

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

PRINTED: 01/03/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>024002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/07/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALASKA PSYCHIATRIC INSTITUTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3700 PIPER STREET</b> <b>ANCHORAGE, AK 99508</b>		
(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 000}	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced survey was conducted at Alaska Psychiatric Institute (API) on 7/16-19/18. The survey found API was not in substantial compliance with Center for Medicare and Medicaid Services (CMS) requirements for hospitals.</p> <p>During a revisit survey conducted at Alaska Psychiatric Institute (API) on 11/27-30/18 and 12/5-7/18. The survey found API was not in substantial compliance with Center for Medicare and Medicaid Services (CMS) requirements for hospitals.</p> <p>The following deficiencies were noted during an unannounced revisit survey conducted on 11/27-30/18 and 12/5-7/18. The sample included 20 patients.</p> <p>State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503</p>	{A 000}	<p><b>WHO:</b></p> <p><b>WHAT:</b></p> <p><b>HOW:</b></p> <p><b>EVALUATION METHOD:</b></p> <p><b>WHO:</b> The Governing Body (GB) and CEO are responsible for this corrective action and the overall ongoing compliance.</p> <p><b>WHAT:</b> The GB shall call a regular meeting on a monthly basis unless and until the GB, upon vote, determines that meetings may be held at a different frequency.</p> <p>The GB shall call special and emergency meetings as necessary to resolve urgent topics as they arise.</p> <p>If necessary, the GB will vote electronically on any policies or matters which need to be resolved between meetings.</p> <p>The CEO shall keep the GB apprised via email about status changes regarding certification, licensing, and safety issues between meetings.</p> <p>This will ensure appropriate engagement and guidance to API on pertinent issues regarding quality and safety.</p> <p><b>HOW:</b> The regular meetings will be conducted in person when possible and called on a monthly basis until the GB votes on an alternate schedule. Additional meetings will be called, to be held in person, via teleconference, or by ad hoc process, depending on the needs of the organization.</p> <p>The Deputy Commissioner will designate a point of contact who will provide the administrative support for the GB. This point of contact will receive input, organize electronic voting, prepare the agenda, and provide other necessary administrative support.</p> <p>Specific corrective action items include:</p> <p>1) Medical Staff Bylaws and Medical Staff Rules and Regulations: The Commissioner's designated administrative support contact made diligent efforts to locate and review the 10/31-11/2 GB responses to Duane</p>		
A 043	<p><b>GOVERNING BODY CFR(s):</b> 482.12</p> <p>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible</p>	A 043			

			<p>Mayes' email and to consult with current GB members regarding those emails. Legal review and advice was also received regarding multiple proposed edits to these documents. Resulting edits were incorporated into Medical Staff Bylaws and Medical Staff Rules and Regulations.</p> <p>These documents were approved on January 11, 2019 by the Medical Staff and by the Governing Body and are effective as of that date.</p> <p>The GB and CEO will ensure compliance. Deviations affecting patient care will be presented at the next scheduled GB meeting.</p> <ol style="list-style-type: none"> <li>2) The GB will approve a policy on contracted services and will delegate to the QAPI Director (and/or CEO) creation of the evaluation form and review of contractor performance.</li> <li>3) The GB will approve the hiring of a qualified QAPI Program Director and will monitor the implementation of QAPI.</li> <li>4) The GB will ensure that Policy and Procedure (P&amp;P) is in place for investigations of abuse and neglect which determine root cause analysis to protect patients from harm. The GB will ensure compliance with these P&amp;P.</li> <li>5) Agendas and minutes from GB meetings will document compliance.</li> </ol> <p>EVALUATION METHOD: An agenda for the meeting shall be distributed at least one week before the meeting. The minutes of the previous meeting, and any documents to be discussed at the meeting shall be attached. If the previous GB meeting resulted in a change to any documents (for example, to the Medical Staff Bylaws, Rules, and Regulations, or to any policy or procedure) the edited and approved version will be attached.</p> <p>The GB will ensure that P&amp;P are updated as appropriate and will monitor compliance. The GB will require reporting from the QAPI Director. GB members may have items put on the agenda by sending items to the designated administrative support contact for the GB.</p> <p>Minutes will be kept. Minutes shall reflect the issues, discussion, voting, any follow up action(s), to include dates as necessary and responsible party. The meeting minutes shall be made available for surveyors and others per policy, statute, by-laws, and other regulatory compliance standards.</p> <p>Prior meeting minutes shall be approved in a timely manner and no later than the close of each succeeding meeting.</p>	
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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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A 043	<p>Continued From page 1</p> <p>for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...</p> <p>This CONDITION is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to effectively manage the hospital to protect patients from harm. Specifically, the facility's governing body (GB) failed to ensure processes related to medical staff bylaws; quality assessment and performance improvement (QAPI); <b>review of contract services, and implementation of patient safety policies were effectively completed and/or implemented.</b></p> <p>This failed practice placed all patients (based on a census of 41) at risk for receiving less than optimal medical and psychiatric care. Findings:</p> <p>1) The GB failed to ensure <b>medical staff bylaws had been approved</b> and implemented (A0047) and medical staff rules and regulations had been approved and implemented (A0048)</p> <p>2) The GB failed to <b>ensure contracted services were reviewed and performance improvement activities were implemented</b> through QAPI program (<b>A0083</b>) and services were provided in a safe manner (<b>A0084</b>);</p> <p>3) The GB of the hospital failed to ensure the <b>maintenance and implementation of a functioning QAPI program (A0263) and improvement activities were identified and implemented (A0283)</b>;</p> <p>4) The GB failed to ensure the processes and policies for the investigations of abuses and</p>	A 043	<p><b>A0083 / A0084</b></p> <p>WHO: The CEO is responsible for this corrective action and the overall ongoing compliance.</p> <p>WHAT: A policy on "Contracted Services" will be adopted and implemented by January 30, 2019.</p> <p>A grid of current contracts will be completed by January 30, 2019 to include a priority ranking assignment.</p> <p>HOW: A listing of contracts in Microsoft Excel will be prepared to prioritize direct patient care related contracts first and then others affecting the facility, along with a date for completion indicator.</p> <p>The evaluator will fill out API's contracted evaluation form and submit the completed form to the COO for signature. The COO will submit the contract evaluation worksheets to the QAPI Director with a copy to the CFO contracts team.</p> <p>EVALUATION METHOD:</p> <p>The contract evaluation form shall be used to determine contract terms compliance. Summary findings on the contract evaluation form shall include but are not limited to:</p> <ol style="list-style-type: none"> <li>1) Current state and or federal licensure / certification / accreditation</li> <li>2) Evaluation for services provided to the written terms of the contract</li> <li>3) Staff/Vendor have proof of training, competency, certification, or licensure (as applicable)</li> <li>4) Performance improvement goals met as outlined in the contract or addendum</li> </ol>	
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- 5) Documentation of any performance concerns along with recommendations to proceed to contract renewal, re-evaluate contract, or indicate other actions needed.

The COO or QAPI Director will report deviations from compliance with contracted services, as noted during the contract evaluation process or through any other quality improvement reporting process [ie: A Plan, Do, Study, Act – (PDSA) Process] to the API Executive Team Leadership and the GB upon discovery, or upon the next scheduled meeting.

**A0283**

**WHO:** The CEO is responsible for this corrective action and the overall ongoing compliance.

**WHAT:** A policy on “Contracted Services” will be adopted and implemented by January 30, 2019.

A grid of current contracts will be completed by January 30, 2019 to include a priority ranking assignment.

**HOW:** A listing of contracts in Microsoft Excel will be prepared to prioritize direct patient care related contracts first and then others affecting the facility, along with a date for completion indicator.

The evaluator will fill out API’s contracted evaluation form, submit the completed form to the COO for signature, the COO will submit the contract evaluation worksheets to the QAPI Director with a copy to the CFO contracts team.

**EVALUATION METHOD:**

The contract evaluation form shall be used to determine contract terms compliance. Summary findings on the contract evaluation form shall include but are not limited to:

- 1) Current state and or federal licensure / certification / accreditation
- 2) Evaluation for services provided to the written terms of the contract
- 3) Staff/Vendor have proof of training, competency, certification, or licensure (as applicable)
- 4) Performance improvement goals met as outlined in the contract or addendum

		<p>Documentation of any performance concerns along with recommendations to proceed to contract renewal, re-evaluate contract, or indicate other actions needed.</p> <p>The COO or QAPI Director will report deviations from compliance with contracted services, as noted during the contract evaluation process or through any other quality improvement reporting process [ie: A Plan, Do, Study, Act – (PDSA) Process] to the API Executive Team Leadership and the GB upon discovery, or upon the next schedule meeting.</p> <p>Annually, at the September GB meeting, the GB will review the list of all contracts for compliance and leadership recommendations, based upon the process described above.</p> <p><b>A0263 / A0283</b> WHO: The CEO, GB, and QAPI Director are responsible for this corrective action and the overall ongoing compliance.</p> <p>WHAT: A QAPI program shall be maintained at the hospital level. This includes, at minimum; the ongoing quality assurance, safety, and hospital readiness functions commensurate with a psychiatric hospital. This includes the ongoing evaluation and compliance with the Joint Commission, Centers for Medicaid and Medicare Services, and State of Alaska Licensing and Certification program requirements. This includes ensuring ongoing PI projects for contracted services as well PI projects for the 23 COPs as outlined by CMS. The QAPI Director shall be engaged in other such committees as the Environment of Care, Safety Committee, and the Life Safety Code Committee.</p> <p>HOW: The QAPI department shall be headed by a qualified leader. This leader will have proper investigatory skills and credentials such that their partnership with the API Nursing / Hospital Education department ensures compliance to proper process for investigating, and recommending disposition of, and reporting allegations of abuse and neglect. A summary of such cases, and recommendations and disposition shall be reported to GB at each scheduled meeting.</p> <p>API Leadership and State of Alaska (SOA) GB Leadership shall ensure the proper resources (funding, staff, leadership emphasis, and time) are allocated to ensure the ongoing compliance with this program, services, activities, and functions.</p>
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EVALUATION METHOD: Annually, in September, the GB shall evaluate the effectiveness of the CEO, to include those clinical, safety, and other quality outcomes commensurate with a psychiatric hospital.

This evaluation (success criteria) shall be accomplished by profiling, and reporting monthly (to Senior Management, Executive Team, and the GB) industry accepted quality metrics as outlined in the QAPI program (ORYX indicators, other patient safety indicators, etc). For example, seclusion and restraint rates, allegations of abuse and neglect rates must improve.

API GB, Executive Team and Senior Management Team leadership have received training on "zero harm" best practices, and *culture change*. A written plan and program on implementing these two important changes, to include timelines for success, shall be developed by January 30, 2019, and approved by the GB in February.

**CEO Signature and Date:**



GAVIN K. CARMICHAEL  
MBA, FACHE

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A 043	Continued From page 2 neglect were implemented <b>to determine root cause analysis (RCA) (A0283)</b> and protected patients from potential harm (A0145).	A 043	<b>A0283 / A0145</b> WHO: The QAPI Director, reporting to the CEO and GB, is responsible for this corrective action and the overall ongoing compliance.  WHAT: All RCAs initiated shall be assigned to a qualified investigator. This may be a SMT or ET member, or a licensed independent practitioner (LIP). Active RCAs shall be completed and reported- out to the API ET within 30 days of assignment, unless upon extenuating circumstances / occasions a reasonable extension is granted.  HOW: A roster of outstanding and assigned RCAs, and their status, shall be reported to the ET and GB monthly.  EVALUATION METHOD: The "Assigned RCA roster" shall be reviewed by the ET monthly. Reports of Findings (RoF) shall be presented to the ET, and summary findings shall be reported to the GB at regularly scheduled meetings.		
A 047	MEDICAL STAFF - BYLAWS CFR(s): 482.12(a)(3)  [The governing body must] assure that the medical staff has bylaws.  This STANDARD is not met as evidenced by:  Based on record review and interview the Governing Body (GB), of the facility, failed to ensure medical staff had current bylaws in accordance with Federal Laws and regulations. This failed practice places all patients (based on a census of 41) at risk for less than optimal necessary care and services in a safe setting. Findings:  Record review, on 11/28-29/18 of the "[Alaska Psychiatric Institute - API] Governance Committee Urgent Meeting ...," dated 9/28/18, revealed "Medical Staff Bylaws Update The bylaws and medical staff rules and regulations need to be updated ...The <b>[governing body] will review the electronic copy of the Medical Staff Bylaws to provide feedback and approval for implementation.</b> "  Review of a facility provided e-mail, dated 10/31/18, revealed the Chief Executive Officer (CEO) sent an e-mail to voting members of the Governing Body (GB) which stated "Attached are the Medical Staff Bylaws and Medical Staff Rules and Regulations that need approval for [Alaska	A 047	<b>A043 / A047 (invest A &amp; N timely)</b>  WHO: The CEO is responsible for corrective action and ongoing compliance.  WHAT: The CEO will ensure the QAPI Director has proper investigatory skills and credentials such that their partnership with the API Nursing / Hospital Education department ensures compliance to proper process for investigating, and recommending disposition of, and reporting allegations of abuse and neglect.  HOW: A log of all ongoing investigations shall be presented to the ET, and summary findings shall be reported to the GB at regularly scheduled meetings.  EVALUATION METHOD: A summary of such cases, and recommendations and disposition shall be reported to GB at each scheduled meeting.		

**A047 / A048**

WHO: The Director of Psychiatry (DoP) is responsible for corrective action and ongoing compliance.

WHAT: The DoP shall ensure Medical Staff By-Laws, and Rules and Regulations are evaluated annually by the GB.

HOW: The DoP shall review the Medical Staff bylaws and Rules and Regulations before the August GB meeting. The August GB agenda will include a report from the DoP regarding changes or lack thereof. Any proposed edits shall be attached to the August GB agenda.

GB members and Medical Staff members will submit proposed edits to and inquiries about Medical Staff Bylaws, Rules, and Regulations to the designated point of contact for the GB.

If a proposed edit comes from Medical Staff, the proposed edit shall include a statement regarding whether the Medical Staff as a body has approved, not approved, or not discussed the proposed edit(s).

If the proposed edit comes from a GB member, the proposed edit shall include a statement regarding whether or not the GB has approved, not approved, or not discussed the proposed edit.

All GB member and Medical Staff proposed edits and inquiries will be circulated as attachments to the next GB meeting agenda.

Voting on proposed edits will take place during the GB meeting. Inquiries will be addressed during the meeting.

If the GB approves edit(s), the Medical Staff shall address the GB-approved edits within 7 days of the GB meeting. The CEO shall report to the GB at the next GB meeting whether the Medical Staff approved or did not approve of the GB-approved edit.

If both the GB and Medical Staff approve an edit, the designated point of contact for the GB will ensure that the official Medical Staff Bylaws, Rules, and Regulations reflect the edit. The designated point of contact shall attach the edited version to the next GB meeting agenda and notify the Medical Staff of the edit.

			<p>EVALUATION METHOD: The GB minutes will reflect that the DoP reviewed the Medical Staff bylaws and Rules and Regulations, if the DoP proposed any changes or proposed no changes and what if any action was taken.</p>	
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A 047	<p>Continued From page 3</p> <p>Psychiatric Institute - API] to meet the Plan of Correction with [Center for Medicare and Medicaid - CMS] ...previously provided copies at the last in-person Governance Meeting .... this is a vital part of updating requirements in the plan of correction by noon, Thursday 11/2/18 or sooner ..."</p> <p>Review of three GB (GB) members' submissions for edits to the Medical Staff Documents revealed a <b>multitude of edits and inquiries related to the Medical Staff Bylaws, Rules and Regulations</b>. These edits and inquiries were submitted via e-mail from 10/31/18 to 11/1/18 (over a month after the effective date of the provided documents during the survey) in response to a request submitted by the Chief Executive Officer (CEO).</p> <p>Review of a facility provided e-mail, dated 10/31/18, revealed the CEO sent an e-mail to voting members of the GB which stated "Attached are the Medical Staff Bylaws and <b>Medical Staff Rules and Regulations that need approval for</b> [Alaska Psychiatric Institute - API] to meet the Plan of Correction with [Center for Medicare and Medicaid - CMS] .....previously provided copies at the last in-person Governance Meeting ....this is a vital part of updating requirements in the plan of correction by noon, Thursday 11/2/18 or sooner .. "</p> <p>Review of the facility's Medical Bylaws and Rules and Regulations, dated 9/2018, <b>revealed several edits were not corrected</b> in the documents.</p> <p>Furthermore, no evidence was provided by the facility to show inquiries made by a GB member were addressed to the GB regarding the Medical</p>	A 047			

	Staff Documents. In addition, edits were			
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A 047	Continued From page 4 submitted individually by the GB members without a formal presentation of all suggested edits being reviewed as whole by the GB.  During an interview on 11/29/18 at 10:38 am Office Staff (OS) #1 stated the Medical Bylaws and Medical Rules and Regulations were under review. The <b>Medical Rules and Regulations only had suggestions made by the Chief of Psychiatry with no further comments by the GB.</b> During this interview the OS was only able to provide a <b>draft copy</b> of the Medical Bylaws, as well as, the Medical Rules and Regulations.  Review of the facility provided "Governance Document," dated 11/2/18, revealed the API medical staff shall develop and adopt a Medical Staff Document with rules and regulations to establish framework for self-governance of medical staff activities and provide accountability to the CEO and Governance. <b>The CEO and API Governance must approve the Medical Staff Document, rules, and regulations,</b> and any amendments prior to becoming effective. Neither body may unilaterally amend the Medical Staff Document.	A 047			
A 048	MEDICAL STAFF - BYLAWS AND RULES CFR(s): 482.12(a)(4)  [The governing body must] approve medical staff bylaws and other medical staff rules and regulations.  This STANDARD is not met as evidenced by:  Based on record review and interview the facility	A 048			

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A 048	<p>Continued From page 5</p> <p><b>failed to ensure medical staff bylaws and medical staff rules and regulations with revisions were approved</b> and implemented by the governing body (GB). This failed practice placed all patients (based on a census of 41) at risk for receiving less than optimal medical and psychiatric care. Findings:</p> <p>Review of the "[Alaska Psychiatric Institute - API] Governance Committee Urgent Meeting ...," dated 9/28/18, revealed "Medical Staff Bylaws Update The bylaws and medical staff rules and regulations need to be updated ...The [governing body] will review the electronic copy of the Medical Staff Bylaws to provide feedback and approval for implementation."</p> <p>Review of a facility provided e-mail, dated 10/31/18, revealed the Chief Executive Officer (CEO) sent an e-mail to voting members of the Governing Body (GB) which stated "Attached are the Medical Staff Bylaws and Medical Staff Rules and Regulations that need approval for [Alaska Psychiatric Institute - API] to meet the Plan of Correction with [Center for Medicare and Medicaid - CMS] ...previously provided copies at the last in-person Governance Meeting.... this is a vital part of updating requirements in the plan of correction by noon, Thursday 11/2/18 or sooner ..."</p> <p>Medical Staff Bylaws:</p> <p>Review of a facility provided e-mail, dated 10/31/18, revealed GB Member #1 responded to the CEO's e-mail by stating the Medical Staff Bylaws had several corrections and formatting issues that needed to be made and provided an attachment with suggested edits.</p>	A 048			

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A 048	<p>Continued From page 6</p> <p>Review of a facility provided e-mail, dated 11/1/18, revealed GB Member #2 stated the Medical Bylaws had several typo corrections and a clarification question regarding the Commissioner's designation of "ex officio".</p> <p>During an interview on 11/29/18, Office Staff (OS) #1 stated the Medical Staff <b>Bylaws were still in draft form</b> but had been reviewed by the GB and the facility was still awaiting a final approval.</p> <p>Review of the facility provided draft form of the Medical Bylaws provided 11/29/18 with an "Effective date 8/2018," revealed the front page stated "This document within is the bylaws for the Medical Staff of the Alaska psychiatric Institute and <b>was approved by the sitting Medical Staff on September 2018.</b>" Further review revealed <b>none of the provided changes by the GB were illustrated.</b></p> <p>Review of a facility provided second draft form of the Medical Bylaws provided 12/10/18 with an "Effective date 8/2018," revealed the front page stated "This document within is the bylaws for the Medical Staff of the Alaska Psychiatric Institute and was approved by the sitting Medical Staff on September 2018." Further review <b>revealed some of the changes by the GB were illustrated.</b></p> <p>Review of a third copy of the Medical Bylaws provided 12/13/18 with an "Effective date of 9/2018," revealed the front page stated "This document within is the bylaws for the Medical Staff of the Alaska Psychiatric Institute and was approved by the sitting Medical Staff on September 2018." Further review <b>revealed some of the suggested changes by the GB</b></p>	A 048			

	Member #2			

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>024002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/07/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALASKA PSYCHIATRIC INSTITUTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3700 PIPER STREET</b> <b>ANCHORAGE, AK 99508</b>		
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A 048	<p>Continued From page 7 were not illustrated.</p> <p>No additional documentation was provided to show the GB's approval of all changes submitted by members. GB Member #2's inquiry regarding <b>the concern with the Commissioner's designation of "ex officio" was not addressed in any documents</b> provided by the facility. The three voting members that participated in the edits provided responses to the document, dated 9/2018, electronically to the CEO between 10/31/18 and 11/1/18.</p> <p>Medical Staff Rules and Regulations:</p> <p>Review of a facility provided e-mail, dated 11/1/18, revealed GB Member #2 stated the Medical Staff Rules and Regulations had <b>typos and a clarification question</b> regarding if a section of the document had been reviewed by legal staff. This e-mail was in response to the CEO's request via e-mail on 10/31/18.</p> <p>During an interview on 11/29/18, OS #1 stated the Medical Rules and Regulations were reviewed by the <b>Chief of Psychiatry and sent to the GB with no returned comments or changes at that time. In addition the OS #1 stated the Medical Staff Rules and Regulations still needed a completed signature page from the GB.</b></p> <p>Review of the facility provided draft form of the Medical Rules and Regulations, provided on 11/29/18 with an "Effective date 8/2018," revealed none of the provided changes by the GB were illustrated.</p> <p>Review of a facility provided second copy of the Medical Rules and Regulations, obtained</p>	A 048			

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A 048	Continued From page 8 12/10/18 with an "Effective date 8/2018," revealed the provided edits from GB Member #2 had not been corrected.  No additional documentation was provided to show the GB's approval of all changes submitted by members. GB Member #2's inquiry regarding if a legal staff had reviewed a particular section was not addressed in any documents provided by the facility. <b>No completed signature page</b> was provided in relation to the Medical Staff Rules and Regulations.  Review of the facility provided "Governance Document," dated 11/2/18 revealed the "API Governance is responsible for approving facility medical staff or professional staff, Medical Staff Document, rules, and regulations...." <b>In addition the document revealed the API medical staff shall develop and adopt a medical Staff Document with rules and regulations to establish framework</b> for self-governance of medical staff activities and provide accountability to the CEO and Governance. The CEO and API Governance must approve the Medical Staff Document, rules, and regulations, and any amendments prior to becoming effective. Neither body may unilaterally amend the Medical Staff Document.	A 048			
A 083	<b>CONTRACTED SERVICES</b> CFR(s): 482.12(e)  The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a <b>contractor</b>		<b>A083 (contracted services WEKA)</b>  A 083 WHO: The GB, QAPI Director, and COO are responsible for corrective action and ongoing compliance with this issue.  WHAT: The GB will adopt a Contracted Services policy by January 30, 2019. This policy will require contractors to be subject to the same QAPI requirements as direct hospital services and that contracted service providers are assessed for competence in their work. Issues		

	<p>of services (including one for shared services and</p>		<p>with contractor performance will be reported to the GB.</p> <p>The GB will adopt a QAPI policy by January 30, 2019.</p> <p>The COO will ensure contracted services team members are appropriately trained (according to NAPPI standards and/or any other current appropriate policies and standards), and that documentation to this effect is provided to the API Hospital Education department for archiving. Such documentation shall be made available to surveyors, or other deemed appropriate entities or agencies.</p> <p>The QAPI Director will ensure that contracted services comply with standards and will address any deficiencies. Any deficiencies affecting patient care or safety will be reported to the GB.</p> <p>WHEN: Proof of appropriate remedial training for the WEKA contracted services team members involved in this incident, as required by policy, shall be available in API Hospital Education Department no later than January 30, 2019.</p> <p>EVALUATION METHOD: A roster of trained contracted (WEKA security services) personnel shall be present. If after appropriate training, a WEKA staff member performs services in a way inconsistent with training, then the CEO or COO will notify WEKA of the incident and inform WEKA that API considers the incident unacceptable. The QAPI Director shall ensure that proper follow up takes place on the incident.</p>	
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A 083	<p>Continued From page 9</p> <p>joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review and interview the facility's Governing Body (GB) failed to ensure identified performance problems by contracted support services (<b>WEKA- security staff hired within the facility to help with escalated situations who must comply with facility approved NAPPI hold techniques) was analyzed and implemented into Quality Improvement (QI) activities.</b> This failed practice placed all patients (based on census of 41) in the facility at risk for injury/harm or having their rights violated. Findings:</p> <p>Review of the facility policy "Quality Assurance and Performance Improvement (QAPI) Program," dated 10/31/18, revealed <b>the QAPI plan established a system that included an ongoing assessment, using internal and external knowledge and experience to prevent errors</b> and maintain and improve health care safety and quality. This was done by identifying and mitigate risk and medical errors by analyzing data, monitoring, improving and sustain performance.</p> <p>During the survey the facility provided two policies entitled "Quality Assurance and Performance Improvement (QAPI) Program [QI-010-06.01]," dated 10/31/18. Review of <b>both policies revealed they did not match under Executive Responsibilities and Prioritization.</b></p>	A 083			

	During an interview on 11/29/18 the Chief Nursing Officer (CNO) stated the facility currently did not			
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A 083	<p>Continued From page 10</p> <p><b>have a Quality Assurance Director or Risk Management Lead.</b> In addition, she stated the staff who performed risk management duties was reassigned to conduct environment of care duties only. The position for Quality Assurance Director and Risk Manager were not occupied at the time of survey. The CNO stated the Quality Assurance and Performance Improvement (QAPI) program was to review audits conducted by nursing staff, but due to no QAPI program no audits have been analyzed at time of survey.</p> <p>Review of the facility policy "Risk Management Plan," dated 12/7/12, revealed Risk Management was to work under the QAPI umbrella to facilitate identification, follow-up, corrective action or prevention of actual or potential problems/needs in patient care and safety.</p> <p>During an interview on 11/29/18 the Chief of Operations (COO) stated the facility was lacking a QAPI department but the facility had attempted to hold a type of QAPI meeting but was unable to provide any meeting minutes or provide details of the outcome related to this meeting. The COO stated the Executive Team was attempting to develop sub-committees that would report to the Executive Team since the facility didn't have a QAPI program. The data would then be used by the Executive Team to determine QAPI projects, but the COO stated these committees were still in the beginning phases of development.</p> <p>During an interview on 12/5//18 at 1:30 pm, when asked about an event in which <b>WEKA</b> staff had not implemented NAPPi (Non-Abusive Psychological and Physical Intervention -</p>	A 083	<p><b>A083</b> See O083 answer above.</p>		

	behavior assessment, de-escalation, and defusing skills for humane and effective response			
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A 083	<p>Continued From page 11</p> <p>to violent and/or unsafe patient behavior) restraint techniques for 1 patient (#9), NAPPI Instructor #1 stated he/she completed <b>the audit of this video on 12/2/18 at 6:30 pm and sent the report, which included the inappropriate NAPPI hold techniques, to the Chief Nursing Officer (CNO).</b></p> <p>Review of the WEKA staff work schedule, from 12/2/18 to 12/7/18, revealed the facility could not provide an account of <b>WEKA staff #1's and #2's hours worked within the facility after the inappropriate NAPPI techniques were identified and reported.</b></p> <p>Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "Those who apply the restraints ...and those who monitor patients while restrained ...will receive the training, and demonstrate the safe use of all approved restraint types, including physical hold techniques ..."</p> <p>Further review revealed: "Only NAPPI approved techniques for physical intervention will be used ...High risk considerations for ...physical or mechanical restraint(s) include ...Restraint in supine position (laying down, face up) may result in aspiration. <b>Restraint against a wall or other vertical surface is not permitted under any circumstances.</b> Pressure placed on the neck may result in an obstructed airway, and is prohibited. Weight placed on the back, abdomen, or chest may result in asphyxiation."</p> <p>Review of the facility's policy, "Quality Assurance Performance Improvement (QAPI) Program", dated 10/31/18, <b>revealed no information about assessing the services provided by the contractor WEKA was reported to QAPI.</b></p>	A 083			

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A 083	Continued From page 12  Review of the contract with the facility and WEKA, dated 3/15/18, revealed no information about evaluating performance and/or concerns and <b>how the facility would ensure improvement of services.</b>  During the survey from 11/27-30/18 and 12/5-6/18 the facility was asked to demonstrate evidence of its QAPI program for effectiveness and functionality. <b>No evidence of QAPI meetings or activities</b> , per facility policy, were provided by the end of survey.  Review of the facility provided "Governance Document," dated 11/2/18, revealed it was a responsibility of the Governing Body (GB) to assure the Chief Executive Officer (CEO) used appropriate and available resources to support the quality assessment and improvement functions and risk management functions related to patient care and safety. <b>In addition, the document revealed the GB was responsible for the annual reporting and approval of the performance improvement plan, as well as, quarterly QAPI reports.</b>	A 083	<b>A084 –(contracted svc training WEKA)</b> WHO: The GB, QAPI Director, and COO are responsible for corrective action and ongoing compliance with this issue.  WHAT: The GB will adopt a Contracted Services policy by January 30, 2019. This policy will require contractors to be subject to the same QAPI requirements as direct hospital services and that contracted service providers are assessed for competence in their work. Issues with contractor performance will be reported to the GB.  The COO will ensure contracted services team members are appropriately trained (according to NAPPI standards and/or any other current appropriate policies and standards), and that documentation to this affect is provide to the API Hospital Education department for archiving. Such documentation shall be made available to surveyors, or other deemed appropriate entities or agencies.  The QAPI Director will ensure that contracted services comply with standards and will address any deficiencies. Any deficiencies affecting patient care or safety will be reported to the GB.		
A 084	CONTRACTED SERVICES CFR(s): 482.12(e)(1)  The <b>governing body must ensure</b> that the services performed under a contract are provided in a safe and effective manner.  This STANDARD is not met as evidenced by:	A 084			

			<p>WHEN: Proof of appropriate remedial training for the WEKA contracted services team members involved in this incident, as required by policy, shall be available in API Hospital Education Department no later than January 30, 2019.</p> <p>EVALUATION METHOD: A roster of trained contracted (WEKA security services) personnel shall be present. If after appropriate training, a WEKA staff member performs services in a way inconsistent with training, then the CEO will notify WEKA of the incident and inform WEKA that API considers the incident unacceptable. The QAPI Director shall ensure that proper follow up takes place on the incident.</p>	
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A 084	<p>Continued From page 13</p> <p>Based on record review, camera review, and interview the facility's <b>governing body failed to ensure a contracted security service (WEKA) provided duties in a safe and effective manner</b>. Specifically, the facility failed to ensure the safe application of NAPPI (Non-Abusive Psychological and Physical Intervention - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) restraint techniques by contracted personnel for 1 patient (#9), out of 6 sampled patients who experienced a seclusion or restraint. This failed practice placed the patient at risk for injury and created a non-therapeutic environment. Findings:</p> <p>Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #9 was admitted to the facility with diagnoses that included major depression and post-traumatic stress disorder (PTSD - anxiety and flashbacks triggered by a traumatic event). Further review revealed the Patient had a history of physical abuse.</p> <p>Review of Patient #9's medical record revealed a Brief Manual Restraint (BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely) occurred on 11/23/18 at 9:38 pm and 5- point restraint (a method of using a mechanical device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. 5-point restraint - 2 wrist restraint, 2 ankle restraints, and one restraint across the Patient's chest while the Patient is lying on his/her back) occurred at 10:12 pm.</p> <p>Camera review on 12/5/18 at 1:15 pm, of the</p>	A 084			

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A 084	<p>Continued From page 14</p> <p>11/23/18 incident revealed the following non-approved NAPPI techniques used by Psychiatric Nursing Assistants (PNAs) and WEKA support staff (contract security staff hired within the facility to help with escalated situations who must comply with facility approved NAPPI hold techniques):</p> <ul style="list-style-type: none"> <li>- 9:38:00 pm - <b>Patient #9 kissed a peer.</b> To stop the behavior, PNA #4 placed his/her hand on Patient's forehead and pushed his/her head away from the peer. This caused the Patient to become assaultive.</li> <li>- 9:38:09 pm - As Patient #9 stood up, PNA #4 grabbed the Patient from behind, over his/her arms, and <b>the PNA locked his/her arms together in front of Patient's body</b> (hugging him/hertightly from behind).</li> <li>- 9:38:14 pm - Due to <b>head butting behavior</b>, PNA #5 was observed to grab the back of Patient #9's neck and place his/her other hand on Patient's forehead.</li> <li>- 9:38:27 pm - Staff attempted to walk Patient #9 to the Oak Room (a separate room in the facility for seclusion or restraint) however the Patient was able to struggle free. At 9:38:29 pm, <b>WEKA staff #1 and PNA #5 placed Patient #9 in another BMR by placing the Patient's chest against the wall.</b></li> <li>- 9:38:31 pm - The audible comment "get [him/her] off the wall" can be heard (unknown who spoke).</li> <li>- 9:38:32 pm - WEKA Staff #2 grabbed Patient #9's legs as the Patient was against the wall.</li> </ul>	A 084			

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A 084	<p>Continued From page 15</p> <p>-9:38:36 pm - WEKA Staff #1, #2, and PNA #5 took Patient #9 to the floor in a controlled manner. Staff restrained the Patient on the floor for 6 minutes, patient positioned on his/her back and staff holding all limbs. Patient #9 walked to the Oak Room at 9:44:13 pm after other staff arrived.</p> <p>- 10:04:43 pm - Patient #9 became assaultive in the Oak Room, BMR on the restraint bed initiated (Patient placed on his/her back). <b>WEKA Staff #2 was observed to place his/her right knee on Patient #9's right arm</b> (the arm was raised, bent at 90 degrees, back of hand lying flat on the restraint bed), at the elbow and upper arm junction. The WEKA Staff #2 apply pressure with his/her knee to keep arm stationary. WEKA Staff #2 restrained the arm <b>in this manner for 2 minutes and 15 seconds.</b></p> <p>- 10:10:54 pm - A release from the BMR was attempted, to lock Patient #9 in seclusion, however he/she became assaultive again. As BMR was re-initiated (Patient was standing), <b>WEKA Staff #2 was observed to put his/her right hand on Patient's left facial cheek and grab the back of Patient #9's neck with his/her left hand. WEKA Staff #2 pushed Patient's head down onto the restraint bed, forcing Patient #9 to bend over, face to bed.</b></p> <p>- 10:12:16 pm - As restraints were being placed (Patient laying on back on restraint bed), it was observed that <b>WEKA Staff #2 leaned his/her left elbow onto Patient #9's chest and pushed down with his body weight to restrain Patient's shoulder and chest.</b></p>	A 084			

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A 084	<p>Continued From page 16</p> <p>During an interview on 12/5/18 at 1:30 pm, NAPPI Instructors #1 and #2 stated these non-approved techniques are not safe and should not have been used:</p> <ul style="list-style-type: none"> <li>- Neck holds, as seen multiple times in the camera review, are extremely dangerous and could injure the neck.</li> <li>- A Patient cannot be held against a wall or hard surface, as this can impede breathing.</li> <li>- <b>WEKA Staff #2</b> increased the risk to Patient #9, as well as <b>WEKA #1 and PNA #5 when he/she immobilized the Patient's legs as the Patient was held against the wall.</b> This could have caused the group to trip and fall, which could have potentially caused injury.</li> <li>- <b>WEKA Staff #2 increased the risk of injury to Patient #9's arm by restraining it with his/her knee.</b></li> <li>- <b>WEKA Staff #2 increased the risk of breathing difficulty when he/she leaned onto Patient #9's chest.</b></li> </ul> <p>During an interview on 12/6/18 at 2:45 pm, the Chief of Operations stated he reviewed WEKA Staff interactions and concluded the actions taken by the contracted staff were inappropriate and unacceptable.</p> <p>Review of the "API Governance Committee Urgent Meeting ...," dated 9/28/18, revealed "Staff Safety A contract has been in place with [Security Support] to provide security serves from morning till evening at API. This has been successful model, and the contract is currently under review.</p>	A 084			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>024002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/07/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALASKA PSYCHIATRIC INSTITUTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3700 PIPER STREET</b> <b>ANCHORAGE, AK 99508</b>		
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A 084	<p>Continued From page 17</p> <p>There <b>was no information about prior reviews and how the GB</b> monitored contacted staff to ensure the safety and well-being of the patients.</p> <p>Review of the State of Alaska Amendment to Professional Services Contract, dated 10/31/18 revealed an Appendix C - Amendment 3 that stated "API requires the presence and engagement of security staff on API clinical units on campus so as to ensure patient and staff safety ...Security Staff Training ...The contractor must ensure all security staff meet the requirements outlined in the original contract prior to provision of any of the service components outlined in this contract."</p> <p>Review of the Standard Agreement Form for Professional Services, dated 3/15/18 revealed Appendix C - Descriptions of Services. Review of Appendix C revealed "<b>Should physical patient contact occur, Contractor shall use only minimally necessary force to gain control of the situation.</b>"</p> <p>Review of the facility's policy "Seclusion and Restraint," dated 6/1/18, revealed: "<b>Those who apply the restraints ...and those who monitor patients while restrained ...will receive the training, and demonstrate the safe use of all approved restraint types, including physical hold techniques ...</b>"</p> <p>Further review revealed: "<b>Only NAPPI approved techniques for physical intervention will be used</b> ... High risk considerations for ...physical or mechanical restraint(s) include ... Restraint in supine position (laying down, face up) may result in aspiration. Restraint against a wall or other vertical surface is not permitted under any</p>	A 084			

	circumstances. Pressure placed on the neck may			
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A 084	Continued From page 18 result in an obstructed airway, and is prohibited. Weight placed on the back, abdomen, or chest may result in asphyxiation."	A 084			
{A 115}	<p><b>PATIENT RIGHTS</b> CFR(s): 482.13</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by:</p> <p>Based on record review and interviews the facility failed to ensure the hospital met the Condition of Participation for Patient Rights. The hospital failed to assure patients rights were protected and promoted.</p> <p>Findings:</p> <p>1) 1 patient (#9) was free from physical abuse; 2) 1 patient (#19) was free from sexual abuse and neglect; and 3) 2 patients (#s 1 and 2) with allegations of abuse and/or neglect were <b>reported to State Agencies in an appropriate time frame.</b> (Reference at tag A-0145);</p> <p>2) <b>1 patient (#16), out of 6 sampled patients who experienced a restraint or seclusion, was free from unnecessary seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff.</b> (Referenced at tag A-0154);</p> <p>3) <b>1 patient (#1) out of 6 sampled patients who experienced a seclusion or restraint, was free from unnecessary seclusion</b> (Referenced at tag A-0162);</p>	{A 115}	<p><b>A115</b> (patient rights – unnecessary seclusion and restraint)</p> <p>Who: The DON is responsible for this corrective action and the overall ongoing compliance.</p> <p>The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.</p> <p>The QAPI Director is responsible for maintaining a system of monitoring and correction.</p> <p>What:</p> <p>DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].</p> <p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps, with specific emphasis on:</p> <p>Re-educate staff on</p> <ol style="list-style-type: none"> <li>1. Reasons for use of seclusion and/or restraints (not for coercion, discipline, convenience, retaliation).</li> <li>2. Must use least restrictive means to help patients re-gain control of behavior.</li> <li>3. Only use current behavior management program in use that was approved through GB. Stress importance of de-escalation and defusing.</li> <li>4. Discontinue at earliest possible time.</li> <li>5. Signs that it is time to discontinue S/R.</li> <li>6. Appropriate monitoring of patients during seclusion or restraints.</li> </ol>		

			<p>7. Must have immediate need for S/R. HED to send weekly email to all patient care staff on current behavior management program in use approved through GB.</p> <p>HED to send weekly de-escalation tip/technique via email to all patient care staff.</p> <p>HED to make copy of all S/R for RN IIIs to review with their staff for the purposes of ongoing S/R training. RN IIIs will document education on a sign in sheet.</p> <p>Unit managers and nursing shift supervisors to observe S/R, de-escalation situations (not become involved) so they can offer corrective guidance during and after.</p> <p>Education on how to engage with patients for all floor staff. PNAs to document how they engaged with patient and RNs to review and supervise.</p>	
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{A 115}	Continued From page 19  4) The <b>least restrictive interventions</b> were attempted and determined to be ineffective prior to a seclusion for 2 patients (#1 and 16), out of 6 sampled patients. (Referenced at tag A-0164);  5) <b>Safe application of NAPPI</b> (Non-Abusive Psychological and Physical Intervention - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) restraint <b>techniques for 1 patient (#9), out of 6 sampled</b> patients who experienced a seclusion or restraint. (Reference at tag A-0167);  6) <b>Seclusions were discontinued at the earliest possible time for 2 patients (#1 and #16) out of 6 sampled</b> patients who experienced a seclusion or restraint. (Reference at tag A-0174);  7) Ongoing, <b>line of sight monitoring and assessment of 2 patients</b> (#s 15 & 17) while in restraint, <b>out of 6 sampled</b> patients who experienced seclusion and/or restraint. (Reference at tag A-0175); and  8) Documentation reflected the immediate condition or symptom(s) that warranted the use of seclusion for 2 patients (#1 and 16), out of 6 sampled patients who experienced a seclusion or restraint. Reference at tag A-0187;  <b>The failure to ensure policies and procedures were followed placed patients (#1; 2; 9; 15; 16; and 17) out of 6 patients</b> reviewed for restraint and/or seclusion at risk for injury and/or further trauma.	{A 115}			

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{A 145}	<p><b>PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</b> CFR(s): 482.13(c)(3)</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure: 1) 1 patient (#9) was free from physical abuse; 2) 1 patient (#19) was free from sexual abuse and neglect; and 3) 2 patients (#'s 1 and 2) with allegations of abuse and/or neglect were reported to the State agency per facility policy. This failed practice resulted in 2 patients enduring abuse and/or neglect and 2 patients at risk for prolonged exposure to an unsafe environment. Findings:</p> <p>Patient #9 - Physical Abuse</p> <p>Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #9 was admitted to the facility with diagnoses that included major depression and post-traumatic stress disorder (PTSD - anxiety and flashbacks triggered by a traumatic event). Further review revealed the Patient had a history of physical abuse.</p> <p>Review of Patient #9's medical record revealed a Brief Manual Restraint (BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely) occurred on 11/23/18 at 9:38 pm and 5-point restraint (a method of using a mechanical device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. 5-point restraint - 2 wrist restraint, 2 ankle</p>	{A 145}	<p><b>A145 PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</b> CFR(s): 482.13(c)(3)</p> <p>Who: The DON is responsible for this corrective action and the overall ongoing compliance.</p> <p>The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.</p> <p>The QAPI Director is responsible for maintaining a system of monitoring and correction.</p> <p>What:</p> <p>DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].</p> <p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps, with specific emphasis on:</p> <ol style="list-style-type: none"> <li>1. Reasons for use of seclusion and/or restraints (not for coercion, discipline, convenience, retaliation).</li> <li>2. Must use least restrictive means to help patients re-gain control of behavior.</li> <li>3. Only use current behavior management program in use that was approved through GB. Stress importance of de-escalation and defusing. Stress importance of dangerous behaviors and what can happen (i.e., don't use body parts to immobilize patient)</li> </ol> <p>Staff will be educated on abuse and neglect reporting (forms, where to fax, what to report, report immediately).</p>		

			<p>RNs will be educated on what to do when abuse/neglect occurs (take corrective action immediately)</p> <p>Unit managers and nursing shift supervisors will be educated on appropriate investigation procedures.</p> <p>Any staff member who is suspected to have engaged in behaviors that harm a patient will be immediately removed from patient care. The staff member may not return to those duties until appropriate action has been determined and completed, which may include re-training and/or discipline up to and including termination.</p> <p>How: HED to send weekly NAPPI skill via email to all patient care staff.</p> <p>HED will provide training to unit managers and nursing shift supervisors on reporting of abuse and neglect and appropriate investigation procedures.</p> <p>Evaluation methods: A sign-in sheet with attached curriculum will be utilized for education and training. QAPI will monitor UORs, reports of harm, and follow-up.</p>
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{A 145}	<p>Continued From page 21</p> <p>restraints, and one restraint across the Patient's chest while the Patient is lying on his/her back) occurred at 10:12 pm.</p> <p>Camera review on 12/5/18 at 1:15 pm, of the 11/23/18 incident revealed the following non-approved NAPPI techniques used by Psychiatric Nursing Assistants (PNAs) and WEKA support staff (contract security staff hired within the facility to help with escalated situations who must comply with facility approved NAPPI hold techniques):</p> <ul style="list-style-type: none"> <li>- 9:38:00 pm - Patient #9 kissed a peer. To stop the behavior, PNA #4 placed his/her hand on Patient's forehead and pushed his/her head away from the peer. This caused the Patient to become assaultive.</li> <li>- 9:38:09 pm - As Patient #9 stood up, PNA #4 grabbed the Patient from behind, over his/her arms, and the PNA locked his/her arms together in front of Patient's body (hugging him/hertightly from behind).</li> <li>- 9:38:14 pm - Due to head butting behavior, PNA #5 was observed to grab the back of Patient #9's neck and place his/her other hand on Patient's forehead.</li> <li>- 9:38:27 pm - Staff attempted to walk Patient #9 to the Oak Room (a separate room in the facility for seclusion or restraint) however the Patient was able to struggle free. At 9:38:29 pm, WEKA staff #1 and PNA #5 placed Patient #9 in another BMR by placing the Patient's chest against the wall.</li> <li>- 9:38:31 pm - The audible comment "get</li> </ul>	{A 145}			

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{A 145}	<p>Continued From page 22</p> <p>[him/her] off the wall" can be heard (unknown who spoke).</p> <p>- 9:38:32 pm - WEKA Staff #2 grabbed Patient #9's legs as the Patient was against the wall.</p> <p>-9:38:36 pm - WEKA Staff #1, #2, and PNA #5 took Patient #9 to the floor in a controlled manner. Staff restrained the Patient on the floor for 6 minutes, patient positioned on his/her back and with staff on all limbs. Patient #9 walked to the Oak Room at 9:44:13 pm after other staff arrived.</p> <p>- 10:04:43 pm - Patient #9 became assaultive in the Oak Room, BMR on the restraint bed initiated (Patient placed on his/her back). WEKA Staff #2 was observed to place his/her right knee on Patient #9's right arm (the arm was raised, bent at 90 degrees, back of hand lying flat on the restraint bed), at the elbow and upper arm junction. The WEKA Staff #2 apply pressure with his/her knee to keep arm stationary. WEKA Staff #2 restrained the arm in this manner for 2 minutes and 15 seconds.</p> <p>- 10:10:54 pm - A release from the BMR was attempted, to lock Patient #9 in seclusion, however he/she became assaultive again. As BMR was re-initiated (Patient was standing), WEKA Staff #2 was observed to put his/her right hand on Patient's left facial cheek and grab the back of Patient #9's neck with his/her left hand. WEKA Staff #2 pushed the Patient's head down onto the restraint bed, forcing Patient #9 to bend over, face to bed.</p> <p>- 10:12:16 pm - As restraints were being placed (Patient laying on back on restraint bed), it was</p>	{A 145}			

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{A 145}	<p>Continued From page 23</p> <p>observed that WEKA Staff #2 leaned his/her left elbow onto Patient #9's chest and pushed down with his/her body weight to restrain Patient's shoulder and chest.</p> <p>During an interview on 12/5/18 at 1:30 pm, NAPPI Instructors #1 and #2 stated these non-approved techniques are not safe and should not have been used:</p> <ul style="list-style-type: none"> <li>- It is never authorized to push a Patient's head away with staff's hands, this could injure the Patient's neck.</li> <li>- Placing a Patient in a hug from behind could impede the Patient's breathing.</li> <li>- Neck holds, as seen multiple times in the camera review, are extremely dangerous and could injure the neck.</li> <li>- A Patient cannot be held against a wall or hard surface, as this can impede breathing.</li> <li>- WEKA Staff #2 increased the risk to Patient #9, as well as WEKA #1 and PNA #5 when he/she immobilized the Patient's legs as the Patient was held against the wall. This could have caused the group to trip and fall, which could have potentially caused injury.</li> <li>- WEKA Staff #2 increased the risk of injury to Patient #9's arm by restraining it with his/her knee.</li> <li>- WEKA Staff #2 increased the risk of breathing difficulty when he/she leaned onto Patient #9's chest.</li> </ul>	{A 145}			

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{A 145}	<p>Continued From page 24</p> <p>In addition, NAPPI Instructor #1 stated he/she completed the audit of this video on 12/2/18 at 6:30 pm and sent the report, which included the inappropriate NAPPI hold techniques, to the Chief Nursing Officer (CNO).</p> <p>Review of the WEKA staff work schedule, from 12/2/18 to 12/7/18, revealed the facility could not provide an account of WEKA staff #1's and #2's hours worked within the facility after the inappropriate NAPPI techniques were identified and reported.</p> <p>Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "Those who apply the restraints ...and those who monitor patients while restrained ...will receive the training, and demonstrate the safe use of all approved restraint types, including physical hold techniques ..."</p> <p>Further review revealed: "Only NAPPI approved techniques for physical intervention will be used ...High risk considerations for ...physical or mechanical restraint(s) include ...Restraint in supine position (laying down, face up) may result in aspiration. Restraint against a wall or other vertical surface is not permitted under any circumstances. Pressure placed on the neck may result in an obstructed airway, and is prohibited. Weight placed on the back, abdomen, or chest may result in asphyxiation."</p> <p>Additional review of the policy revealed: "Intentional misuse of a restraint technique or any handling of a patient with more force than reasonable for a patient's proper control, treatment or management will be reported as</p>	{A 145}			

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{A 145}	<p>Continued From page 25</p> <p>abuse per the [Alaska Psychiatric Institute] Conduct Involving Patients policy (see P&amp;P LD-020-13 "Conduct Involving Patient") ..."</p> <p>Patient #2 and Patient #19 - Sexual Assault/Abuse</p> <p>Record review of the Patient #2's medical record, dated 11/14/18 at 7:17 am, revealed Patient #2 self-reported inappropriate and non-consented sexual act toward Patient #19.</p> <p>Record review of Patient #19's medical record, dated 11/14/18 at 4:52 pm, revealed Patient #19 stated that Patient #2 did conduct an inappropriate sexual act in October 2018 after taking a nap right after lunch.</p> <p>During an interview on 12/5/18 at 12:33 pm Registered Nurse (RN) #13 stated the night nurse working 11/13-14/18 reported the allegation to him/her the morning of 11/14/18 that Patient #2 self-reported unsolicited sexual act toward another patient. RN #13 stated he/she interviewed both patients and substantiated the accusation by both patients' accounts. Patient #19 stated he/she didn't feel safe. RN #13 stated he/she was surprised nothing was done to separate the two patients or protect Patient #19 when reported to the night shift nurse. The RN further stated Patient #2 had a history of sexual assault in the community, as well as, diagnoses such as Schizophrenia, antisocial personality disorder and mild intellectual disability.</p> <p>Record review of a facility provided document entitled "Alaska Psychiatric Institute - Unusual Occurrence Report (UOR)," dated 11/14/18 at 1:30 pm, and supported documents revealed</p>	{A 145}			

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{A 145}	<p>Continued From page 26</p> <p>Patient #2 stated that he/she conducted an inappropriate and non-consented sexual act toward Patient #19 sometime in October 2018. This was allegedly reported to the RN #12 sometime during his/her shift from 11/13/18-11/14/18. The document indicated the facility was to call the local police (note dated 11/14/18 at 2:00 pm). Furthermore, the documented revealed on 11/14/18 at 6:00 pm, the local police arrived that day at 4:50 pm, and interviewed both patients. As a result, both patients remained in the facility.</p> <p>Review of Patient #2's medical record revealed the Patient was placed on 1 to 1 supervision at 5:47 pm on 11/14/18. This occurred approximately 11 hours after allegation was reported from the night nurse to the day nurse. Further review revealed the patient was moved to a different unit on 11/16/18, 2 days after the facility was aware of the allegation.</p> <p>Review of the facility provided policy "Patient Sexual Activity," dated 4/4/11, revealed inappropriate sexual activity included any touching of a patient in a sexual manner, with or without the patient's permission. The policy further revealed patients are not allowed to engage in sexual activity with other because patients must be protected from exploitation by others. Hospital staff members will response to every incident of reported or suspected sexual activity in order to ensure every patient is protected.</p> <p>Review of the facility provided policy "Response to Assaults," dated 6/1/15, revealed assaults include sexually aggressive act. In addition, when a patient to patient assault occurs the</p>	{A 145}			

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{A 145}	<p>Continued From page 27</p> <p>supervisor is to be notified and will immediately arrange for the continued monitoring and safety of the alleged assailant, victim, and milieu.</p> <p>Reporting of Allegations:</p> <p>Patient #1</p> <p>Record review of Patient #1's medical record dated 11/11/18 revealed the Patient was experiencing multiple daily episodes of vomiting that resulted in the Patient being transferred to a local medical hospital. Further review revealed a nursing note dated 11/12/18 that stated a nurse from the medical hospital informed RN #10 that Resident #1 self-reported consuming hand sanitizer while in the exercise room over the past few days.</p> <p>During an interview on 11/29/18 at 12:24 pm, Patient #1 stated staff would open the door to the area off to the side of the gym so the patient could have some alone time. The patient further stated he/she would be in the room for up to 5 minutes unsupervised. When asked how many times he/she would go into the area and drink hand sanitizer, he/she stated approximately five times over the 1-2 weeks prior to his/her transfer to the medical hospital.</p> <p>During an interview on 11/29/18 at 1:38 pm, the Chief Nursing Officer (CNO) stated a root-cause analysis (RCA) was given to Physician #1 on 11/20/18. The CNO stated a RCA should have been conducted sooner.</p> <p>This alleged event was not reported to the State Agency until 11/21/18, 9 days after the facility</p>	{A 145}			

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{A 145}	<p>Continued From page 28 became aware of the allegation.</p> <p>Patient #2</p> <p>Record review of the Patient #2's medical record, dated 11/14/18 at 7:17 am, revealed Patient #2 self-reported inappropriate and non-consented sexual act toward Patient #19.</p> <p>Record review of Patient #19's medical record, dated 11/14/18 at 4:52 pm, revealed Patient #19 stated that Patient #2 did conduct an inappropriate sexual act in October 2018 after taking a nap right after lunch.</p> <p>This alleged event of unwanted sexually behavior was not reported to the State Agency until 11/16/18, 2-3 days after the facility became aware of the allegation.</p> <p>During an interview on 11/27/18 at 12:16 am the Chief of Operations (COO) stated the facility's Executive Team would receive UORs for review each morning. When asked how reporting of alleged abuse, neglect and malpractice occurred on the nights and weekends, the COO stated the current process of reviewing allegations is problematic on the nights and weekends.</p> <p>During second interview on 11/29/18 at 11:27 am the COO stated the facility could improve the review process of allegations and understood the facility was not compliant with reporting requirements.</p> <p>Review of the facility policy, Abuse and Neglect Prevention Policy, dated 10/31/18, revealed "If the employee making the report to the CEO,</p>	{A 145}			

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{A 145}	<p>Continued From page 29</p> <p>Safety Officer (SO), Nursing Shift Supervisor (NSS) or designee is a mandatory reported per Reporting requirements for Vulnerable Adults-A.S. 47.24.010 &amp; Mandatory Reporter for Child Abuse and Neglect A.S. 47.17.020 the staff member will comply with the applicable statutes."</p> <p>AS 47.24.010 states:</p> <p>(a) Except as provided in (e) and (f) of this section, the following persons who, in the performance of their professional duties, have reasonable cause to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect shall, not later than 24 hours after first having cause for the belief, report the belief to the department's central information and referral service for vulnerable adults:</p> <p>(1) a physician or other licensed health care provider;</p> <p>(2) a mental health professional as defined in AS 47.30.915 (11) and including a marital and family therapist licensed under AS 08.63;</p> <p>(3) a pharmacist;</p> <p>(4) an administrator of a nursing home, residential care or health care facility;</p> <p>(5) a guardian or conservator;</p> <p>(6) a police officer;</p> <p>(7) a village public safety officer;</p> <p>(8) a village health aide;</p> <p>(9) a social worker;</p> <p>(10) a member of the clergy;</p> <p>(11) a staff employee of a project funded by the Department of Administration for the provision of services to older Alaskans, the Department of Health and Social Services, or the Council on Domestic Violence and Sexual Assault;</p> <p>(12) an employee of a personal care or home</p>	{A 145}			

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{A 145}	<p>Continued From page 30</p> <p>health aide program;</p> <p>(13) an emergency medical technician or a mobile intensive care paramedic;</p> <p>(14) a caregiver of the vulnerable adult;</p> <p>(15) a certified nurse aide.</p> <p>(b) A report made under this section may include the name and address of the reporting person and must include</p> <p>(1) the name and address of the vulnerable adult;</p> <p>(2) information relating to the nature and extent of the abandonment, exploitation, abuse, neglect, or self-neglect;</p> <p>(3) other information that the reporting person believes might be helpful in an investigation of the case or in providing protection for the vulnerable adult.</p> <p>AS 47.17.010 states: To protect children whose health and well-being may be adversely affected through the infliction , by other than accidental means, of harm through physical injury or neglect, mental injury, sexual abuse, sexual exploitation, or maltreatment, the legislature requires the reporting of these cases by practitioners of the healing arts and others to the department. It is not the intent of the legislature that persons required to report suspected child abuse or neglect under this chapter investigate the suspected child abuse or neglect before they make the required report to the department. Reports must be made when there is a reasonable cause to suspect child abuse or neglect in order to make state investigative and social services available in a wider range of cases at an earlier point in time, to make sure that investigations regarding child abuse and neglect are conducted by trained investigators, and to avoid subjecting a child to</p>	{A 145}			

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{A 145}	Continued From page 31 duplicative interviews about the abuse or neglect. It is the intent of the legislature that, as a result of these reports, protective services will be made available in an effort to:  (1) prevent further harm to the child;  (2) safeguard and enhance the general well-being of children in this state; and  (3) preserve family life unless that effort is likely to result in physical or emotional damage to the child.	{A 145}			
{A 154}	USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e)  Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.  This STANDARD is not met as evidenced by:  Based on record review, camera review, and interview the facility failed to ensure 1 patient (#16), out of 6 sampled patients who experienced a seclusion or restraint, was free from unnecessary seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff. This failed practice has the potential to	{A 154}	A154 USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e)  Who: The DON is responsible for this corrective action and the overall ongoing compliance.  The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.  The QAPI Director is responsible for maintaining a system of monitoring and correction.  WHAT:  DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].  All nursing staff will be re-educated [by date] on current applicable P&Ps, with specific emphasis on:  1. Reasons for use of seclusion and/or restraints (not for coercion, discipline,		

		<p>convenience, retaliation).</p> <ol style="list-style-type: none"> <li>2. Must use least restrictive means to help patients re-gain control of behavior.</li> <li>3. Only use current behavior management program in use that was approved through GB. Stress importance of de-escalation and defusing.</li> <li>4. Discontinue at earliest possible time.</li> <li>5. Signs that it is time to discontinue S/R.</li> <li>6. Patients must be appropriately monitored during seclusion or mechanical restraints.</li> <li>7. Must have immediate need for S/R.</li> </ol> <p>How: The unit managers will be trained on the education required and will conduct the trainings on their respective units.</p> <p>HED to send weekly email to all patient care staff on current behavior management program in use approved through GB.</p> <p>HED to send weekly de-escalation tip/technique via email to all patient care staff.</p> <p>HED to make copy of all S/R for RN IIIs to review with their staff for the purposes of ongoing S/R training. RN IIIs will document education on a sign in sheet.</p> <p>RN IIIs to observe S/R, de-escalation situations (not become involved) so they can offer guidance and education during and after.</p> <p>Education on how to engage with patients for all floor staff. PNAs to document how they engaged with patient and RNs to review and supervise.</p> <p>Unit managers will conduct specific supervision time for individuals found to be out of compliance during video review.</p> <p>Evaluation Method: A sign in sheet will be utilized for all training and review with a copy of the curriculum attached. Copies of the emails sent will be maintained. Written details of supervision will be reviewed by the director of nursing.</p>
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{A 154}	<p>Continued From page 32</p> <p>effect the patient's response to treatment and increase potential risk for injury. Findings:</p> <p>Patient #16</p> <p>Episode #1 (11/19/18)</p> <p>Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #16 was admitted to the facility with a diagnosis of Pervasive Developmental Disorder (characterized by delays in the development of socialization and communication skills).</p> <p>Record review of Patient #16's medical record on 11/29/18 revealed a seclusion (a method of preventing a patient from leaving an area) occurred on 11/19/18 at 1:48 pm. Indication for the seclusion was "Patient was spitting at staff [and] struck a peer. Shouting and swearing and seclusion was initiated." This seclusion lasted 1 hour and 42 minutes.</p> <p>Camera review on 11/29/18 at 1:53 pm, of the 11/19/18 event, revealed at 1:36 pm the Patient started yelling the Registered Nurse (RN) #1's name repeatedly when multiple requests to use headphones were denied. Psychiatric Nursing Assistant (PNA) #6 walked out of the nurse's station behind the staff desk and told Patient "That is not how you make a request" while pointing a finger at the Patient. At 1:42 pm the Patient spit over the staff desk counter. At this time, PNA #6 immediately called for a "code gray" on his/her radio (a call for immediate assistance from other staff within the hospital due to violent or threatening behavior that does not involve a weapon). Patient #16 can be observed to start to walk to the Oak Room, intercepted a peer on the</p>	{A 154}			

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{A 154}	<p>Continued From page 33</p> <p>way and struck that peer in the chest. Once separated, the Patient walked to the Oak Room and calmly sat on the bed without assistance at 1:42 pm. RN #1 was observed to say "We tried a 5 minutes time out before" (due to earlier behavior) and "A time out is not acceptable anymore. I think we need a seclusion." The door was locked at this time.</p> <p>Review of Patient's medical record on 11/19/18 revealed the Patient had a behavioral plan. The plan documented "Escalation Warning Signs" that stated: "...If behaviors continue for 10 minutes or escalate to the point of concern for safety, please call the charge nurse to assess and follow policy and procedure for safety." The plan also stated: "When escalation continues to the point of concern for safety, make sure core staff and RN [registered nurse] are involved to assess the situation ..."</p> <p>During the camera review, no observation of the behavior plan was followed prior to the code gray.</p> <p>Review of the "Seclusion Face to Face Flow Sheet" for 11/19/18 revealed Patient # 16's behavior was documented as "lying/sitting," "standing still," or "walking/pacing" from 2:00 pm to 3:30 pm of the seclusion.</p> <p>Camera review further revealed the following nurse processing/interactions with the Patient during the seclusion:</p> <p>- RN #2 processed with Patient #16 at 2:24 pm, giving him/her release criteria (while Patient was seated and calm) with a 10 minute timeframe for release.</p>	{A 154}			

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{A 154}	<p>Continued From page 34</p> <ul style="list-style-type: none"> <li>- RN #2 returned at 2:48 pm (24 minutes later), talked with the PNA however did not talk with the Patient.</li> <li>- RN #2 spoke to Patient at 2:50 pm (26 minutes after he/she first talked with the Patient), "you're not being dangerous but you're laughing a lot" and gave Patient an additional 10 minutes in seclusion with instructions " ...calm and respectful. Don't put your face on the window."</li> <li>- RN #2 processed with Patient at 3:09 pm (19 minutes later) while he/she sat on the bed calmly, and asked him/her "Have you been calm?" When Patient stated "Yes," RN #2 asked "Are you sure?" RN #2 extended seclusion (could not hear audio clearly to ascertain why).</li> <li>- RN #1 offered Patient water at 3:14 pm while Patient sat quietly on the floor in seclusion, then relocked the door.</li> <li>- RN #2 processed with Patient the final time at 3:20 pm. Patient was then released at 3:27 pm.</li> </ul> <p>During an interview on 11/29/18 at 2:06 pm, the NAPPI Instructors #1 and #2 stated spitting is not an indication to call a code gray and/or use the Oak Room.</p> <p>During an interview on 11/29/18 at 3:10 pm, NAPPI Instructors #1 and #2 stated Patient #16 should have been released from seclusion sooner. They both could not see any criteria that would justify continued seclusion. They further stated that laughing or placing face on the window is not justification to keep a Patient in seclusion.</p>	{A 154}			

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{A 154}	<p>Continued From page 35 Episode #2 (11/25/18)</p> <p>Record review of Patient #16's medical record on 12/5/18 revealed a seclusion occurred on 11/25/18 at 7:56 pm. Indication for the seclusion was "...Patient responded by spitting on staff. Code [gray] [a call for immediate assistance from other staff within the hospital due to violent or threatening behavior that does not involve a weapon] initiated. Patient was initially aggressive towards staff, raising fist at staff. Responded to verbal prompts by RN and entered Oak Room. Voluntary timeout initiated at [5:50 pm]. Patient agreed to "think about it" after being unable to reflect and continuing to perseverate sexually. Locked seclusion at [5:56 pm]." This seclusion lasted 1 hour and 19 minutes.</p> <p>Review of Patient #1's medical record on 12/5/18 revealed the nurse's note "RN Emergency Seclusion Initial ..." dated 12/4/18 at 1:15 pm, which documented Patient #1's behavior at the time of the initiation of the seclusion as: [Patient] threatening with fists, poised to strike: directed at staff, [Patient] charging/lunging/close physically: threat, directed at staff, [Patient] spitting: directed at staff and directed at environment, [Patient] ramming into walls/pounding doors: actual, [Patient] hitting/kicking: threat, directed at staff." Further review revealed less restrictive alternatives to emergency seclusion attempted were documented as "voluntary time out," "verbal de-escalation," and "[by mouth] [as needed] medication. Patient's response to attempted less restrictive alternatives was documented as "Threatened staff, spit at staff, shouted and utilized racial slurs."</p> <p>Camera review on 12/5/18 revealed the Patient</p>	{A 154}			

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{A 154}	<p>Continued From page 36</p> <p>spit at PNA #6 after he/she was told to clean up first before headphones would be granted. A code gray was immediately called. The Patient yelled "No!" after this, spit one more time, then walked unassisted to the Oak Room. Patient sat on the bed in the Oak Room and processed with RN #2 for 10 minutes without any violent or threatening behavior. RN #2 stated the door would be locked for 15 minutes. Patient was observed to remain seated on the bed, waving hands and yelling "Please no! No, no, no!" as door was being locked.</p> <p>Review of the "Seclusion Face to Face Flow Sheet" for 11/25/18 revealed Patient #16 had no violent or threatening behavior from 6:45 pm to 7:15 pm of the seclusion.</p> <p>During an interview on 12/5/18 at 12:30 pm, NAPPI Instructors #1 and #2 stated spitting is not a justification for a code gray. They further stated a seclusion was not necessary based on the camera review of the Patient's calm behavior and willingness to process for 10 minutes safely prior to the Oak Room door being locked.</p> <p>Review of the facility's policy "Management of Patient Behavior," dated 6/1/18, revealed: "... staff will intervene in the least restrictive manner effective to assist the patient to regain emotional control and to mitigate the danger of the situation ...Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member or others and must be discontinued at the earliest possible time."</p> <p>Further review revealed: "Seclusion is prohibited as a form of coercion, discipline, convenience, retaliation or as a consequence. (e.g. Telling a</p>	{A 154}			

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{A 154}	Continued From page 37 patient they must comply with a staff directive or be secluded can be considered coercion; telling a patient they did not comply with a staff directive so they will be secluded can be considered discipline or retaliation; secluding a patient because they are loud, bothersome to others or otherwise disruptive to the milieu can be considered convenience; secluding a patient who is assaultive and then immediately calm after the assault can be considered retribution, retaliatory, or disciplinary)."  Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "API is committed to providing the least restrictive environment that supports the safe and therapeutic treatment of patients; and in doing so, API allows the use of seclusion and restraint only in response to a clear and significant risk to the patient or others."  Further review of the policy revealed: "Psychiatric Nursing Assistant (PNA) responsibilities ...Determine readiness for discontinuation for [Seclusion/Restraint] based on meeting behavior criteria for discontinuation ...Release from seclusion/restraint ...The patient will be released when the RN or [Provider] determines the need for restraint is no longer present or the patient's needs can be addressed using less restrictive methods."	{A 154}			
{A 162}	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(1)(ii)  Seclusion is the involuntary confinement of a	{A 162}	A162 PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(1)(ii)  Who: The DON is responsible for this corrective		

		<p>action and the overall ongoing compliance.</p> <p>The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.</p> <p>The QAPI Director is responsible for maintaining a system of monitoring and correction.</p> <p>What:</p> <p>DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].</p> <p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps, with specific emphasis on:</p> <ol style="list-style-type: none"><li>1. Reasons for use of seclusion and/or restraints (not for coercion, discipline, convenience, retaliation).</li><li>2. Must use least restrictive means to help patients re-gain control of behavior.</li><li>3. Only use current behavior management program in use that was approved through GB. Stress importance of de-escalation and defusing.</li><li>4. Discontinue at earliest possible time.</li><li>5. Signs that it is time to discontinue S/R.</li><li>6. Patients must be continuously monitored during seclusion or mechanical restraints.</li><li>7. Must have immediate need for S/R.</li></ol> <p>How: The unit managers will be trained on the education required and will conduct the trainings on their respective units.</p> <p>HED to send weekly email to all patient care staff on current behavior management program in use approved through GB.</p> <p>HED to send weekly de-escalation tip/technique via email to all patient care staff.</p> <p>HED to make copy of all S/R for RN IIIs to review with their staff for the purposes of ongoing S/R training. RN IIIs will document education on a sign in sheet.</p> <p>RN IIIs to observe S/R, de-escalation situations (not become involved) so they can offer guidance and education during and after.</p> <p>Education on how to engage with patients for all floor staff. PNAs to document how they engaged with patient and RNs to review and supervise.</p>
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			<p>Unit managers will conduct specific supervision time for individuals found to be out of compliance during video review.</p> <p>Evaluation Method: A sign in sheet will be utilized for all training and review with a copy of the curriculum attached. Copies of the emails sent will be maintained. Written details of supervision will be reviewed by the director of nursing.</p>	
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{A 162}	<p>Continued From page 38</p> <p>patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review, camera review, and interview the facility failed to ensure 1 patient (#1) out of 6 sampled patients who experienced a seclusion or restraint, was free from unnecessary seclusion. This failed practice created a non-therapeutic environment and an increased potential for injury. Findings:</p> <p>Record review on 11/27-29/18 and 12/5-6/18 revealed Patient #1 was admitted to the facility with a diagnoses that included Major Depression and Post Traumatic Stress Disorder (PTSD - anxiety and flashbacks triggered by a traumatic event).</p> <p>Brief Manual Restraint (BMR)</p> <p>Record review of Patient #1's medical record on 12/5/18 revealed the nurse's note "Brief Manual Restraint Event," dated 12/4/18 at 1:09 pm, which documented clinical rationale for BMR: "Patient was able to acquire a pencil with a no sharps/no pens [an order that prohibits access to any potential weapon that could be used to harm self or others] order. Patient refused to surrender [his/her] pencil. Patient threw hardcover book at staff, and then punched staff in face. Patient put in BMR and escorted to oak room. Patient held in BMR while [as needed medication] were administered. Patient refused [by mouth] meds."</p> <p>Seclusion</p>	{A 162}			

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{A 162}	Continued From page 39  Record review of Patient #1's chart on 12/5/18 revealed a seclusion (the act prohibiting a patient from leaving an area) occurred on 12/4/18 at 1:15 pm. Indication for the seclusion was "...walked to the Oak Room [a separate room in the facility for seclusion and restraint] using a 2-arm assist ...locked for staff safety." This seclusion lasted 1 hour and 9 minutes.  Camera review on 12/5/18 at 2:12 pm of the 12/4/18 event revealed that after the assault, Patient #1 calmly walked to the seclusion with 2 staff, each holding an arm. He/she sat with staff on the bed inside the Oak Room and cooperated while an emergency intramuscular (IM) medication (a medication given as needed for agitation) was administered. Once the medication was administered, staff released the Patient from the BMR and left the room (Patient remained seated on the bed). Based on this camera review it appeared the BMR was successful in resolving the Patient's assaultive behavior, however a seclusion was still initiated.  Review of the "Seclusion Face to Face Flow Sheet" for 11/19/18 revealed Patient # 16's behavior was documented as "lying/sitting" or "quiet" from 1:30 pm to 2:24 pm of the seclusion.  During an interview on 12/5/18 at 2:20 pm, the Non-Abusive Psychological and Physical Intervention (NAPPI - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructors #1 and #2 stated a seclusion did not need to be initiated for Patient #1 on 12/4/18 based on his/her cooperative behavior while in the BMR and in the Oak Room,	{A 162}			

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{A 162}	Continued From page 40 as well as, his/her willingness to remain in the oak room once released from the BMR.  Review of the facility's policy "Management of Patient Behavior," dated 6/1/18, revealed: "... staff will intervene in the least restrictive manner effective to assist the patient to regain emotional control and to mitigate the danger of the situation ...Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member or others and must be discontinued at the earliest possible time."  Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "API is committed to providing the least restrictive environment that supports the safe and therapeutic treatment of patients; and in doing so, API allows the use of seclusion and restraint only in response to a clear and significant risk to the patient or others."	{A 162}			
{A 164}	<b>PATIENT RIGHTS: RESTRAINT OR SECLUSION</b> CFR(s): 482.13(e)(2)  Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.  This STANDARD is not met as evidenced by:  Based on record review, camera review, and interview the facility failed to ensure least restrictive interventions were attempted and determined to be ineffective prior to a seclusion	{A 164}	<b>A164</b> <b>PATIENT RIGHTS: RESTRAINT OR SECLUSION</b> CFR(s): 482.13(e)(2)  Who: The DON is responsible for this corrective action and the overall ongoing compliance.  The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.  The QAPI Director is responsible for maintaining a system of monitoring and correction.		

		<p>What:</p> <p>DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].</p> <p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps, with specific emphasis on:</p> <ol style="list-style-type: none"><li>1. Reasons for use of seclusion and/or restraints (not for coercion, discipline, convenience, retaliation).</li><li>2. Must use least restrictive means to help patients re-gain control of behavior.</li><li>3. Only use current behavior management program in use that was approved through GB. Stress importance of de-escalation and defusing.</li><li>4. Discontinue at earliest possible time.</li><li>5. Signs that it is time to discontinue S/R.</li><li>6. Patients must be appropriately monitored during seclusion or mechanical restraints.</li><li>7. Must have immediate need for S/R.</li></ol> <p>How: The unit managers will be trained on the education required and will conduct the trainings on their respective units.</p> <p>HED to send weekly email to all patient care staff on current behavior management program in use approved through GB.</p> <p>HED to send weekly de-escalation tip/technique via email to all patient care staff.</p> <p>HED to make copy of all S/R for RN IIIs to review with their staff for the purposes of ongoing S/R training. RN IIIs will document education on a sign in sheet.</p> <p>RN IIIs to observe S/R, de-escalation situations (not become involved) so they can offer guidance and education during and after.</p> <p>Education on how to engage with patients for all floor staff. PNAs to document how they engaged with patient and RNs to review and supervise.</p> <p>Unit managers will conduct specific supervision time for individuals found to be out of compliance during video review.</p> <p>Evaluation Method: A sign in sheet will be utilized for all training and review with a copy of the curriculum attached. Copies of the emails sent will be maintained. Written details of</p>
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			supervision will be reviewed by the director of nursing.	
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{A 164}	<p>Continued From page 41</p> <p>for 2 patients (#1 and 16), out of 6 sampled patients. This failed practice violated the patient's right to be free from seclusions which could affect the patient's response to treatment and increase potential risk for injury. Findings:</p> <p><b>Patient #1</b></p> <p>Record review on 11/27-29/18 and 12/5-6/18 revealed Patient #1 was admitted to the facility with a diagnoses that included Major Depression and Post Traumatic Stress Disorder (PTSD - anxiety and flashbacks triggered by a traumatic event).</p> <p><b>Brief Manual Restraint (BMR)</b></p> <p>Record review of Patient #1's medical record on 12/5/18 revealed the nurse's note "Brief Manual Restraint [BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely] Event," dated 12/4/18 at 1:09 pm, which documented clinical rationale for BMR: "Patient was able to acquire a pencil with a no sharps/no pens [an order that prohibits access to any potential weapon that could be used to harm self or others] order. Patient refused to surrender [his/her] pencil. Patient threw hardcover book at staff, and then punched staff in face. Patient put in BMR and escorted to oak room. Patient held in BMR while [as needed medication] were administered. Patient refused [by mouth] meds."</p> <p><b>Seclusion</b></p> <p>Record review of Patient #1's chart on 12/5/18 revealed a seclusion (the act prohibiting a patient</p>	{A 164}			

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{A 164}	<p>Continued From page 42</p> <p>from leaving an area) occurred on 12/4/18 at 1:15 pm. Indication for the seclusion was "...walked to the Oak Room [a separate room in the facility for seclusion and restraint] using a 2-arm assist ...locked for staff safety." This seclusion lasted 1 hour and 9 minutes.</p> <p>Review of Patient #1's medical record on 12/5/18 revealed the nurse's note "RN [Registered Nurse] Emergency Seclusion Initial ..." dated 12/4/18 at 1:15 pm, which documented the following behavior directed toward staff at the time of the initiation of the seclusion as: "[Patient] threatening with fists, poised to strike, [Patient] charging/lunging/close physically, [Patient] bumping/shoving/grabbing/pinching, [Patient] throwing objects, [Patient] hitting/kicking." Further review revealed less restrictive alternatives to emergency seclusion attempted were documented as "verbal de-escalation" and "1:1 supervision" (one staff member monitoring only this patient). Patient's response to attempted less restrictive alternatives was documented as "Patient became more aggressive with verbal interventions."</p> <p>Camera review on 12/5/18 at 2:12 pm of the 12/4/18 event revealed that after the assault, Patient #1 calmly walked to the seclusion with 2 staff, each holding an arm. He/she sat with staff on the bed inside the Oak Room and cooperated while an emergency intramuscular (IM) medication (a medication given as needed for agitation) was administered. Once the medication was administered, staff released the Patient from the BMR and left the room (Patient remained seated on the bed). Based on this camera review it appeared the BMR was successful in resolving the Patient's assaultive</p>	{A 164}		

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{A 164}	<p>Continued From page 43</p> <p>behavior, however a seclusion was still initiated.</p> <p>Review of the "Seclusion Face to Face Flow Sheet" for 11/19/18 revealed Patient # 16's behavior was documented as "lying/sitting" or "quiet" from 1:30 pm to 2:24 pm of the seclusion.</p> <p>During an interview on 12/5/18 at 2:20 pm, the Non-Abusive Psychological and Physical Intervention (NAPPI - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructors #1 and #2 stated a seclusion did not need to be initiated for Patient #1 on 12/4/18 based on his/her cooperative behavior while in the BMR and in the Oak Room, as well as, his/her willingness to remain in the Oak Room once released from the BMR.</p> <p>Patient #16</p> <p>Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #16 was admitted to the facility with a diagnosis of Pervasive Developmental Disorder (characterized by delays in the development of socialization and communication skills).</p> <p>Record review of Patient #16's medical record on 12/5/18 revealed a seclusion occurred on 11/25/18 at 7:56 pm. Indication for the seclusion was " ...Patient responded by spitting on staff. Code [gray] [a call for immediate assistance from other staff within the hospital due to violent or threatening behavior that does not involve a weapon] initiated. Patient was initially aggressive towards staff, raising fist at staff. Responded to verbal prompts by [RN - Registered Nurse] and entered Oak Room. Voluntary timeout initiated at</p>	{A 164}			

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{A 164}	<p>Continued From page 44</p> <p>[5:50 pm]. Patient agreed to "think about it" after being unable to reflect and continuing to perseverate sexually. Locked seclusion at [5:56 pm]." This seclusion lasted 1 hour and 19 minutes.</p> <p>Review of Patient #1's medical record on 12/5/18 revealed the nurse's note "RN Emergency Seclusion Initial ..." dated 12/4/18 at 1:15 pm, which documented Patient #1's behavior at the time of the initiation of the seclusion as: [Patient] threatening with fists, poised to strike: directed at staff, [Patient] charging/lunging/close physically: threat, directed at staff, [Patient] spitting: directed at staff and directed at environment, [Patient] ramming into walls/pounding doors: actual, [Patient] hitting/kicking: threat, directed at staff." Further review revealed less restrictive alternatives to emergency seclusion attempted were documented as "voluntary time out," "verbal de-escalation," and "[by mouth] [as needed] medication." Patient's response to attempted less restrictive alternatives was documented as "Threatened staff, spit at staff, shouted and utilized racial slurs."</p> <p>Camera review on 12/5/18 revealed the Patient spit at Psychiatric Nursing Assistant (PNA) #6 after he/she was told to clean up first before headphones would be granted. A code gray was immediately called. The Patient yelled "No!" after this, spit one more time, then walked unassisted to the Oak Room. Patient sat on the bed in the Oak Room and processed with RN #2 for 10 minutes without any violent or threatening behavior. RN #2 stated the door would be locked for 15 minutes. Patient was observed to remain seated on the bed, waving hands and yelling "Please no! No, no, no!" as door was being</p>	{A 164}			

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{A 164}	<p>Continued From page 45</p> <p>locked. Based on this camera review, it appeared the 10 minute processing was successful in de-escalating the Patient, however a seclusion was still initiated.</p> <p>Review of the "Seclusion Face to Face Flow Sheet" for 11/25/18 revealed Patient #16 had no violent or threatening behavior from 6:45 pm to 7:15 pm while in seclusion.</p> <p>During an interview on 12/5/18 at 12:30 pm, NAPPI Instructors #1 and #2 stated spitting is not a justification for a code gray. They further stated a seclusion was not necessary based on the camera review of the Patient's calm behavior and willingness to process for 10 minutes safely prior to the Oak Room door being locked.</p> <p>Review of the facility's policy "Management of Patient Behavior," dated 6/1/18, revealed: " ... staff will intervene in the least restrictive manner effective to assist the patient to regain emotional control and to mitigate the danger of the situation ...Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member or others and must be discontinued at the earliest possible time."</p> <p>Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "[Alaska Psychiatric Institute] is committed to providing the least restrictive environment that supports the safe and therapeutic treatment of patients; and in doing so, API allows the use of seclusion and restraint only in response to a clear and significant risk to the patient or others."</p> <p>Further review of the policy revealed: "Examples of when seclusion or restraint would be</p>	{A 164}		

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{A 164}	Continued From page 46 appropriate for a patient ... When a patient is causing severe physical harm to self (i.e. cutting, stabbing, repetitively hitting their head or remainder of their body against a hard surface). When a patient is causing harm to others (i.e. hitting, pulling of hair) and will not be redirected or de-escalate."	{A 164}			
A 167	<p><b>PATIENT RIGHTS: RESTRAINT OR SECLUSION</b> CFR(s): 482.13(e)(4)(ii)</p> <p>[The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital <b>policy in accordance with State law.</b></p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review, camera review, and interview the facility failed to ensure the safe application of NAPPI (Non-Abusive Psychological and Physical Intervention - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) restraint techniques for 1 patient (#9), out of 6 sampled patients who experienced a seclusion or restraint. This failed practice placed the patient at risk for injury and created a non-therapeutic environment. Findings:</p> <p>Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #9 was admitted to the facility with diagnoses that included major depression and post-traumatic stress disorder (PTSD - anxiety and flashbacks triggered by a traumatic</p>	A 167	<p><b>A167</b> <b>PATIENT RIGHTS: RESTRAINT OR SECLUSION</b> CFR(s): 482.13(e)(4)(ii)</p> <p>Who: The DON is responsible for this corrective action and the overall ongoing compliance.</p> <p>The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.</p> <p>The QAPI Director is responsible for maintaining a system of monitoring and correction.</p> <p>What:</p> <p>DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].</p> <p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps.</p> <p>Staff will be educated on the importance of using only current behavior management program in use that was approved through GB for the physical management of patient behavior.</p>		

			<p>Staff will be educated on the potential hazards to patients and staff during seclusion/restraints.</p> <p>How: Unit managers will provide education to the staff on their respective units.</p> <p>HED will develop a list of dangerous procedures and handling of patients during restraints/holds. Unit managers will educate staff on these hazards.</p> <p>Evaluation Method: Unit managers will utilize a sign in sheet for all education and attach the curriculum that was used.</p>
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A 167	<p>Continued From page 47 event). Further review revealed the Patient had a history of physical abuse.</p> <p>Review of Patient #9's medical record revealed a Brief Manual Restraint (BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely) occurred on 11/23/18 at 9:38 pm and 5- point restraint (a method of using a mechanical device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. 5-point restraint - 2 wrist restraint, 2 ankle restraints, and one restraint across the Patient's chest while the Patient is lying on his/her back) occurred at 10:12 pm.</p> <p>Camera review on 12/5/18 at 1:15 pm, of the 11/23/18 incident revealed the following non-approved NAPPI techniques used by Psychiatric Nursing Assistants (PNAs) and WEKA support staff (contract security staff hired within the facility to help with escalated situations who must comply with facility approved NAPPI hold techniques):</p> <ul style="list-style-type: none"> <li>- 9:38:00 pm - Patient #9 kissed a peer. To stop the behavior, PNA #4 placed his/her hand on Patient's forehead and pushed his/her head away from the peer. This caused the Patient to become assaultive.</li> <li>- 9:38:09 pm - As Patient #9 stood up, PNA #4 grabbed the Patient from behind, over his/her arms, and the PNA locked his/her arms together in front of Patient's body (hugging him/hertightly from behind).</li> <li>- 9:38:14 pm - Due to head butting behavior, PNA</li> </ul>	A 167			

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A 167	<p>Continued From page 48</p> <p>#5 was observed to grab the back of Patient #9's neck and place his/her other hand on Patient's forehead.</p> <p>- 9:38:27 pm - Staff attempted to walk the Patient #9 to the Oak Room (a separate room in the facility for seclusion or restraint) however the Patient was able to struggle free. At 9:38:29 pm, WEKA staff #1 and PNA #5 placed Patient #9 in another BMR by placing the Patient's chest against the wall.</p> <p>- 9:38:31 pm - The audible comment "get [him/her] off the wall" can be heard (unknown who spoke).</p> <p>- 9:38:32 pm - WEKA Staff #2 grabbed Patient #9's legs as the Patient was against the wall.</p> <p>- 9:38:36 pm - WEKA Staff #1, #2, and PNA #5 took Patient #9 to the floor in a controlled manner. Staff restrained the Patient on the floor for 6 minutes, patient positioned on his/her back and staff on all limbs. Patient #9 walked to the Oak Room at 9:44:13 pm after other staff arrived.</p> <p>- 10:04:43 pm - Patient #9 became assaultive in the Oak Room, BMR on the restraint bed initiated (Patient placed on his/her back). WEKA Staff #2 was observed to place his/her right knee on Patient #9's right arm (the arm was raised, bent at 90 degrees, back of hand lying flat on the restraint bed), at the elbow and upper arm junction. The WEKA Staff #2 apply pressure with his/her knee to keep arm stationary. WEKA Staff #2 restrained the arm in this manner for 2 minutes and 15 seconds.</p> <p>- 10:10:54 pm - A release from the BMR was</p>	A 167			

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A 167	<p>Continued From page 49</p> <p>attempted, to lock Patient #9 in seclusion, however he/she became assaultive again. As BMR was re-initiated (Patient was standing), WEKA Staff #2 was observed to put his/her right hand on the Patient's left facial cheek and grab the back of Patient #9's neck with his/her left hand. WEKA Staff #2 pushed Patient's head down onto the restraint bed, forcing Patient #9 to bend over, face to bed.</p> <p>- 10:12:16 pm - As restraints were being placed (Patient laying on back on restraint bed), it was observed that WEKA Staff #2 leaned his/her left elbow onto the Patient #9's chest and pushed down with his/her body weight to restrain the Patient's shoulder and chest.</p> <p>During an interview on 12/5/18 at 1:30 pm, NAPPI Instructors #1 and #2 stated these non-approved techniques are not safe and should not have been used:</p> <p>- It is never authorized to push a Patient's head away with staff's hands, this could injure the Patient's neck.</p> <p>- Placing a Patient in a hug from behind could impede the Patient's breathing.</p> <p>- Neck holds, as seen multiple times in the camera review, is extremely dangerous and could injure the neck.</p> <p>- A Patient cannot be held against a wall or hard surface, as this can impede breathing.</p> <p>- WEKA Staff #2 increased the risk to Patient #9, as well as WEKA #1 and PNA #5 when he/she immobilized the Patient's legs as the Patient was</p>	A 167		

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A 167	<p>Continued From page 50</p> <p>held against the wall. This could have caused the group to trip and fall, which could have potentially caused injury.</p> <p>- WEKA Staff #2 increased the risk of injury to Patient #9's arm by restraining it with his/her knee.</p> <p>- WEKA Staff #2 increased the risk of breathing difficulty when he/she leaned onto Patient #9's chest.</p> <p>In addition, NAPPI Instructor #1 stated he/she completed the audit of this video on 12/2/18 at 6:30 pm and sent the report, which included the inappropriate NAPPI hold techniques, to the Chief Nursing Officer (CNO).</p> <p>Review of the WEKA staff work schedule, from 12/2/18 to 12/7/18, revealed the facility could not provide an account of WEKA staff #1's and #2's hours worked within the facility after the inappropriate NAPPI techniques were identified and reported.</p> <p>Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "Those who apply the restraints ...and those who monitor patients while restrained ...will receive the training, and demonstrate the safe use of all approved restraint types, including physical hold techniques ..."</p> <p>Further review revealed: "Only NAPPI approved techniques for physical intervention will be used ...High risk considerations for ...physical or mechanical restraint(s) include ...Restraint in supine position (laying down, face up) may result in aspiration. Restraint against a wall or other</p>	A 167			

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A 167	Continued From page 51 vertical surface is not permitted under any circumstances. Pressure placed on the neck may result in an obstructed airway, and is prohibited. Weight placed on the back, abdomen, or chest may result in asphyxiation."  Additional review of the policy revealed: "Intentional misuse of a restraint technique or any handling of a patient with more force than reasonable for a patient's proper control, treatment or management will be reported as abuse per the [Alaska Psychiatric Institute] Conduct Involving Patients policy (see P&P LD-020-13 "Conduct Involving Patient") ..."	A 167			
{A 174}	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9)  Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.  This STANDARD is not met as evidenced by:  Based on record review, camera review, and interview the facility failed to ensure seclusions were discontinued at the earliest possible time for 2 patients (#1 and #16) out of 6 sampled patients who experienced a seclusion or restraint. This failed practice created a non-therapeutic environment and an increased potential for injury. Findings:  Patient #1  Record review on 11/27-29/18 and 12/5-6/18	{A 174}	A174 PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9)  Who: The DON is responsible for this corrective action and the overall ongoing compliance.  The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.  The QAPI Director is responsible for maintaining a system of monitoring and correction.  What:  DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].		

			<p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps, with specific emphasis on:</p> <ol style="list-style-type: none"><li>1. Seclusion and restraints are to be discontinued at the earliest possible time.</li><li>2. Signs that it is time to discontinue S/R.</li><li>3. LIPs to provide discontinuation criteria at the time of order.</li><li>4. RNs to be educated on documentation of detailed discontinuation criteria.</li></ol> <p>How: Unit managers will provide education to their unit staff.</p> <p>Evaluation method: A sign-in sheet will be used with the curriculum attached to document all education and training.</p> <p>Unit managers will audit all seclusion and restraint documentation for presence of discontinuation criteria in the order and in the RN documentation.</p>	
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{A 174}	<p>Continued From page 52</p> <p>revealed Patient #1 was admitted to the facility with a diagnoses that included Major Depression and Post Traumatic Stress Disorder (PTSD - anxiety and flashbacks triggered by a traumatic event).</p> <p>Review of Patient #1's medical record on 12/5/18 revealed a Brief Manual Restraint (BMR- any manual method that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely) and seclusion (the act prohibiting a patient from leaving an area) occurred on 12/4/18 at 1:15 pm. Indication for the BMR was " ...[Patient #1] was assaultive and punched staff in face. [Patient] was placed in a BMR ...walked to the Oak Room [a separate room in the facility for seclusion and restraint] using a 2-arm assist ...locked for staff safety." This seclusion lasted 1 hour and 9 minutes.</p> <p>Camera review on 12/5/18 at 2:12 pm of the 12/4/18 event revealed that Patient #1 calmly walked to the seclusion with 2 staff, each holding an arm. He/she sat with staff on the bed inside the Oak Room and cooperated while an emergency intramuscular (IM) medication (a medication given as needed for agitation) was administered. Once the medication was administered, staff released the Patient from the BMR and left the room (Patient remained seated on the bed). The door was locked at that time.</p> <p>Review of the RN documentation "RN Emergency Seclusion Initial...", dated 12/4/18 at 1:15 pm, revealed the release criteria for this seclusion was "Patient will stop verbally threatening, and punching staff. Patient will follow directions."</p> <p>Review of the "Seclusion Face to Face Flow</p>	{A 174}			

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{A 174}	<p>Continued From page 53 Sheet" for 12/4/18 revealed the Patient's behavior during the seclusion and Registered Nurse's (RNs) comments:</p> <p>-1:30 pm: "Lying/sitting" - "[Patient] lying on bed, playing with [his/her] tongue ring. [Patient] appears to be sleeping."</p> <p>-1:45 pm: "[Patient] lying/sitting on bed asked to use restroom, was asked to wait for RN ..."</p> <p>-2:00 pm: "Lying/sitting" and "quiet" - "[Patient] sitting on oak room bed, used bathroom and returned to oak room."</p> <p>-2:15 pm: "Lying/sitting" and "quiet" - "[Patient] sitting on floor picking at [his/her] feet and playing with tongue ring."</p> <p>-2:24 pm: "Lying/sitting" - "[Patient] sitting on bed, [Patient] agreed to not assault staff and follow directions as requested ..."</p> <p>When this documentation was compared with camera review, on 12/5/18, it was observed that Patient #1 was calm and non-threatening throughout the seclusion:</p> <p>- At 1:47 pm, the Physician #1 had the Oak Room door opened and assessed the Patient. The Patient was calm, cooperative, and talked while seated on the bed. The Oak Room door was relocked after this assessment.</p> <p>- At 1:54 pm, the Patient used the bathroom and did so calmly and safely. The Patient left the Oak Room, used the bathroom, and reentered the Oak Room unassisted with no prompts from staff.</p>	{A 174}			

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{A 174}	<p>Continued From page 54</p> <p>- The staff documented "kicking" in the timeframes of 2:00 pm and 2:15 pm on the "Seclusion Face to Face Flow Sheet" however this was not observed during the camera review.</p> <p>During an interview on 12/5/18 at 2:23 pm, the Non-Abusive Psychological and Physical Intervention (NAPPI - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructors #1 and #2 stated once 5 to 10 minutes of calm behavior is observed, the Psychiatric Nursing Assistants (PNAs) monitoring the patient during seclusions or restraints should call the RN on the radio to assess the patient for release. They both stated this was not observed during the camera review.</p> <p>During an interview on 12/5/18 at 2:32 pm, the NAPPI Instructors #1 and #2 stated that based on camera review, there could have been an opportunity to end the seclusion 1) when Physician #1 talked with the Patient and 2) after the bathroom break. The Instructors could not find justification to continue the seclusion.</p> <p>Patient #16</p> <p>Record review on 11/27-29/18 and 12/5-6/18 revealed Patient #1 was admitted to the facility with a diagnosis of Pervasive Developmental Disorder (characterized by delays in the development of socialization and communication skills).</p> <p>Review of Patient #16's medical record on 11/29/18 revealed a seclusion occurred on 11/19/18 at 1:48 pm. Indication for the seclusion was "Patient was spitting at staff [and] struck a</p>	{A 174}			

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{A 174}	<p>Continued From page 55</p> <p>peer. Shouting and swearing and seclusion was initiated." This seclusion lasted 1 hour and 42 minutes.</p> <p>Camera review on 11/29/18 at 1:53 pm, of the 11/19/18 event, revealed Patient #16 walked to the Oak Room after the spitting and altercation with the other peer and sat on the Oak Room bed. RN #1 was observed to say "We tried a 5 minutes time out before" (due to earlier behavior) and "A time out is not acceptable anymore. I think we need a seclusion." The door was locked at this time.</p> <p>Review of the nursing documentation "RN [Registered Nurse] Emergency Seclusion Initial..." dated 11/19/18 at 1:48 pm, revealed the release criteria for this seclusion was "1. Patient will not actually or threaten to hit, spit-at, kick, or bite staff or peers. 2. Patient will demonstrate 10 minutes of calm behavior and ability to follow staff prompts."</p> <p>During an interview on 11/29/18 at 2:22 pm, NAPPI Instructors #1 and #2 stated there was no justification to seclude Patient #16 based on camera review and Patient's cooperation to walk to the Oak Room and process with the RN.</p> <p>Review of the "Seclusion Face to Face Flow Sheet" for 11/19/18 revealed the Patient's behavior during the seclusion and RN's comments:</p> <p>-2:00 pm: "Standing still" - "[Patient] was observed quietly standing at the door and sat back on the bed but sill quiet."</p> <p>-2:15 pm: "Lying/sitting" and "walking/pacing" -</p>	{A 174}			

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{A 174}	<p>Continued From page 56</p> <p>"[Patient] sitting on the bed and still requesting to know how [many] more minutes. [Patient] stood at the door and was pushing the door but still asking how many more minutes. [Patient] started pacing around the bed and stood by the door again still [questioning] what time it was."</p> <p>-2:32 pm: "Lying/sitting" - "[Patient] was educated on release criteria including no hitting, kicking, spitting, spanking and demonstrating 10 minutes calm behavior and ability to follow prompts. [Patient] sat on the floor and started pushing the door with the legs. [Patient] stood by the door laughing ...put his lips [on] the door."</p> <p>-2:45 pm: "Lying/sitting" - "[Patient] sat back on the floor and still laughing. [Patient] was engaged with staff on a release criteria. Released criteria was discontinued because failed to demonstrate good feedback."</p> <p>-3:00 pm: "Standing still" - "[Patient] was observed still laughing and pushing the door. [Patient] was observed licking the door. [Patient] was provided some water and patient was asking what is wrong with spanking."</p> <p>-3:15 pm: "Lying/sitting" - "[Patient] was observed zipping out [unzipped] his pants laying on the bed and still laughing."</p> <p>-3:30 pm: "Lying/sitting" - "[Patient] was engaged by staff on the release criteria. [Patient] was released."</p> <p>When this documentation was compared with camera review, on 11/29/18, it was observed:</p> <p>- At 2:15 pm it was documented Patient #16 was</p>	{A 174}			

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{A 174}	<p>Continued From page 57</p> <p>pushing on the door, however this behavior was very passive with minimal force.</p> <p>- RN #2 processed with Patient #16 at 2:24 pm, giving him/her release criteria (while Patient was seated and calm) with a 10 minute timeframe for release.</p> <p>- At 2:32 pm it was documented Patient #16 was pushing on the door with legs, however this behavior was very passive with minimal force.</p> <p>- RN #2 returned at 2:48 pm (24 minutes later), talked with the PNA #7 however did not talk with the Patient.</p> <p>- RN #2 spoke to Patient at 2:50 pm (26 minutes after he/she first talked with the Patient), "you're not being dangerous but you're laughing a lot" and gave Patient an additional 10 minutes in seclusion with instructions " ...calm and respectful. Don't put your face on the window."</p> <p>- RN #2 processed with Patient at 3:09 pm (19 minutes later) while he/she sat on the bed calmly, and asked him/her "Have you been calm?" When Patient stated "Yes," RN #2 asked "Are you sure?" RN #2 extended seclusion (could not hear audio clearly to ascertain why).</p> <p>- RN #1 offered Patient water at 3:14 pm while Patient sat quietly on the floor in seclusion, then relocked the door.</p> <p>- RN #2 processed with Patient the final time at 3:20 pm. Patient was then released at 3:27 pm.</p> <p>During an interview on 11/29/18 at 3:10 pm, NAPPI Instructors #1 and #2 stated Patient #16</p>	{A 174}			

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{A 174}	Continued From page 58 should have been released from seclusion sooner. They both could not see any criteria that would justify continued seclusion. They further stated that laughing or placing face on the window is not justification to keep a Patient in seclusion.  Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "...Those authorized to provide monitoring or 15-minute assessments are competent and demonstrate competence in ...identifying readiness for discontinuation, assisting the patient in meeting the behavioral criteria for discontinuation ...Persons authorizing ...seclusion ...have demonstrated competence in choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition; recognizing how ...developmental considerations ...and history of sexual or physical abuse may affect a patient's reactions, and using behavioral criteria for discontinuing ...seclusion, and assisting patients in meeting these criteria."	{A 174}			
{A 175}	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10)  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:	{A 175}	A175 PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10)  Who: The DON is responsible for this corrective action and the overall ongoing compliance.  The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and		

			<p>reporting requirements.</p> <p>The QAPI Director is responsible for maintaining a system of monitoring and correction.</p> <p>What:</p> <p>DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].</p> <p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps, and will receive specific re-education on:</p> <ol style="list-style-type: none"><li>1. line of sight, continuous monitoring for patients in seclusion and/or restraints.</li><li>2. the correct head position and it will be stressed that patient's head must be observable at all times to assess and monitor breathing and physical status.</li><li>3. lights must be on while patient is in seclusion or restraints to allow for visualization of patient for safety.</li></ol> <p>How: Unit managers will provide education for the staff on their respective units.</p> <p>Evaluation method: Unit managers will utilize a sign-in sheet and attach a copy of the curriculum to document training was completed.</p>	
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{A 175}	Continued From page 59  Based on record review, camera review, and interview the facility failed to ensure ongoing, line of sight monitoring and assessment of 2 patients (#'s 15 & 17) while in restraint, out of 6 sampled patients who experienced seclusion and/or restraint. This failed practice placed the patients at risk for injury and/or death from complications while in restraint. Findings:  Patient #15  Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #15 was admitted to the facility with a diagnosis of Schizoaffective Disorder (a mental disorder characterized by abnormal thought processes and disturbance in the person's mood).  Review of Patient #15's medical record on 11/29/18 revealed a Brief Manual Restraint (BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely) and restraint (a method of using a mechanical device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. 5-point restraint - 2 wrist restraint, 2 ankle restraints, and one restraint across the Patient's chest while the Patient is lying on his/her back) occurred on 11/4/18 at 6:35 pm. This 5-point restraint lasted 30 minutes.  Camera review on 11/29/18 at 11:23 am, of the 11/4/18 incident revealed Patient #15 was placed in 5-point restraints at 6:35 pm with his/her head positioned within the room by the wall opposite the door and his/her feet positioned by the door.	{A 175}			

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{A 175}	<p>Continued From page 60</p> <p>Further review revealed after Patient #15 was completely in restraints, a blanket was placed over his/her body. Psychiatric Nursing Assistant (PNA) #1 assigned to monitor patient, while in restraints, positioned himself/herself outside the restraint room door in the alcove hallway. Due to Patient #15's large size and blanket use, and the position of the Patient's head away from the door, the Patient's face was not visible from the door. This impaired the PNA's ability to assess for any complications while in restraints.</p> <p>During an interview on 11/29/18 at 11:42 am, the Non-Abusive Psychological and Physical Intervention (NAPPI - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructors #1 and #2 stated patients should not be placed head-first into restraint rooms because PNAs are unable to view the Patient's head and monitor breathing unless they are directly in the room next to the Patient. They further stated that based on the camera review, PNA #1 could not have visualized Patient #15 appropriately to monitor for complications while in restraint.</p> <p>Patient #17</p> <p>Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #17 was admitted to the facility with diagnoses that included intermittent explosive disorder (behavior disorder characterized by explosive outbursts of anger and violence, often to the point of rage, that are disproportionate to the situation at hand) and intellectual disability (below average intelligence and set of life skills present before age 18).</p>	{A 175}			

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{A 175}	Continued From page 61  Review of Patient #17's medical record on 12/5/18 at 1:45 pm revealed a BMR and 4-point restraint (4-point restraint - 2 wrist restraint and 2 ankle restraints while the Patient is lying on his/her back) occurred on 11/16/18 at 7:24 pm due to assaultive behavior. This 4-point restraint lasted 1 hour and 8 minutes.  Camera review on 12/5/18 at 1:51 pm, of the 11/16/18 incident revealed Patient #17 was placed in 4-point restraints (2 wrist restraints and 2 ankle restraints) at 7:17 pm with his/her head positioned within the room by the wall opposite the door and his/her feet positioned by the door. Further review revealed that once emergency intramuscular (IM) medication was given all staff left the restraint room, turned off the lights and closed the door, leaving the Patient alone in the dark. The Patient could be heard crying. The lights were turned back on 17 seconds later, however the door remained closed.  Additional camera review revealed PNA #2 positioned himself/herself in the alcove hallway by the main unit hall doorway. Camera review revealed PNA #2 could only view Patient #17's feet through the window of the closed restraint room door. Eight minutes later, Registered Nurse (RN) #3 was observed to open the restraint room to assess and process with the Patient. Once completed, the RN closed the door again. The door was closed for 24 minutes and PNA #2 could not visualize the Patient's head or monitor appropriately for complications while in restraint. When PNA #3 replaced PNA #2, he/she opened the seclusion door and positioned himself/herself in line of sight to Patient, which allowed him/her to see the Patient's face, for the remainder of the	{A 175}			

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{A 175}	<p>Continued From page 62 restraint.</p> <p>During an interview on 12/5/18 at 2:00 pm, NAPPI Instructors #1 and #2 stated Patient #17 should not have been positioned head first in the restraint room because the PNA cannot monitor the Patient's head and breathing. They further stated the light should never be turned off when a Patient is in the room and the door should not be closed when a Patient is in restraint. They also stated that based on camera review, PNA #2 could only have seen the Patient's feet through the door closed based on where he/she was sitting. The Instructors stated RN #3 should have corrected the closed door upon entering the restraint room and instructed the PNA to keep it open.</p> <p>NAPPI Instructor #1 further stated he/she completed the audit of this event and forwarded the results, which included the staff turning off the light while the Patient was in restraints, to the Chief Nursing Officer (CNO).</p> <p>Review of the facility's policy, "Seclusion and or Restraint," dated 6/1/18, revealed: "Patient's in restraints will be monitored continuously in order to observe the patient's respirations by being physically present within the room or immediately outside the room with no obstructions blocking the view of the patient."</p> <p>Further review revealed: "Labored or rapid respiration, wheezing or other signs of respiratory abnormalities must be reported to RN immediately for assessment ...staff should always be aware of danger of aspiration of vomit while in any type of restraints."</p>	{A 175}			

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{A 175}	Continued From page 63	{A 175}			
{A 187}	<p><b>PATIENT RIGHTS: RESTRAINT OR SECLUSION</b> CFR(s): 482.13(e)(16)(iv)</p> <p>[there must be documentation in the patient's medical record of the following: ]</p> <p>The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review, camera review, and interview the facility failed to ensure documentation reflected the immediate condition or symptom(s) that warranted the use of seclusion for 2 patients (#1 and 16), out of 6 sampled patients who experienced a seclusion or restraint. This failed practice eliminated the use of the least restrictive intervention to effectively manage a patient's behavior, which violated the patient's right to be free from seclusions.</p> <p>Findings:</p> <p>Patient #1</p> <p>Record review on 11/27-29/18 and 12/5-6/18 revealed Patient #1 was admitted to the facility with a diagnoses that included Major Depression and Post Traumatic Stress Disorder (PTSD - anxiety and flashbacks triggered by a traumatic event).</p> <p>Brief Manual Restraint (BMR)</p> <p>Record review of Patient #1's medical record on 12/5/18 revealed the nurse's note "Brief Manual</p>	{A 187}	<p><b>A187</b> <b>PATIENT RIGHTS: RESTRAINT OR SECLUSION</b> CFR(s): 482.13(e)(16)(iv)</p> <p>Who: The DON is responsible for this corrective action and the overall ongoing compliance.</p> <p>The GB is responsible for ensuring that proper policies are adopted and implemented regarding seclusion and restraint, abuse and neglect, and reporting requirements.</p> <p>The QAPI Director is responsible for maintaining a system of monitoring and correction.</p> <p>What:</p> <p>DON: Will forward to the GB the current policies for review and potential revision. If changes are made, DON will ensure that staff are educated on the new policies within [timeframe].</p> <p>All nursing staff will be re-educated [by date] on current applicable P&amp;Ps, with specific emphasis on:</p> <ol style="list-style-type: none"> <li>1. Reasons for use of seclusion and/or restraints (not for coercion, discipline, convenience, retaliation).</li> <li>2. Must use least restrictive means to help patients re-gain control of behavior.</li> <li>3. Must have immediate need for S/R.</li> <li>4. Early intervention techniques that will help avoid the use of S/R.</li> <li>5. How to engage with patients.</li> </ol> <p>How: Unit managers will provide education and training for the staff on their respective units.</p>		

			<p>Evaluation Methods: Unit managers will utilize a sign-in sheet and attach a copy of the curriculum to document completion of education and training. PNAs will document how they engaged with patient and RNs will review and supervise throughout the shift. Unit managers will audit documentation of patient engagement weekly.</p>	
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{A 187}	<p>Continued From page 64</p> <p>Restraint Event," dated 12/4/18 at 1:09 pm, which documented clinical rationale for BMR: "Patient was able to acquire a pencil with a no sharps/no pens [an order that prohibits access to any potential weapon that could be used to harm self or others] order. Patient refused to surrender [his/her] pencil. Patient threw hardcover book at staff, and then punched staff in face. Patient put in BMR and escorted to oak room. Patient held in BMR while [as needed medication] were administered. Patient refused [by mouth] meds."</p> <p>Seclusion</p> <p>Record review of Patient #1's chart on 12/5/18 revealed a seclusion (the act prohibiting a patient from leaving an area) occurred on 12/4/18 at 1:15 pm. Indication for the seclusion was " ...walked to the Oak Room [a separate room in the facility for seclusion and restraint] using a 2-arm assist ...locked for staff safety." This seclusion lasted 1 hour and 9 minutes.</p> <p>Review of Patient #1's medical record on 12/5/18 revealed the nurse's note "RN Emergency Seclusion Initial ..." dated 12/4/18 at 1:15 pm, which documented the following behavior directed toward staff at the time of the initiation of the seclusion as: "[Patient] threatening with fists, poised to strike, [Patient] charging/lunging/close physically, [Patient] bumping/shoving/grabbing/pinching, [Patient] throwing objects, [Patient] hitting/kicking." Further review revealed less restrictive alternatives to emergency seclusion attempted were documented as "verbal de-escalation" and "1:1 supervision" (one staff member monitoring only this patient). Patient's response to attempted less restrictive alternatives was</p>	{A 187}			

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{A 187}	<p>Continued From page 65</p> <p>documented as "Patient became more aggressive with verbal interventions."</p> <p>Camera review on 12/5/18 at 2:12 pm of the 12/4/18 event revealed that after the assault, Patient #1 calmly walked to the seclusion with 2 staff, each holding an arm. He/she sat with staff on the bed inside the Oak Room and cooperated while an emergency intramuscular (IM) medication (a medication given as needed for agitation) was administered. Once the medication was administered, staff released the Patient from the BMR and left the room (Patient remained seated on the bed). The door was locked at that time.</p> <p>Review of the "Seclusion Face to Face Flow Sheet" for 11/19/18 revealed Patient # 16's behavior was documented as "lying/sitting" or "quiet" from 1:30 pm to 2:24 pm of the seclusion.</p> <p>During an interview on 12/5/18 at 2:20 pm, the Non-Abusive Psychological and Physical Intervention (NAPPI - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructors #1 and #2 stated a seclusion did not need to be initiated for Patient #1 on 12/4/18 based on his/her cooperative behavior while in the BMR and in the Oak Room, as well as, his/her willingness to remain in the Oak Room once released from the BMR.</p> <p>Patient #16</p> <p>Record review on 11/27-30/18 and 12/5-6/18 revealed Patient #16 was admitted to the facility with a diagnosis of Pervasive Developmental Disorder (characterized by delays in the</p>	{A 187}			

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{A 187}	<p>Continued From page 66</p> <p>development of socialization and communication skills).</p> <p>Record review of Patient #16's medical record on 12/5/18 revealed a seclusion occurred on 11/25/18 at 7:56 pm. Indication for the seclusion was " ...Patient responded by spitting on staff. Code [gray] [a call for immediate assistance from other staff within the hospital due to violent or threatening behavior that does not involve a weapon] initiated. Patient was initially aggressive towards staff, raising fist at staff. Responded to verbal prompts by [RN - Registered Nurse] and entered Oak Room. Voluntary timeout initiated at [5:50 pm]. Patient agreed to "think about it" after being unable to reflect and continuing to persevere sexually. Locked seclusion at [5:56 pm]." This seclusion lasted 1 hour and 19 minutes.</p> <p>Review of Patient #1's medical record on 12/5/18 revealed the nurse's note "RN Emergency Seclusion Initial ..." dated 12/4/18 at 1:15 pm, which documented Patient #1's behavior at the time of the initiation of the seclusion as: [Patient] threatening with fists, poised to strike: directed at staff, [Patient] charging/lunging/close physically: threat, directed at staff, [Patient] spitting: directed at staff and directed at environment, [Patient] ramming into walls/pounding doors: actual, [Patient] hitting/kicking: threat, directed at staff." Further review revealed less restrictive alternatives to emergency seclusion attempted were documented as "voluntary time out," "verbal de-escalation," and "[by mouth] [as needed] medication." The Patient's response to attempted less restrictive alternatives was documented as "Threatened staff, spit at staff, shouted and utilized racial slurs."</p>	{A 187}			

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{A 187}	<p>Continued From page 67</p> <p>Camera review on 12/5/18 revealed the Patient spit at Psychiatric Nursing Assistant (PNA) #6 after he/she was told to clean up first before headphones would be granted. A code gray was immediately called. The Patient yelled "No!" after this, spit one more time, then walked unassisted to the Oak Room. Patient sat on the bed in the Oak Room and processed with RN #2 for 10 minutes without any violent or threatening behavior. RN #2 stated the door would be locked for 15 minutes. Patient was observed to remain seated on the bed, waving hands and yelling "Please no! No, no, no!" as door was being locked.</p> <p>Review of the "Seclusion Face to Face Flow Sheet" for 11/25/18 revealed Patient #16 had no violent or threatening behavior from 6:45 pm to 7:15 pm while in seclusion.</p> <p>During an interview on 12/5/18 at 12:30 pm, NAPPI Instructors #1 and #2 stated spitting is not a justification for a code gray. They further stated a seclusion was not necessary based on the camera review of the Patient's calm behavior and willingness to process for 10 minutes safely prior to the Oak Room door being locked.</p> <p>Review of the facility's policy "Management of Patient Behavior," dated 6/1/18, revealed: "... staff will intervene in the least restrictive manner effective to assist the patient to regain emotional control and to mitigate the danger of the situation ... Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member or others and must be discontinued at the earliest possible time."</p>	{A 187}		

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{A 187}	Continued From page 68 Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "[Alaska Psychiatric Institute] is committed to providing the least restrictive environment that supports the safe and therapeutic treatment of patients; and in doing so, API allows the use of seclusion and restraint only in response to a clear and significant risk to the patient or others."  Further review of the policy revealed: "Examples of when seclusion or restraint would be appropriate for a patient ...When a patient is causing severe physical harm to self (i.e. cutting, stabbing, repetitively hitting their head or remainder of their body against a hard surface). When a patient is causing harm to others (i.e. hitting, pulling of hair) and will not be redirected or de-escalate."	{A 187}			
A 263	QAPI CFR(s): 482.21  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	A 263	A263 QAPI Program - CFR(s): 482.21  WHO: The CEO is responsible for this corrective action and the overall ongoing compliance.  WHAT: A QAPI program shall be maintained at the hospital level. This includes, at minimum; the ongoing quality improvement, safety, and hospital readiness functions commensurate with a psychiatric hospital per (A039). This includes the ongoing evaluation and compliance with the Joint Commission, Centers for Medicare and Medicaid Services (CMS), State of Alaska Licensing and Certification program requirements. This includes ensuring ongoing PI projects for contracted services as well PI projects for the 23 COPs as outlined by CMS. The QAPI Director shall be engaged in other		

		<p>such committees as the Environment of Care, Safety Committee, and the Life Safety Code Committee.</p> <p>HOW: The QAPI department shall be headed by a qualified leader. This leader will have proper investigatory skills and credentials such that their partnership with the API Nursing / Hospital Education department ensures compliance to proper process for investigating, and recommending disposition of, and reporting allegations of abuse and neglect. A summary of such cases, and recommendations and disposition shall be reported to GB at each scheduled meeting.</p> <p>The QAPI team shall ensure organizational compliance with the following items by:</p> <ol style="list-style-type: none"><li>1) using data from performance reviews and unusual occurrence reports to perform analysis of performance of employees and contracted staff to identify problem areas, and to ensure advise leadership on corrective action areas. (Reference A-0308);</li><li>2 ) adopting a formalized QAPI committee structure (Reference A-0309);</li><li>3) ensuring nursing care plans are kept up to date (Reference A-0396) by providing quantitative and qualitative audits (Hospital Education Department); through the API SMT and ET monthly.</li><li>4) ensuring the appropriate review of supervision of contract staff, and provide specific example feedback to the API SMT responsible for the contract supervision. Deficiencies and corrective action taken shall be logged and tracked in the QAPI department, and education provided shall be documented and maintained in QAPI.</li></ol> <p>API leadership and SOA GB leadership shall ensure the proper resources (funding, staff, leadership emphasis, and time) are allocated to ensure the ongoing compliance with this program, services, activities, and functions.</p> <p>EVALUATION METHOD: Annually, in September, the GB shall evaluate the effectiveness of the CEO, to include those clinical, safety, and other quality outcomes commensurate with a psychiatric hospital.</p> <p>This evaluation (success criteria) shall be</p>
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			<p>accomplished by profiling, and reporting monthly (to Senior Management, Executive Team, and the GB) industry accepted quality metrics as outlined in the QAPI program (ORYX indicators, other patient safety indicators, etc). For example, seclusion and restraint rates, allegations of abuse and neglect rates must improve.</p> <p>API GB, Executive Team and Senior Management Team leadership have attended training on "zero harm" best practices, and <i>culture change</i>. A written plan and program on implementing these two important changes, to include timelines for success, shall be developed by January 30, 2019, and approved by the GB in February.</p>	
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A 263	<p>Continued From page 69</p> <p>evidence of its QAPI program for review by CMS.</p> <p>This CONDITION is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) Program was effectively implemented and functioning to ensure improved outcomes and improve patient care services through systemic collection of hospital wide performance data. This failed practice limited the hospitals ability to identify problems and formulate action plans and reduced the likelihood of sustained improvements in clinical care and patient outcomes. Findings:</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> <li>1) ensure their QAPI program was operational and functioning in a manner to conduct a thorough analysis of problems and concerns (Reference A-0283)</li> <li>2) utilize data from performance reviews and unusual occurrence reports to utilize analysis of performance of employees and contracted staff to identify problem areas. (Reference A-0308);</li> <li>3) develop a formalized QAPI committee structure (Reference A-0309);</li> <li>4) ensure nursing care plans were kept up to date (Reference A-0396); and</li> <li>5) ensure review of supervision of contract staff</li> </ol>	A 263			

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A 263	Continued From page 70 (A-0398).	A 263			
{A 283}	<p>QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)</p> <p>(b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement.</p> <p>(c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.</p> <p>(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.</p> <p>This STANDARD is not met as evidenced by:  Based on record review and interview the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) Program was operational to identify opportunities for improvement and change, as well as, create QAPI program activities. This failed practice placed all</p>	{A 283}	<p>A283 QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)</p> <p>WHO: The QAPI Director is responsible for this corrective action and the overall ongoing compliance.</p> <p>WHAT: The QAPI Director, at the direction and discretion of the CEO and GB, will aggregate data from the 23 conditions of participation, and associated contacts to determine priorities and identify opportunities for improvement.</p> <p>Currently, API priorities are data points related to</p> <ol style="list-style-type: none"> <li>1) Episodes of seclusion and restraint</li> <li>2) Nursing care plan (improving through audits, leadership engagement, etc)</li> <li>3) General patient rights</li> </ol> <p>HOW: A listing of contracts in Microsoft Excel will be prepared to prioritize direct patient care related contracts first and then others affecting the facility, along with a date for completion indicator.</p> <p>The evaluator will fill out API's contracted evaluation form, submit the completed form to the COO for signature, the COO will submit the contract evaluation worksheets to the QAPI Director with a copy to the CFO contracts team.</p> <p>EVALUATION METHOD:  The contract evaluation form shall be used to determine contract terms compliance. Summary findings on the contract evaluation form shall include but are not limited to:</p>		

			<ol style="list-style-type: none"> <li>1) Current state and or federal licensure / certification / accreditation</li> <li>2) Evaluation for services provided to the written terms of the contract</li> <li>3) Staff/Vendor have proof of training, competency, certification, or licensure (as applicable)</li> <li>4) Performance improvement goals met as outlined in the contract or addendum</li> </ol> <p>Documentation of any performance concerns along with recommendations to proceed to contract renewal, re-evaluate contract, or indicate other actions needed.</p> <p>The COO or QAPI Director will report deviations from compliance with contracted services, as noted during the contract evaluation process or through any other quality improvement reporting process [ie: A Plan, Do, Study, Act – (PDSA) Process] to the API Executive Team Leadership and the GB upon discovery, or upon the next schedule meeting.</p> <p>Annually, at the September GB meeting, the GB will review the list of all contracts for compliance and leadership recommendations, based upon the process described above.</p>	
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{A 283}	<p>Continued From page 71</p> <p>patients (based on census of 41) at risk for disruptions in continuity of care and receiving less than optimal medical and psychiatric care.</p> <p>Findings:</p> <p>QAPI Program/Risk Management:</p> <p>Review of the facility policy "Quality Assurance and Performance Improvement (QAPI) Program," dated 10/31/18, revealed the QAPI plan establishes a system that includes an ongoing assessment, using internal and external knowledge and experience to prevent errors and maintain and improve health care safety and quality. This is done by identifying and mitigate risk and medical errors by analyzing data, monitoring, improving and sustain performance.</p> <p>During the survey the facility provided two policies entitled "Quality Assurance and Performance Improvement (QAPI) Program [QI-010-06.01]," dated 10/31/18. Review of both policies revealed they did not match under Executive Responsibilities and Prioritization.</p> <p>During an interview on 11/29/18 the Chief Nursing Officer (CNO) stated the facility currently did not have a Quality Assurance Director or Risk Management Lead. In addition, she stated the staff who performed risk management duties was reassigned to conduct environment of care duties only. The position for Quality Assurance Director and Risk Manager were not occupied at the time of survey. The CNO stated the Quality Assurance and Performance Improvement (QAPI) program was to review audits conducted by nursing staff, but due to no QAPI program no audits have been analyzed at time of survey.</p>	{A 283}		

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{A 283}	<p>Continued From page 72</p> <p>Review of the facility policy "Risk Management Plan," dated 12/7/12, revealed Risk Management was to work under the QAPI umbrella to facilitate identification, follow-up, corrective action or prevention of actual or potential problems/needs in patient care and safety.</p> <p>During an interview on 11/29/18 the Chief of Operations (COO) stated the facility was lacking a QAPI department but the facility had attempted to hold a type of QAPI meeting but was unable to provide any meeting minutes or provide details of the outcome related to this meeting. The COO stated the Executive Team was attempting to develop sub-committees that would report to the Executive Team since the facility didn't have a QAPI program. The data would then be used by the Executive Team to determine QAPI projects, but the COO stated these committees were still in the beginning phases of development.</p> <p>During an interview on 11/29/18 RN #8 and RN #9 stated the facility did not have a QAPI program and did not have an QAPI activities on their units.</p> <p>During the survey from 11/27-30/18 and 12/5-6/18 the facility was asked to demonstrate evidence of its QAPI program for effectiveness and functionality. No evidence of QAPI meetings or activities, per facility policy, were provided by the end of survey.</p> <p>Review of the facility provided "Governance Document," dated 11/2/18, revealed it was a responsibility of the Governing Body (GB) to assure the Chief Executive Officer (CEO) used appropriate and available resources to support the quality assessment and improvement functions and risk management functions related</p>	{A 283}			

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{A 283}	<p>Continued From page 73</p> <p>to patient care and safety. In addition, the document revealed the GB was responsible for the annual reporting and approval of the performance improvement plan, as well as, quarterly QAPI reports.</p> <p>Unusual Occurrence Reports (UOR) and Risk-Cause Analysis (RCA):</p> <p>Patient #1</p> <p>Record review of Patient #1's medical record dated 11/11/18 revealed the Patient was experiencing multiple daily episodes of vomiting that resulted in the Patient being transferred to a local medical hospital. Further review revealed a nursing note dated 11/12/18 that stated a nurse from the medical hospital informed RN #10 that Resident #1 self-reported consuming hand sanitizer while in the exercise room over the past few days.</p> <p>During an interview on 11/29/18 at 12:24 pm Patient #1 stated staff would open the door to the area off to the side of the gym so the Patient could have some alone time. The Patient further stated he/she would be in the room for up to 5 minutes unsupervised. When asked how many times he/she would go into the area and drink hand sanitizer, he/she stated approximately five times over the 1-2 weeks prior to his/her transfer to the medical hospital.</p> <p>During an interview on 11/29/18 at 1:38 pm, the CNO stated a root-cause analysis (RCA) was given to Physician #1 on 11/20/18. The CNO stated a RCA should have been conducted sooner.</p>	{A 283}		

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{A 283}	<p>Continued From page 74</p> <p>During an interview on 11/29/18, RN #11 stated he/she was unable to locate the investigation related to the event.</p> <p>During an interview on 11/29/18 the CNO stated the facility was unable to locate a UOR for the investigation related to Patient #1 consuming hand sanitizer. The facility created a new one during the survey. When asked if accountability of the staff had been reviewed, the CNO was unable to provide any information.</p> <p>Patient #2</p> <p>Record review of a facility provided document entitled "Alaska Psychiatric Institute [API] - Unusual Occurrence Report (UOR)," dated 11/14/18, revealed Patient #2 stated that he/she conducted an inappropriate and non-consented sexual act toward Patient #19 sometime in October 2018. This was allegedly reported to the RN #12 sometime during his/her evening shift from 11/13/18-11/14/18.</p> <p>When asked if the facility conducted any investigation into staff accountability and preventability, the CNO was unable to provide any information.</p> <p>Further review of the QAPI policy, dated 10/31/18, indicated that the facility utilized an UOR system to report identified safety events and near misses. Data from these reports were to be reported to QAPI. The QAPI program was to oversee patient safety events, including adverse events and sentinel events in which were to be reported in accordance with all state and federal regulations. In addition the QAPI plan was to include input from several committees and work</p>	{A 283}			

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{A 283}	<p>Continued From page 75 groups.</p> <p>During an interview on 11/29/18 the COO stated that QAPI was ultimately in charge of reviewing UORs and conducting Risk-Cause Analysis (RCA) but due to not having a QAPI department, the UORs had not been reviewed by a QAPI. The UORs were attempted to be absorbed through the Executive Team.</p> <p>During random interviews with the Executive Team (Chief Executive Officer, Chief of Operations, Chief Nursing Officer, Chief Financial Officer, and Chief of Psychiatry) of API from 11/27-30/18 and 12/5-6/18 the team was unable to provide any information regarding the investigation process when looking at unusual occurrence reports related to preventability and staff accountability.</p> <p>Review of the facility policy "Risk Management Plan," dated 12/7/12, revealed Risk Management was purposed with the responsibility of sentinel events policy and procedure, and root-cause analysis action plan. These components were described as the practical application and implementation in which requires immediate team analysis of all root causes of any defined sentinel event.</p> <p>Review of the API Committee Structure document (approved document Appendix A), dated 10/31/18 revealed the Director of QAPI was to co-chair the QAPI Committee. The responsibilities of the committee was to approve all QAPI projects, review Risk-Cause Analysis, monitor QAPI projects and monitor any citations by the Center for Medicare and Medicaid Service (CMS) as a QAPI project.</p>	{A 283}			

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{A 283}	Continued From page 76  Review of the facility provided "Hospital Based Incident UOR Flow Chart," dated 11/26/18, revealed once an incident has been identified it is sent to a supervisor for review. After the supervisory review the document indicated " ALL UOR Given to [Quality Improvement] Admin Box/QAPI by 7:30 am ..." and must be logged by "QAPI Admin."  Grievance:  Review of the facility policy "Complaint and Grievance Policy," dated 10/31/18, revealed "Quality Improvement ...The [Recovery Support Specialist] will maintain a tracking log of all complaints and grievances ...Data collected regarding patient grievances, as well as other complaints that are not defined as grievances, will be incorporated in the Quality Assessment and Performance Improvement (QAPI) Program. Trends will be identified, and action plans will be initiated when required ...The QAPI Director will provide a summary report on the grievance process, timeframes, and trends to the Governing Body quarterly and as needed.  During random interviews during the survey, the COO and CNO stated no data was sent to a QAPI Lead due to the lack of the position being filled and the absences of a QAPI program.	{A 283}			
A 308	QAPI GOVERNING BODY, STANDARD TAG CFR(s): 482.21  ... The hospital's governing body must ensure that the program reflects the complexity of the	A 308	A308 – see next page		

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A 308	<p>Continued From page 77</p> <p>hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review and interview the governing body failed to maintain and implement a quality assurance and performance improvement (QAPI) plan to monitor, evaluate, and improve the quality of patient care services through analysis of performance reviews. The failure to monitor the quality of care limited the hospitals ability to identify problems and formulate action plans, thus reducing the likelihood of systemic corrections in patient care. Findings:</p> <p>Record review of the facility policy, on 11/28-29/18, revealed "Quality Assurance and Performance Improvement (QAPI) Program," dated 10/31/18, revealed the QAPI plan establishes a system that includes an ongoing assessment, using internal and external knowledge and experience to prevent errors and maintain and improve health care safety and quality. This is done by identifying and mitigate risk and medical errors by analyzing data, monitoring, improving and sustain performance.</p> <p>During the survey the facility provided two policies entitled "Quality Assurance and Performance Improvement (QAPI) Program [QI-010-06.01]," dated 10/31/18. Review of both policies revealed they did not match under Executive Responsibilities and Prioritization.</p>	A 308	<p>A308</p> <p>WHO: The CEO, GB, and QAPI Director are responsible for this corrective action and the overall ongoing compliance.</p> <p>WHAT: A QAPI program shall be maintained at the hospital level. This includes, at minimum; the ongoing quality assurance, safety, and hospital readiness functions commensurate with a psychiatric hospital. This includes the ongoing evaluation and compliance with the Joint Commission, Centers for Medicaid and Medicare Services, and State of Alaska Licensing and Certification program requirements. This includes ensuring ongoing PI projects for contracted services as well PI projects for the 23 COPs as outlined by CMS. The QAPI Director shall be engaged in other such committees as the Environment of Care, Safety Committee, and the Life Safety Code Committee.</p> <p>HOW: The QAPI department shall be headed by a qualified leader. This leader will have proper investigatory skills and credentials such that their partnership with the API Nursing / Hospital Education department ensures compliance to proper process for investigating, and recommending disposition of, and reporting allegations of abuse and neglect. A summary of such cases, and recommendations and disposition shall be reported to GB at each scheduled meeting.</p> <p>API Leadership and State of Alaska (SOA) GB Leadership shall ensure the proper resources (funding, staff, leadership emphasis, and time) are allocated to ensure the ongoing compliance with this program, services, activities, and functions.</p> <p>EVALUATION METHOD: A QAPI Director shall be hired by 20 Jan 2019. The appropriate structure, with respect to committee, data reporting, contract analysis, and evaluation of 23 CoP shall be in place by January 30, 2019.</p>		

			<p>Annually, in September, the GB shall evaluate the effectiveness of the CEO, to include those clinical, safety, and other quality outcomes commensurate with a psychiatric hospital.</p> <p>This evaluation (success criteria) shall be accomplished by profiling, and reporting monthly (to Senior Management, Executive Team, and the GB) industry accepted quality metrics as outlined in the QAPI program (ORYX indicators, other patient safety indicators, etc). For example, seclusion and restraint rates, allegations of abuse and neglect rates must improve.</p> <p>API GB, Executive Team and Senior Management Team leadership have received training on "zero harm" best practices, and <i>culture change</i>. A written plan and program on implementing these two important changes, to include timelines for success, shall be developed by January 30, 2019, and approved by the GB in February.</p>	
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A 308	<p>Continued From page 78</p> <p>During an interview on 11/29/18 the Chief Nursing Officer (CNO) stated the facility currently did not have a Quality Assurance Director or Risk Management Lead. In addition, she stated the staff who performed risk management duties was reassigned to conduct environment of care duties only. The position for Quality Assurance Director and Risk Manager were not occupied at the time of survey. The CNO stated the Quality Assurance and Performance Improvement (QAPI) program was to <b>review audits</b> conducted by nursing staff, but due to no QAPI program no audits have been analyzed at time of survey.</p> <p>Review of the facility policy "Risk Management Plan," dated 12/7/12, revealed Risk Management was to work under the QAPI umbrella to facilitate identification, follow-up, corrective action or prevention of actual or potential problems/needs in patient care and safety.</p> <p>During an interview on 11/29/18 the Chief of Operations (COO) stated the facility was lacking a QAPI department but the facility had attempted to hold a type of QAPI meeting but was unable to provide any meeting minutes or provide details of the outcome related to this meeting. The COO stated the Executive Team was attempting to develop sub-committees that would report to the Executive Team since the facility didn't have a QAPI program. The data would then be used by the Executive Team to determine QAPI projects, but the COO stated these committees were still in the beginning phases of development.</p> <p>During an interview on 11/29/18 RN #8 and RN #9 stated the facility did not have a QAPI program.</p>	A 308			

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A 308	Continued From page 79 During the survey from 11/27-30/18 and 12/5-6/18 the facility was asked to demonstrate evidence of its QAPI program for effectiveness and functionality. No evidence of QAPI meetings or activities, per facility policy, were provided by the end of survey.  Review of the facility provided "Governance Document," dated 11/2/18, revealed it was a responsibility of the Governing Body (GB) to assure the Chief Executive Officer (CEO) used appropriate and available resources to support the quality assessment and improvement functions and risk management functions related to patient care and safety. In addition, the document revealed the GB was responsible for the annual reporting and approval of the performance improvement plan, as well as, quarterly QAPI reports.	A 308			
A 309	<b>QAPI EXECUTIVE RESPONSIBILITIES</b> CFR(s): 482.21(e)(1), (e)(2), (e)(5)  The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:  1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are	A 309	<b>A309</b>  WHO: The CEO, GB, and QAPI Director are responsible for this corrective action and the overall ongoing compliance.  WHAT: A QAPI program shall be maintained at the hospital level. This includes, at minimum; the ongoing quality assurance, safety, and hospital readiness functions commensurate with a psychiatric hospital. This includes the ongoing evaluation and compliance with the Joint Commission, Centers for Medicaid and Medicare Services, and State of Alaska Licensing and Certification program requirements. This includes ensuring ongoing PI projects for contracted services as well PI projects for the 23 COPs as outlined by CMS. The QAPI Director shall be engaged in other such committees as the Environment of Care, Safety Committee, and the Life Safety Code Committee.		

		<p>HOW: The QAPI department shall be headed by a qualified leader. This leader will have proper investigatory skills and credentials such that their partnership with the API Nursing / Hospital Education department ensures compliance to proper process for investigating, and recommending disposition of, and reporting allegations of abuse and neglect. A summary of such cases, and recommendations and disposition shall be reported to GB at each scheduled meeting.</p> <p>API Leadership and SOA GB Leadership shall ensure the proper resources (funding, staff, leadership emphasis, and time) are allocated to ensure the ongoing compliance with this program, services, activities, and functions.</p> <p>EVALUATION METHOD: A QAPI Team leaders shall be hired by January 30, 2019. The appropriate structure, with respect to committee, data reporting, contract analysis, and evaluation of 23 CoP shall be in place by January 30, 2019.</p> <p>Annually, in September, the GB shall evaluate the effectiveness of the CEO, to include those clinical, safety, and other quality outcomes commensurate with a psychiatric hospital.</p> <p>This evaluation (success criteria) shall be accomplished by profiling, and reporting monthly (to Senior Management, Executive Team, and the GB) industry accepted quality metrics as outlined in the QAPI program (ORYX indicators, other patient safety indicators, etc). For example, seclusion and restraint rates, allegations of abuse and neglect rates must improve.</p> <p>API GB, Executive Team and Senior Management Team leadership have received training on "zero harm" best practices, and <i>culture change</i>. A written plan and program on implementing these two important changes, to include timelines for success, shall be developed by January 30, 2019, and approved by the GB in February.</p>
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A 309	<p>Continued From page 80 evaluated.</p> <p>(5) That the determination of the number of distinct improvement projects is conducted annually.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure a functional Quality Assurance and Performance Improvement (QAPI) program that maintained an ongoing program to identify problems and formulate action plans. This failed practice reduced the likelihood of sustained improvements hospital practice. Findings:</p> <p>Record review, on 11/28-29/18, of the facility policy "Quality Assurance and Performance Improvement (QAPI) Program," dated 10/31/18, revealed the QAPI plan establishes a system that includes an ongoing assessment, using internal and external knowledge and experience to prevent errors and maintain and improve health care safety and quality. This is done by identifying and mitigate risk and medical errors by analyzing data, monitoring, improving and sustain performance.</p> <p>During the survey the facility provided two policies entitled "Quality Assurance and Performance Improvement (QAPI) Program [QI-010-06.01]," dated 10/31/18. Review of both policies revealed they did not match under Executive Responsibilities and Prioritization.</p> <p>During an interview on 11/29/18 the Chief Nursing Officer (CNO) stated the facility currently did not have a Quality Assurance Director or Risk</p>	A 309			

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A 309	<p>Continued From page 81</p> <p>Management Lead. In addition, she stated the staff who performed risk management duties was reassigned to conduct environment of care duties only. The position for Quality Assurance Director and Risk Manager were not occupied at the time of survey. The CNO stated the Quality Assurance and Performance Improvement (QAPI) program was to review audits conducted by nursing staff, but due to no QAPI program no audits have been analyzed at time of survey.</p> <p>Review of the facility policy "Risk Management Plan," dated 12/7/12, revealed Risk Management was to work under the QAPI umbrella to facilitate identification, follow-up, corrective action or prevention of actual or potential problems/needs in patient care and safety.</p> <p>During an interview on 11/29/18 the Chief of Operations (COO) stated the facility was lacking a QAPI department but the facility had attempted to hold a type of QAPI meeting but was unable to provide any meeting minutes or provide details of the outcome related to this meeting. The COO stated the Executive Team was attempting to develop sub-committees that would report to the Executive Team since the facility didn't have a QAPI program. The data would then be used by the Executive Team to determine QAPI projects, but the COO stated these committees were still in the beginning phases of development.</p> <p>During an interview on 11/29/18 RN #8 and RN #9 stated the facility did not have a QAPI program.</p> <p>During the survey from 11/27-30/18 and 12/5-6/18 the facility was asked to demonstrate evidence of its QAPI program for effectiveness</p>	A 309			

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A 309	Continued From page 82 and functionality. No evidence of QAPI meetings or activities, per facility policy, were provided by the end of survey.	A 309			
{A 396}	<p><b>NURSING CARE PLAN</b> CFR(s): 482.23(b)(4)</p> <p>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure nursing care plans were kept up to date for 4 patients (#s 3, 11, 14, and 18), out of 8 sampled patients whose care plan was reviewed. Without appropriate and current care plans patients are at risk for not receiving the necessary and/or appropriate care and services. Findings:</p> <p>During an interview on 11/27/18 at 10:12 am, Registered Nurse (RN) #1 stated nursing care plans have been recently separated from the interdisciplinary treatment plans (a treatment plan developed by the doctors and clinical therapists used to address psychiatric problems and goals set during hospitalization to address them). He/she further stated nursing care plans were to focus on nursing interventions.</p> <p>During an interview on 11/27/18 at 2:50 pm, RN #5 stated nursing care plans were done upon admission and updated "as necessary."</p>	{A 396}	A396		
			<p>Who: The DON is responsible for this corrective action and the overall ongoing compliance.</p> <p>What: All licensed nursing staff will be trained on how to complete a nursing care plan, to include all areas addressed.</p> <p>All licensed nursing staff will be educated that nursing care plans must include medical problems for which the patient is being treated or monitored.</p> <p>How: Unit managers will educate all licensed nursing staff on completion of nursing care plans.</p> <p>Evaluation Method: Unit managers will utilize a sign-in sheet with the curriculum attached to document completion of education and training on nursing care plans. Unit managers will audit nursing care plans weekly.</p>		

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{A 396}	<p>Continued From page 83</p> <p>Patient #3</p> <p>Record review from 11/27-30/18 and 12/5-6/18 revealed Patient #3 was admitted to the facility with a diagnosis of moderate intellectual disability (defined as low IQ score in addition to one or more physical or neurological abnormalities).</p> <p>Review of the Patient's nursing admission assessment, dated 11/2/18 at 12:45 pm, revealed the Patient reported moderate pain to his/her left hand. "[Patient] told RN that [he/she] hurt [his/her] left hand while doing push ups while [he/she] was in jail. RN observed normal [range of motion] on [his/her] [left] hand." The RN indicated in the assessment this Patient did not need intervention for this pain.</p> <p>Review of the Patient's Health and Physical, dated 11/2/18 at 9:30 pm, revealed the Patient was diagnosed with "left wrist mild ligamentous strain secondary to exercise" and was given a wrist soft splint for wrist support for 3 days.</p> <p>Review of Patient #3's medical record on 11/27/18 revealed a nursing care plan, dated 11/2/18, labeled as: "medical diagnosis: moderate intellectual disability. Assessment: Risk for violence self-directed and directed to others [as evidenced by] [history] of assaults to others and [history] of harming self." Further review revealed no identification of the left wrist strain was documented within the care plan.</p> <p>Additional review of the nursing care plan revealed it was last updated on 11/9/18.</p> <p>Patient #11</p>	{A 396}			

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NAME OF PROVIDER OR SUPPLIER  <b>ALASKA PSYCHIATRIC INSTITUTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3700 PIPER STREET</b> <b>ANCHORAGE, AK 99508</b>		
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{A 396}	<p>Continued From page 84</p> <p>Record review from 11/27-30/18 and 12/5-6/18 revealed Patient #11 was admitted to the facility with a diagnosis of schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression). Further review revealed the Patient had self-inflicted lacerations to the abdomen and neck upon admission from a suicide attempt.</p> <p>Review of the Patient's nursing admission assessment, dated 11/6/18 at 3:14 pm, revealed the Patient's abdominal wound was assessed: "self inflicted laceration with closure-glue. Patient has dressing to area and has verbalized desire/attempted to reopen wound."</p> <p>Review of the Patient's Health and Physical, dated 11/7/18 at 8:55 am, revealed the Patient's self-inflicted lacerations to his/her neck and abdomen were identified and daily wound care assessment and dressing changes to the abdomen were ordered.</p> <p>Review of Patient #11's medical record on 11/27/18 revealed a nursing care plan, dated 11/6/18, labeled as: "Primary diagnosis: schizoaffective disorder. Assessment: high risk for self directed violence as evidenced by verbalization of desire to harm/kill self, recent serious event with [overdose] and self inflicted wounds, and attempting to reopen self inflicted wounds ..." Further review revealed the wound care assessment and daily dressing changes were not included in the nursing care plan interventions.</p> <p>During an interview on 11/27/18 at 1:45 pm, RN</p>	{A 396}			

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{A 396}	<p>Continued From page 85</p> <p>#5 and #7 stated wound care intervention are not part of the nursing care plan, the care plans are directed toward psychiatric behavior that could place the patient at risk for harm. They further stated medical interventions are added to the interdisciplinary treatment plan by the doctors and physician's assistants.</p> <p>During an interview on 11/28/18 at 2:10 pm, the Nursing Educator stated nursing care plans should include medical interventions, such as wound care. When asked if the training about the new nursing care plan process included the expectation that medical interventions needed to be documented on the care plans, the Nursing Educator stated the curriculum did not state this, "I just talked about it in my examples."</p> <p>Patient #14</p> <p>Record review from 11/27-30/18 and 12/5-6/18 revealed Patient #14 was admitted to the facility with diagnoses that included schizophrenia and obesity.</p> <p>Review of the Patient's Health and Physical, dated 11/7/18 at 9:22 am, revealed the Patient had a history of elevated blood sugars. A Hemoglobin A1C blood test (a test to tell you the average level of blood sugar over the past 2 to 3 months) and fasting blood glucose (blood sugar) test was ordered.</p> <p>Review of the Patient's medical record revealed the lab work for the fasting blood glucose returned on 11/8/18 which showed an elevated level of 175 milligrams/deciliter (normal range is 65-99). In addition, lab work for the Hemoglobin A1C returned on 11/10/18 which showed an</p>	{A 396}			

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{A 396}	Continued From page 87  Review of the Patient's Health and Physical, dated 11/15/18 at 6:23 pm, revealed these diagnoses were assessed and orders for medication intervention was placed.  Review of Patient #18's medical record on 11/27/18 revealed a nursing care plan, dated 11/15/18, labeled as: "medical diagnosis: type II diabetes, [hypertension], hypercholesterolemia. Assessment: Risk for violence to self or others." This care plan did not address the medical diagnoses it identified. Further review revealed the care plan had not been updated since written.  During an interview on 11/27/18 at 3:15 pm, RN #5 stated Patient #18's care plan was updated in the electronic medical record, but the nurse failed to update the paper in the chart. He/she further stated the policy on nursing care plans is not very clear and can be misinterpreted as to what to do when developing the care plan.  During an interview on 11/28/18 a 2:50 pm, the Nursing Educator stated the nursing care plan training was about goal writing and not directly about expectations of what should be written in the care plan. When the Nursing Educator reviewed the facility policy "Nursing Care Plan," dated 10/15/18, he/she stated it does not address what should be written in a care plan.  During an interview on 11/29/18 at 3:53 pm, RN Supervisor #1 stated the care plan education was only on goal writing. There were no care plan expectations, or education on adding active medical interventions. He/she stated medical interventions should be on the care plans.	{A 396}			

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{A 396}	Continued From page 88 Review of the facility's policy "Nursing Care Plan," dated 10/15/18, revealed: "A registered nurse will develop and keep current a nursing care plan for each patient, based on nursing assessments, re-assessments, and input from the patient/guardian and other relevant sources. A registered nurse will document patient progress toward nursing goals ...The nursing care plan is based on the patient's needs and includes relevant nursing interventions ...The registered nurse completes ongoing assessments of the patient, to include assessment of the patient's needs and response to interventions. Revision to the nursing care plan are made based on these ongoing assessments ...The nursing care plan must be consistent with the medical plan of care."	{A 396}			
A 398	<b>SUPERVISION OF CONTRACT STAFF</b> CFR(s): 482.23(b)(6)  Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services.  This STANDARD is not met as evidenced by:  Based on record review, video review, and interview the family failed to ensure the clinical activities of contracted support services staff (WEKA-security staff hired within the facility to help with escalated situations who must comply with facility approved NAPPI hold techniques) were supervised and evaluated to ensure	A 398	<b>A398</b> <b>SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) – Licensed nurses and WEKA ED</b>  WEKA staff are not licensed nurses and WEKA is not part of the nursing department. The nursing department does not contract for WEKA services. The nursing department does not supervise WEKA staff. WEKA is considered security, not patient care staff. The concerns about WEKA staff are addressed in the other tags. Additionally, the GB will adopt a Contracted Services policy by January 30, 2019. This policy will require contractors to be subject to the same QAPI requirements as direct hospital services and that contracted service providers are assessed for competence in their work. Issues with contractor performance will be reported to the GB.		

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A 398	<p>Continued From page 89</p> <p>compliance with facility policies and/or the safety of the patients. This failed practice placed all patients (based on a census of 41) at risk for injury and/or harm from inappropriate hold techniques. Findings:</p> <p>During a video review of a brief manual hold (BMR) and restraint of Patient #9, on 11/23/18, at 9:38pm, revealed WEKA Staff #1, #2, and Psychiatric Nurse Aide (PNA) #5 took Patient #9 to the floor in a controlled manner. Staff restrained the Patient on the floor for 6 minutes, patient positioned on his/her back and staff on all limbs. Patient #9 was walked to the Oak Room (seclusion room) at 9:44 pm after other staff arrived.</p> <p>When Patient #9 became assaultive in the Oak Room, BMR on the restraint bed was initiated (Patient placed on his/her back). WEKA Staff #2 was observed to place his/her right knee on Patient #9's right arm (the arm was raised, bent at 90 degrees, back of hand lying flat on the restraint bed), at the elbow and upper arm junction. WEKA Staff #2 applied pressure with his/her knee to keep arm stationary. WEKA Staff #2 restrained the arm in this manner for 2 minutes and 15 seconds.</p> <p>After a release from the BMR was attempted, to lock Patient #9 in seclusion, however he/she became assaultive again. As BMR was re-initiated (Patient was standing), WEKA Staff#2 was observed to put his/her right hand on the Patient's left facial cheek and grab the back of Patient #9's neck with his/her left hand. WEKA Staff #2 pushed Patient's head down onto the restraint bed, forcing Patient #9 to bend over, face to bed.</p>	A 398			

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A 398	<p>Continued From page 90</p> <p>At 10:12 pm - As restraints were being placed (Patient laying on back on restraint bed), it was observed that WEKA Staff #2 leaned his/her left elbow onto the Patient #9's chest and pushed down with his/her body weight to restrain the Patient's shoulder and chest.</p> <p>During an interview on 12/5/18 at 1:30 pm, NAPPI Instructors #1 and #2 stated these non-approved techniques are not safe and should not have been used:</p> <ul style="list-style-type: none"> <li>- It is never authorized to push a Patient's head away with staff's hands, this could injure the Patient's neck.</li> <li>- Placing a Patient in a hug from behind could impede the Patient's breathing.</li> <li>- Neck holds, as seen multiple times in the camera review, is extremely dangerous and could injure the neck.</li> <li>- A Patient cannot be held against a wall or hard surface, as this can impede breathing.</li> </ul> <p>During an interview on 12/5//18 at 1:30 pm, when asked about an event in which WEKA staff had not implemented NAPPI (Non-Abusive Psychological and Physical Intervention - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) restraint techniques for 1 patient (#9), NAPPI Instructor #1 stated he/she completed the audit of this video on 12/2/18 at 6:30 pm and sent the report, which included the inappropriate NAPPI hold techniques, to the Chief Nursing Officer (CNO).</p>	A 398			

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A 398	Continued From page 91  Review of the WEKA staff work schedule, from 12/2/18 to 12/7/18, revealed the facility could not provide an account of WEKA staff #1's and #2's hours worked within the facility after the inappropriate NAPPI techniques were identified and reported.  Review of the facility's policy "Seclusion and or Restraint," dated 6/1/18, revealed: "Those who apply the restraints ...and those who monitor patients while restrained ...will receive the training, and demonstrate the safe use of all approved restraint types, including physical hold techniques ..."  Further review revealed: "Only NAPPI approved techniques for physical intervention will be used ...High risk considerations for ...physical or mechanical restraint(s) include ...Restraint in supine position (laying down, face up) may result in aspiration. Restraint against a wall or other vertical surface is not permitted under any circumstances. Pressure placed on the neck may result in an obstructed airway, and is prohibited. Weight placed on the back, abdomen, or chest may result in asphyxiation."  Review of the facility's policy, "Quality Assurance Performance Improvement (QAPI) Program, dated 10/31/18, revealed no information about assessing the services provided by the contractor WEKA was reported to QAPI.  Review of the contract with the facility and WEKA, dated 3/15/18, revealed no information about evaluating performance and/or concerns and how the facility would ensure improvement of services.	A 398			

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A 398	Continued From page 92  During the survey from 11/27-30/18 and 12/5-6/18 the facility was asked to demonstrate evidence of its QAPI program for effectiveness and functionality. No evidence of QAPI meetings or activities, per facility policy, were provided by the end of survey.  Review of the facility provided "Governance Document," dated 11/2/18, revealed it was a responsibility of the Governing Body (GB) to assure the Chief Executive Officer (CEO) used appropriate and available resources to support the quality assessment and improvement functions and risk management functions related to patient care and safety. In addition, the document revealed the GB was responsible for the <b>annual reporting and approval of the performance improvement plan</b> , as well as, quarterly QAPI reports.	A 398			