

Alaska Psychiatric Institute CMS Corrective Action Plan
Updated 5-21-2019

Finding ID TAG	Deficiency	Plan of corrective action for each deficiency cited and Procedure/process for implementing the acceptable plan of correction for each deficiency cited.	Monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.	Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice.	The responsible individual	Completion date for correction of each deficiency cited.
A 115 PATIENT RIGHTS CFR(s): 482.13	The hospital failed to ensure patients' rights were protected and promoted.	This citation addressed below.				
A 115 PATIENT RIGHTS CFR(s): 482.13	A-144: The facility failed to ensure a patient on one to one (1:1) supervision was supervised according to facility 1:1 supervision policy and failed to follow procedures for monitoring the Safety of units that housed patients on 1:1 supervision. This failed practice placed all patients at risk for exposure to an unsafe environment.	Personnel assigned to closed camera system observation area will be watching patients and staff during 1:1 assignments. They will be monitoring for safety to include adherence to the policy. Nursing will reinstitute a practice of providing a list of patients currently on 1:1 to WEKA contracted staff, posted in a room observing the live video feed and monitoring for imminent issues of concern and safety. The current list of patients on 1:1 supervision will be provided to WEKA on-duty staff, daily, on every shift.	Staff will document the incidents of notification to the nursing unit, near miss and actual events.	Documentation will be collected via a log on a shift by shift basis and reported to QAPI team for monthly aggregation and escalation of improvement opportunities to Director of Nursing.	Director of Nursing	5/22/2019

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	<p>A-167: The facility failed to ensure the safe application of mechanical restraints:</p> <p>Specifically, the facility failed to:</p> <p>1) Recognize improper fitting of restraints and 2) Identify the risk of improper restraint application and implement interventions for safety.</p>	<p>1.1 The nursing shift supervisor will serve as a third party during a restraint event. They will be responsible for ensuring safety and proper application of the restraint, provide feedback and debrief with staff.</p> <p>1.2 Video footage of all incidents, in which a patient was mechanically restrained, will be reviewed by the Nurse manager or supervisor, following the incident to ensure restraints were applied per policy.</p> <p>1.3 The facility has reinstated weekly meetings for the Seclusion and Restraint Committee. This committee's objective is to review all incidents of seclusion, manual holds, and mechanical restraints and their use, notable trends and compliance in implementation as well as documentation.</p>	<p>Audit of restraint episode will be completed by the NSS to include, proper documentation, order and assessment by LIP.</p> <p>Video will be used by the restraint & seclusion committee for training purposes with frontline staff.</p>	<p>All incidents of mechanical restraints will be reviewed by the Seclusion and Restraint Committee, daily in the morning safety meeting.</p> <p>Data related to the application of mechanical restraints will also be reviewed in Nursing Leadership, Medical Executive Committee, and will be reported in the monthly QAPI meeting by the Risk Manager or designee.</p>	<p>1.1 Director of Nursing</p> <p>1.2 Director of Nursing</p> <p>1.3 Nursing</p>	<p>Data will be reported at the monthly QAPI meeting.</p> <p>Video footage review will begin 5/7/2019.</p> <p>Seclusion and Restraint committee meetings will begin week of 5/6/2019. Monthly reporting to QAPI will begin 6/2019.</p>

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A 202 PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(2)(iv)	Based on record review, camera review, interview, and policy review the facility failed to ensure restraint training included how to: 1) Recognize improper fitting of restraints and 2) Identify the risk of improper restraint application and implement interventions for safety.	The restraint training curriculum will be reviewed and revised, as needed to ensure the training includes techniques for: ○ Proper fitting of mechanical restraints ○ Recognizing improper fitting of restraints ○ Identifying the risk of improper restraint application ○ Updated EMR to include field for restraint sizing Mock restraint drills to be conducted each week on rotating units.	Nursing education team will participate in the safety huddle and review restraint use daily to ensure alignment with hospital policy. Results of the drills will be reviewed by the Restraint/Seclusion committee.	Nursing education team will confirm adherence to policy and seek opportunities to improve based on trends from the safety huddle and weekly restraint/seclusion committee data. The results will be shared with staff during leader rounds.	Designated Hospital Education staff Hospital leadership	The training curriculum will be reviewed and revised, as needed, by 5/13/2019. 5/22/2019

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A 286 PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3)	Based on record review and interview the facility failed to identify and analyze causes of an adverse patient event involving sexualized Behavior and provide feedback and learning to improve facility performance. This failed practice placed patients at risk for exposure to an unsafe environment.	<p>1.1 The facility initiated a comprehensive review of the adverse event. Discussions were held with nursing leaders to specifically review the patient event involving sexualized behavior. In person discussions with direct care staff included a review of the requirement to report immediately to hospital leadership, any patient sexualized behavior and remove all patients from the surrounding area in order to mitigate exposure to an unsafe environment.</p> <p>1.2 To further ensure comprehensive assessments, adverse events, including sexualize behaviors and exposure in the past 24-48 hours, will be reviewed during the daily person served safety huddle. and data will be used to mitigate potential events going forward</p>	<p>Feedback from the review/analysis of the event will be provided to Hospital Leadership to improve facility performance and appropriate corrective actions, will be initiated.</p> <p>During the daily safety huddle, Leadership will validate that a review of any adverse event was initiated following the incident occurrence.</p>	<p>The status of any corrective actions initiated based on incident review and analysis, and Patient Safety Committee discussions will be reported during the monthly QAPI meetings by the Risk Manager or designee.</p> <p>Director QI/designee will report the status of the initiated reviews of the adverse event during the monthly Patient Safety/ QAPI meetings.</p>	<p>1.1 Safety Director</p> <p>1.2 Safety Director</p>	<p>Incident review and analysis was initiated immediately and will be finalized by 5/15/19.</p> <p>Leadership will review and develop corrective actions, as needed by 5/22/19.</p> <p>Daily review of adverse events was initiated in March and will be ongoing.</p>

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A 309 QAPI EXECUTIVE RESPONSIBILITIES CFR(s): 482.21(e)(1), (e)(2), (e)(5)	Based on record review and interview the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) program addressed priorities for improved quality of care and patient safety and develop improvement actions to be evaluated. This failed practice reduced the likelihood of sustained improved hospital practices which placed all patients at risk for receiving care and services in a less than optimal healthcare setting.	<p>The hospital now ensures a QAPI program is in place and active to address priorities for improved quality of care and patient safety.</p> <p>The facility has hired a dedicated QAPI Director, Director of Risk Management and Compliance Director to ensure adequate resources and expertise in maintaining compliance. The start date for these employees was May 6, 2019.</p> <p>The hospital wide QAPI Program includes the input and performance improvement activities of relevant committees and work groups including, but not limited to:</p> <ul style="list-style-type: none"> • <i>Clinical practice council</i> • <i>Quality Assurance and Performance Improvement (QAPI) Committee</i> • <i>Infection Control Committee</i> • <i>Medication Management Committee</i> • <i>Discharge Planning Committee</i> • <i>Grievance Committee</i> • <i>Medical Executive Committee</i> • <i>Policy and Procedure Review Committee</i> • <i>Environment of Care Committee</i> • <i>Seclusion and Restraint Review Committee</i> 	<p>Performance Improvement initiatives are monitored through the monthly QAPI committee meetings.</p> <p>Executive Management and Governance Committees review performance improvement initiatives and progress quarterly.</p>	<p>The 2018-2019 QAPI plan was amended to include additional safety indicators. This is the standard for the hospital's QAPI program as of April 2019.</p>	<p>QAPI Director /designee</p>	<p>Process began in April 2019 and is ongoing.</p>

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		<p>The hospital QAPI program has evaluated the previous year's data and trends. The QAPI committee, including hospital leaders, has developed a comprehensive set of committee initiatives and indicators in order to promote quality of care and patient safety.</p> <p>This information was presented and discussed as part of the April QAPI meeting and disseminated through meeting minutes on April 22, 2019.</p>				
<p>A 396 NURSING CARE PLAN CFR(s): 482.23(b)(4))</p>	<p>Based on record review and interview, the facility failed to develop accurate and up-to-date nursing care plans. This failed practice placed residents at risk for not receiving the necessary and/or appropriate care and services.</p> <p>Specifically, the patient's care plan did not reflect the identification or current plan of care for current active medical conditions.</p>	<p>1.1 On May 1, 2019, representatives from the clinical leadership team, nursing representative from each unit, a medical provider, and the hospital CEO participated in a comprehensive review of the existing treatment planning process, policies and procedures. Redundancies in the existing process were removed and the overall care planning and consultation between all patient care personnel was streamlined.</p> <p>1.2 The existing nursing care plan was incorporated into the Master Treatment Plan to support an integrated document, remove redundancies in between the electronic and paper medical record, and ensure all active medical conditions and current plan of care</p>	<p>The facility will document all education related to the care planning process. All current licensed nursing staff and social service staff who participate in treatment planning will sign off on the receipt of the care planning process education.</p> <p>Designated Hospital Education staff will audit 100% of licensed nursing staff and social services staff education records to ensure</p>	<p>When practices are not individualized, responsible staff will be retrained, shown examples of acceptable care plans, and will be more closely monitored until their care plans are individualized.</p> <p>The Director of Nursing/designee will aggregate the results of the audits and report to the Clinical Practice Committee on a monthly basis. Appropriate action will be taken to address any deviation from a goal of 100% compliance.</p>	<p>Directors of Nursing and Social Work</p>	<p>Education will be completed by 5/15/2019.</p> <p>The revised form and process will begin 5/16/2019.</p> <p>100% audit process of nursing care plans and master treatment plans was initiated in April and will continue on an ongoing basis.</p>

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		<p>are clearly identified. This is congruent with Nursing Care Plan Policy (approval date 3-14-2019).</p> <p>1.3 All nursing personnel and social services staff will receive re-training, with return demonstration of competency, on the treatment planning process, with emphasis on the integration and documentation of active medical comorbid treatment. Training will be initiated on 5/2/2019 and will be completed by 5/15/2019.</p> <p>This education will also be included as part of the New Employee Orientation and an annual refresher.</p>	<p>the completion of the training is on file.</p> <p>Hospital Education designated staff will audit 25 % of all New Employee files for nursing and social services staff and annual completed trainings, monthly, until 100% compliance is sustained for 6 consecutive months, to ensure the training is conducted consistently and the acknowledgement of the receipt of those policies is present in the employee file.</p> <p>100% of all current Care plans will be audited by the acting Director of Nursing /designee to ensure the Care plans are current, individualized, reflect patient's current and active problems and interventions and discharge</p>	<p>This review will continue until compliance is sustained for 6 consecutive months.</p>		<p>100% audit of licensed nursing staff and social services staff education records will begin 5/16/2019. Ongoing audits of 25% of New Employee files and annual completed trainings will begin following the June New Employee Orientation.</p>

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			<p>recommendations are present, and prescribed medications are identified.</p> <p>25% audit of Care plans for New Admissions and 25% of current patients, will be conducted by the Acting Director of Nursing /designee monthly, until 100% is sustained for 6 consecutive months.</p>			