAR were also not reflected on the "Graphic Record". Interview confirmed that only 86% of the pulse oximetry readings ordered by the physician were obtained. Further interview confirmed that only 33% of the pulse oximetry readings were recorded on the "Graphic Record" as indicated on the MAR and per facility policy on documentation of vital signs. Interview confirmed nursing staff did not follow facility policy on obtaining and documenting vital signs as ordered by the physician	A 395	Each UNM is to notify the Director of Nursing (DON) in writing when re- education is complete and all nursing staff members have signed the acknowledgement sheet. The UNM's will randomly audit the graphic sheets for two patients per unit per month for proper documentation of vital signs on the graphic sheet for three (3) months starting April 1, 2008. Results of the audits will be sent in writing to the DON and shared with the Director of Standards.	
	C. The facility's nursing staff failed to ensure the accuracy of patient weights ordered by the physician for 1 of 1 sampled patients on a physician prescribed weight management plan (#4) Open medical record review on 01-16-2008 for patient #4 revealed a 50 year old female admitted to the facility on 10-20-2007 for psychosis with bipolar disorder and currently a patient on the Adult Long-Term Female ward. Review of		**Patient Weights** The issue of ensuring weights on patients are properly done and the RN's role in ensuring that weights are correctly done and documented was reviewed with the Unit Nurse Managers (UNM) in the February 25, 2008 Nurse Managers Meeting.	3/17/08

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PRINTED 02/03/2008
FORM APPROVED
OMB NO 0938-0391

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A 395	Continued From page 11 physician's orders on admission and on 11-13-2007 at 0915 revealed "Weight - weekly". Further review of physician's orders on 12-07-2007 at 1600 revealed "Weights - monthly". Review of an initial nutrition evaluation on 10-26-2007 revealed the patient was admitted with a BMI (Body Mass Index) of 33. Review of the Medical Treatment Plan dated 10-20-2007 revealed "Problems...obesity...Goals . BMI< (less than) 30. Review of the "Psychiatric Intake Evaluation" dated 10-20-2007 revealed the patient's initial weight to be 188 pounds (#). Review of the "Graphic Record" revealed on 10-24-2007 the patient's weight to be 188#, on 10-31-2007 180#, on 11-07-2007 182#, on 11-13-2007 187#, on 11-19-2007 185#, on 11-26-2007 158#, on 12-03-2007 186#, on 12-10-2007 182#, on 12-17-2007 184#, on 12-31-2007 172#, and on 01-07-2008 172#. Review revealed the patient was on a scheduled Leave of Absence from the facility. Interview with Registered Dietician staff on 01-16-2008 at 1250 revealed the staff member did the follow-up nutrition evaluation for patient #4 on 01-14-2008. Interview revealed the typical weight loss with a prescribed weight loss plan would be 2# per week. Interview revealed patient #1's weight loss from 12-17-07 through 12-31-2007 of 12# is above the expected weight loss for a two-week period. Further interview revealed the patient's weight of 158# on 11-26-2007 was probably not an accurate weight. Further interview confirmed the patient weights on 11-26-2007 and 12-31-2007 should have been repeated for accuracy. Interview with nursing management staff on 01-16-2007 at 1350 revealed the nurse who signs	A 395	The UNM's will be provided with training sheets on weighing patients to use in re-educating nursing staff (RN's, LPN's, HCT's) (included on Vital Sign Sheet) After re-education, each nursing staff member will sign a sheet stating that he/she understands the proper protocol for weighing patients and documenting weights and agrees to adhere with the protocol. Each individual nursing staff member's signed sheet will be filed his/her file maintained by the appropriate UNM. All nursing staff members are to be re- educated and have signed the acknowledgement sheet by March 17, 2008. Each UNM is to notify the Director of Nursing (DON) in writing when re-education is complete and all nursing staff members have signed the acknowledgement sheet. The UNM's will randomly audit the documentation of weights for two patients per unit per month for three (3) months starting April 1, 2008. (Included on Vital Sign audit form.) Results of the audits will be sent in writing to the DON and shared with the Director of Standards.	

Nursing Staff: HCT & LPN Vital Signs and Weights

Health Care Technicians (HCT) or Licensed Practical Nurses (LPN) are responsible for the following:

- Obtaining vital signs and weights and recording on worksheet as ordered for their assigned patients.
- Repeating any out of range vital signs.
- Notifying the RN *immediately* of all out of range vital signs.
- Submitting their vital sign worksheet to the RN 2 hours prior to the end of their shift. *Exception: Vital signs taken in the morning are to be given to the RN prior to 0745.*

- **Out of Range Vital Signs:**
- BP $\leq$ 90 or $\geq$180 Systolic or $\geq$ 110 Diastolic
- Pulse $\leq$ 48 or $\geq$ 110
- Respiration $\leq$ 12 or $\geq$ 25
- Temperature (oral or tympanic) $\leq$ 95 or $\geq$ 101 degrees Fahrenheit
- Oxygen Saturation $\leq$ 88%

Please view policy II-3-3 & II-1-1 if more clarification is required.

Nursing Staff: RN
Vital Signs/Weights

1. Vital Signs must be documented on the Graphic Record for every vital sign taken.
2. Nurses your signature at the bottom of the Graphic Record indicates that you have assessed and taken appropriate action regarding the vital sign(s).
3. Vital Signs ordered daily, weekly or monthly are routinely obtained in the morning before change of shift.
4. **Technicians/LPN's are responsible for the following:**

- Obtaining vital signs and record on worksheet as ordered for their assigned patients.
- Repeating any out of range vital signs.
- Notifying the RN *immediately* of all out of range vital signs.
- Submitting their vital sign worksheet to the RN 2 hours prior to the end of their shift. *Exception: Vital signs taken in the morning are to be given to the licensed nurse prior to 0745.*

5. **Registered Nurse is responsible for:**

- Reviewing all vital signs obtained.
- Transcribing vital signs onto the patient vital sign graphic record.
- Assessing patients with out of range vital signs.
- Notifying the medical physician or PA of any out of range vital signs within 2 hours or sooner.
- Documenting the notification and any follow-up ordered.
- Placing the worksheet on the Medical/PA clipboard.

Please view policy II-3-3 & II-1-1 if more clarification is required.

Vital Signs Including Weights Audit

Review Date: _____ Auditor(s): _____

Unit: _____ Patient Record Number: _____

	Yes	No	N/A	Employee Involved
▪ Vital Sign/Weight order was transcribed accurately with two registered nurses (RN) verification.				
▪ Vital Sign/Weight order was carried out as directed.				
▪ Vital Signs/Weight were documented on the Graphics Record sheet with coinciding RN signature.				
▪ If Vital Signs/Weights were not with in physician ordered parameters nurses took action per unit policy and documented care in progress note.				

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A 395	Continued From page 12 the graphics record is responsible for ensuring the accuracy of the information recorded and reporting any information which would be considered abnormal to the physician. Interview confirmed the weights recorded on 11-26-2007 and 12-31-2007 should have been repeated for accuracy. Interview further confirmed nursing staff should have recognized the difference in the weight loss prior to signing the graphics record. Interview confirmed nursing staff failed to ensure the accuracy of information recorded in the medical record for patient #4.	A 395		
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on review of facility policy and procedures, open medical record review, staff interview, and observations during tour, the nursing staff failed to administer medications in accordance with safe and acceptable standards of practice and in accordance with hospital policy and procedure for 1 of 2 medication passes observed (# 8). The findings include:	A 405	**Administration of medication in accordance with safe and acceptable practice and in accordance with hospital policy and procedure** The issue of using two (2) patient identifiers prior to administration of medication and having the MAR present during administration of medications was reviewed with the Unit Nurse Managers (UNM's) during the Nurse Manager's Meeting on February 25, 2008.	3/17/08

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A 405	Continued From page 13 Review of facility policy "Medication Administration Policy II-4-1 reviewed January 2007," revealed " F.Medication Administration... 5 The licensed nurse/medication aide administering the medication will do the following: a correctly identifies the patient as the one for whom the medication was prescribed or ordered, using at least two individual identifiers excluding patient location, b verifies that the medication selected for administration is the correct one based on the medication order and the product label, c verify all medications with the MAR (medication administration record) prior to administration,..." Open medical record review of patient #8 revealed a 17 year old male admitted on 12/22/2007 with Mental Retardation/Developmental Disabilities and limited communication skills to the acute child/youth services Review of a physician's order dated 1/18/08 at 1000 revealed "May give AM (morning) meds (medications) now" Review of the MAR for 1/18/2008 revealed the patient was administered Clonidine (blood pressure medication) 0.1 mg (milligram), Oxcarbazepine (seizure medication) 600 mg, and Risperdal (mood stabilizer) 1mg at 1011 by the medication nurse. Observation during tour of the acute adolescent admission unit on 1/18/2008 at 1005 of a medication pass revealed the medication nurse entered the medication room to retrieve a medication from the male patient medication cart and remove a cup of juice from the refrigerator to administer to patient #8 Observation of the male medication cart revealed no MAR on the cart with medication and identification information.	A 405	Training sheets have been developed on the proper medication administration procedures and will be provided to the UNM's for re-education of all LPN's and RN's. (see attached). At the completion of the re-education, each nurse will sign a sheet acknowledging an understanding of the process and agreement to adhere to the outlined procedure. Signed forms will be filed in each individual nurse's file maintained by the UNM. This process is to be completed by March 17, 2008. Each UNM is to notify the Director of Nurses (DON) in writing when completed. The UNM's will audit three (3) unannounced medication administration on their units each month to monitor for compliance with the proper medication procedures, particularly use of MAR sheet during administration and use of two (2) patient identifiers prior to administration of the medications. (See attached audit form.) Audits will begin April 1, 2008. The results of the audits will be sent by the UNM's to the DON in writing and shared with the Director of Standards.	

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A 405	Continued From page 14 Observation revealed the medication nurse exited the medication room, walked down the hall and entered the male day room where the patient was walking around the room. Observation revealed the nurse opened the medication into a medication administration cup and then proceeded to follow the patient around the room calling the patient's name and instructing the patient to take the medication. Observation revealed the patient stopped turned around towards the nurse then took the medication orally. Further observation revealed, no medical record or MAR present during the medication administration, no patient identifiers utilized prior to administration of the medication, and no patient identification armband or photo identification card on the patient prior to administration of the medication. Interview with the medication nurse during the observation revealed "I already know who he is." Interview with a staff nurse on 1/18/2008 at 1040 revealed the procedure for medication administration to patients is for the patient to come to the medication room. Further interview revealed the nurse is to identify the patient prior to administration of any medication with at least two patient identifiers, such as the patient's name and birthday. Interview revealed if a patient has limited communication skills or does not remember his birthday then the patient is compared to the photo on the MAR. Further interview confirmed the nurse is to have the MAR present during medication pass. Interview with administrative nursing staff on 1/18/2008 at 1155 confirmed that all nurses are to follow the medication administration policy regarding the use of 2 patient identifiers prior to	A 405	The RN involved in the violation of proper standards in administering medications who was observed by the DHRS surveyor received a Documented Counseling on January 18, 2008.	

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A 405	Continued From page 15 the administration of any medication. Further interview confirmed the nursing staff failed to follow hospital policy regarding the use of patient identifiers prior to the administration of a medication to patient #8.	A 405		

Nursing Staff: LPN & RN Medication Administration

1. Medication must be administered by a RN or LPN (LPN are excluded for IV push medications).
2. The **nurse who opens** or prepares the medication must also **document** the medication.
3. Correctly identify the patient for whom the medication is indicated using at **least two** patient identifiers :

- The individual's name
- An assigned identification number
- Telephone number
- Date of birth
- Social Security number
- Photograph

4. **Verify** that the medication selected to be administered is correct based on the Medication Administration Record (MAR) & the product label.
5. **Verify** all medications with the **MAR** prior to administration.
6. Open medication at the point of administration
7. Remain with the patient until medication is taken (excluding infusions).

Please view policy II-4-1 if more clarification is required.

Medication Administration Audit

Review Date: _____ Auditor(s): _____

Unit: _____

Title	Yes	No	N/A	Employee Involved
Medication Nurse				
▪ Verified that the medication selected to be administered was correct based on the Medication Administration Record (MAR) & the product label.				
▪ Verified all medications with the MAR prior to administration.				
▪ Correctly identified the patient for whom the medication is indicated using at **least two** patient identifiers (excluding patient location).				
▪ Opened the medication at the point of administration.				
▪ Remained with the patient until medication is taken (excluding infusions).				
▪ Nurse who opened or prepared medication is the one who documented on the MAR.				

Date: _____

I have reviewed the training materials on: (Check the ones that apply)

_____Medication Administration (RN's and LPN's only)

_____ Patient Transportation

_____Vital Signs/Weights

My signature below indicates comprehension of the procedures and agreement to follow them.

_____

Signature

_____

Print Name Title (RN, LPN, HCT