

Alaska Psychiatric Institute Plan of Correction

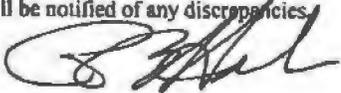
Provider ID: 024002	Name of Provider: Alaska Psychiatric Institute	Department of Health and Human Services Centers for Medicare and Medicaid Services	Date Survey Completed: 8/31/2017
ID Prefix Tag	Summary Statement	Alaska Psychiatric Institute's Plan of Correction	Completion Date
A 115	<p>482.13 PATIENT RIGHTS</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by: The hospital failed to ensure the Condition of Participation: CFR 482.13 Patient's Rights was met as evidenced by:</p> <p>A122- Failed to ensure 1 patient's (#3) grievances were reviewed and investigated within the time frames specified by the facility policy and 2 of the patient's grievances were allegations of abuse.</p> <p>A123 - Failed to ensure 1 patient (#11) had received written notice of the steps taken and resolution of his/her written grievance.</p> <p>A145- Failed to ensure: 1) all allegations of abuse, neglect or mistreatment were investigated in a timely and thorough manner for 1 patient (#3); 2) incidents of potential abuse, neglect or mistreatment were reported to the state agency for 1 patient (#13); and 3) substantiated incidents of staff abuse, neglect or mistreatment by staff (Psychiatric Nurse Assistant) (PNA) #s 3 and 4) and Licensed Nurse (LN) #s 1 and 2) against patient (#s 2, 7, 14) had appropriate corrective, remedial and/or disciplinary action implemented.</p> <p>A167 - Failed to ensure seclusion was implemented for 1 patient (#7) per the facility's policy.</p> <p>A168- Failed to ensure a Time-Out that became seclusion for 1 patient (#7), had physician orders for implementation.</p> <p>The cumulative effect of these systemic problems resulted in failure of the facility to ensure patients were receiving quality care in a safe manner that promoted the rights of the patients and afforded them due process.</p>	<p>Who: The Chief Executive Officer (CEO) is ultimately responsible for the corrective action as well as the overall and ongoing compliance for Alaska Psychiatric Institute.</p> <p>A122 and A123 -</p> <p>What: API will update API Policy and Procedure (P&P) PRE-030-03 Patient Grievance Procedure to include a requirement for API to keep a log to track each grievance received and to provide patients with written notice of its decisions regarding the patient's grievance, the name of hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion. The letter will inform patients of their right to seek assistance from any advocacy agency if they disagree with the disposition of their grievance. The letter will also provide patients with the phone numbers of the Disability Law Center, the State Agency, Adult Protective Services, Office of Children's Services, and the State Ombudsman's Office.</p> <p>A tracking log of all grievances and complaints will be maintained by the Recovery Support Specialist. An additional staff person has been assigned full time to the Quality Improvement Department to ensure all grievances are addressed in a timely manner.</p> <p>The tracking log will be accessible to the CEO, COO, DOP, QIC, and RSS. The RSS will coordinate responses of resolutions to patients per API P&P PRE-030-03 Patient Grievance Procedure. The coordination of the tracking log includes informing the CEO (or other department heads, for Level II responses) when resolution letters are due to the patient. The RSS will ensure all resolution letters contain the required elements to include the requirement for API to provide the patient written notice of its decisions regarding the patient's grievance, the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion.</p> <p>The tracking log will reflect the date a grievance was received, the person(s) responsible for the investigation and the date the resolution letter was delivered (or mailed, when a patient is discharged) to the patient.</p> <p>How: API will preserve patient's rights to due process and timely resolution of the grievance process. API will update and</p>	12/15/2017

		<p>adhere to API P&P PRE-030-03 Patient Grievance Procedures. All staff will receive a copy of the updated policy and a summary of the contents for ease of understanding.</p> <p>Patient care department heads will review the policy with their staff during department meetings and document the information/training and attendance in the meeting minutes. New employees will receive training on the updated policy during new employee training.</p> <p>The tracking log of all grievances will be maintained and reviewed weekly by the RSS and QIC to ensure compliance with the timeframes set forth in the updated policy.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the RSS will send a monthly report of the total number of grievances received, their assigned "level" of resolution, and the number of patients who received (or were mailed) letters within the designated timeframe, per the updated API P&P PRE-030-03 Patient Grievance Procedure. The data will be a Performance Indicator for the RSS department and will be monitored monthly by the CEO and API Senior Management (ASM) team and reported quarterly to Governance.</p> <p>A145 –</p> <p>Who: The Chief Executive Officer (CEO) is ultimately responsible for the corrective action as well as the overall and ongoing compliance for Alaska Psychiatric Institute.</p> <p>What: API will update API P&P LD-020-13 Conduct Involving Patients to clarify that when API staff are alleged maltreatment patients, API will continue to remove staff from patient care and NOT return those staff to patient care until the investigation is fully resolved, and that, absent significant mitigating factors, termination will be API's response to serious and/or repeated substantiated allegations following API's internal investigation. The Director of Behavioral Health will authorize API to not use progressive discipline when serious patient abuse is determined to have occurred and termination is warranted.</p> <p>All API staff will receive a copy of the updated policy and a summary of the contents for ease of understanding. All patient care department heads will review and discuss the policy with their staff in department meetings. All new employees will receive training on the updated policy during new employee orientation.</p> <p>How: API will ensure patients are free from all forms of maltreatment. API will update and adhere to API P&P LD-020-13 Conduct Involving Patients. All staff will receive a copy of the updated policy and a summary of the contents for ease of understanding. All patient care department heads will</p>	
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8/31/17

		<p>review the policy with their staff in department meetings. All new employees will receive training on the updated policy during new employee training. API will notify the DBH Director of all Allegations of Abuse or Neglect and the recommended disposition for each case.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the CEO will provide the DBH Director with regular updates regarding API's Allegations of Patient Maltreatment findings.</p> <p>What: When termination is not the warranted response to an instance of patient maltreatment, API will create a tracking log called "Nursing Department Tracking Log for Allegations of Abuse & Neglect" to ensure compliance with all recommendations (corrective, remedial and/or disciplinary) from the investigation(s). The log will assist with implementing recommendations and ensure the recommendations are monitored. The tracking log will reflect the Unusual Occurrence Report (UOR) number, date of incident, and recommendations from the investigation.</p> <p>All substantiated allegations of abuse or neglect recommendations will include a final face-to-face meeting between the DON and the staff member substantiated for maltreatment. During this meeting, the DON will ensure the staff person acknowledges abuse or neglect occurred, understands their role in the situation and assumes responsibility for changing their behavior. The DON will ensure accountability, review expectations and answer any further questions or concerns before the staff will be authorized to return to patient care.</p> <p>The tracking log will name the staff person providing any recommended supervision, date the weekly checks completed by the DON, show the date of the monthly report provided to the Quality Improvement (QI) Department, and show the date actions were finalized.</p> <p>How: A tracking log of all recommendations from investigations will be maintained and reviewed weekly by the DON and monitored monthly by the CEO.</p> <p>Education and guidance will be provided to the supervisors on their weekly submission of their supervision logs by the DON.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the DON will provide a monthly report to the API Senior Management (ASM) Team and provide a quarterly report to Governance. The CEO will review the tracking log in supervision, at least monthly with the DON.</p>	
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		<p>education and feedback to each patient care unit and report on the rounding during ASM.</p> <p>A 168 –</p> <p>What: API update and provide additional training to support the Seclusion and /or Restraint, Time –Out Patient Safety Equipment (PSE) P&P SC-030-02.01b, specifically the RN Responsibilities Section, to ensure if a seclusion and/or restraint occurs there is a LIP order in place.</p> <p>How: API will ensure the use of seclusion or restraint will be implemented in accordance with safe and appropriate techniques. API will update and adhere to Seclusion and /or Restraint, Time–Out Patient Safety Equipment (PSE) P&P SC-030-02.01b. All API nursing and LIP staff will receive a copy of the updated policy and a summary of the contents for ease of understanding. Nursing Administration and the Director of Psychiatry will review the policy with their staff during unit and team meetings and document the information and training and attendance in the meeting minutes. New nursing staff and new LIPs will receive training on the updated policy during new employee training</p> <p>Evaluation Method: The API Clinical/Administrative Team will review episodes of seclusion & restraint in their weekly rounding providing education and feedback to each patient care unit.</p> <p>All nurses will receive information about NDP F-10 “24 Hour Night Nurse Audits” instructing them to track any variations in requirements of seclusion/restraint procedures including LIP orders. The Director of Psychiatry & Nursing Administration will be notified of any discrepancies.</p> <p>CEO Signature: </p>	
<p>A 122</p>	<p>482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES</p> <p>At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response.</p> <p>This STANDARD is not met as evidenced by: Continued From page 2</p>	<p>Who: The Quality Improvement Coordinator (QIC) is ultimately responsible for the corrective action as well as the overall and ongoing compliance.</p> <p>What: API will update API Policy and Procedure (P&P) PRE-030-03 Patient Grievance Procedure to include a requirement for API to keep a log to track each grievance received and to provide patients with written notice of its decisions regarding the patient’s grievance, the name of hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion. The letter will inform patients of their right to seek</p>	<p>12/13/2017</p>

<p>Based on record review, interview and policy review the facility failed to ensure 1 patient's (#3) grievances were reviewed and investigated. This failed practice denied the patient due process and having concerns about staff mistreatment addressed in a timely manner. Findings:</p> <p>Record review on 8/16-17/17 revealed Patient #3 was admitted to the facility with a diagnosis that included Schizophrenia.</p> <p>During an interview on 8/17/17 at 12:40 pm - 1:00 pm, Recovery Support Specialists (RSS) #'s 1 and 2 were asked for their log or list of patient grievances. RSS #1 said there was a log, but it was not current. He/she continued to say that there was a stack of written grievances in their office that had not been documented in the grievance log.</p> <p>Review of the stack of unlogged written grievances revealed Patient #3 had written 3 separate grievances/complaints.</p> <p>During the interview, RSS #1 was asked if there were any grievances or complaints from Patient #3. RSS #1 stated, "No, I don't think so. That name does not ring a bell." After showing RSS #1 Patient #3's written grievances/complaints, he/she disclosed he/she had not seen them and confirmed they had not been reviewed or investigated. The 3 written grievances/concerns were:</p> <ol style="list-style-type: none"> 1. Dated 5/31/17 at 3:04 pm revealed, Patient #3 wrote "Too much abuse observed which are done by API staff..."; 2. Dated 6/1/17 at 8:45 pm revealed, "...[another Patient's name]...located on [a unit] was left to suffer through agonizing pain with no emergency services/911 called...she is vomiting and shivering with gnashing teeth in obvious pain..."; and 3. Dated 6/2/17 at 6:45 am, revealed Patient #3 had concerns regarding his/her admission. <p>During the interview on 8/17/17 at 12:40 pm - 1:00 pm RSS #'s 1 and 2 stated patients can call, fill out a complaint form (located on the units), and/or verbally tell staff to file grievances for them. RSS #1</p>	<p>assistance from any advocacy agency if they disagree with the disposition of their grievance. The letter will also provide patients with the phone numbers of the Disability Law Center, the State Agency, Adult Protective Services, Office of Children's Services, and the State Ombudsman's Office.</p> <p>A tracking log of all grievances and complaints will be maintained by the Recovery Support Specialist. An additional staff person has been assigned full time to the Quality Improvement Department to ensure all grievances are addressed in a timely manner.</p> <p>The tracking log will be accessible to the CEO, COO, DOP, QIC, and RSS. The RSS will coordinate responses of resolutions to patients per API P&P PRE-030-03 Patient Grievance Procedure. The coordination of the tracking log includes informing the CEO (or other department heads, for Level II responses) when resolution letters are due to the patient. The RSS will ensure all resolution letters contain the required elements to include the requirement for API to provide the patient written notice of its decisions regarding the patient's grievance, the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion.</p> <p>The tracking log will reflect the date a grievance was received, the person(s) responsible for the investigation and the date the resolution letter was delivered (or mailed, when a patient is discharged) to the patient.</p> <p>How: API will preserve patient's rights to due process and timely resolution of the grievance process. API will update and adhere to API P&P PRE-030-03 Patient Grievance Procedures. All staff will receive a copy of the updated policy and a summary of the contents for ease of understanding.</p> <p>Patient care department heads will review the policy with their staff during department meetings and document the information/training and attendance in the meeting minutes. New employees will receive training on the updated policy during new employee training.</p> <p>The tracking log of all grievances will be maintained and reviewed weekly by the RSS and QIC to ensure compliance with the timeframes set forth in the updated policy.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the RSS will send a monthly report of the total number of grievances received, their assigned "level" of resolution, and the number of patients who received (or were mailed) letters within the designated timeframe, per the updated API P&P PRE-030-03 Patient Grievance Procedure. The data will be a Performance Indicator</p>
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	<p>stated since starting his employment last May, he/she had not been able to keep up with a log tracking the patients' grievances and resolutions.</p> <p>RSS #1 was unable to provide evidence Patient #3's grievances had been investigated, 2 of which were allegations of abuse/and or neglect.</p> <p>Review of the facility's policy and procedure "No: PRE 030-03", dated 8/15/16, revealed "...LEVELS OF RESPONSE TO GRIEVANCES...an RSS, NSS or designee will...immediately report to the Chief Executive Officer (CEO) or designee any grievance that alleges abuse, neglect or serious staff misconduct...See to resolve with the patient...(immediately or within three business days)."</p> <p>Review of the facility's policy and procedure "No: PRE 030-03", dated 8/15/16, revealed " ...LEVELS OF RESPONSE TO GRIEVANCES...an RSS, NSS or designee will...immediately report to the Chief Executive Officer (CEO) or designee any grievance that alleges abuse, neglect or serious staff misconduct...See to resolve with the patient... (immediately or within three business days)."</p>	<p>for the RSS department and will be monitored monthly by the CEO and API Senior Management (ASM) team and reported quarterly to Governance.</p> <p>CEO Signature: </p>	
<p>A 123</p>	<p>482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION</p> <p>At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.</p> <p>This STANDARD is not met as evidenced by: Based on record review, interview and policy review the facility failed to ensure 1 patient (# 11) had received written notice of the steps taken and resolution of his/her</p>	<p>Who: The Quality Improvement Coordinator (QIC) is ultimately responsible for the corrective action as well as the overall and ongoing compliance.</p> <p>What: API will update API Policy and Procedure (P&P) PRE-030-03 Patient Grievance Procedure to include the requirement for API to provide patients with written notice of its decisions regarding the patient's grievance, the name of hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion. The letter will inform patients of their right to seek assistance from any advocacy agency if they disagree with the disposition of their grievance. The letter will also provide patients with the phone numbers of the Disability Law Center, the State Agency, Adult Protective Services, Office of Children's Services, and the State Ombudsman's Office.</p>	<p>12/13/2017</p>

	<p>written grievance. This failed practice denied the patient written knowledge of the steps and actions taken on his/her behalf. Findings:</p> <p>Review of a stack of written grievances with Recovery Support Specialist (RSS) #'s 1 and 2 on 8/17/17 revealed Patient #11 had filed a written grievance with the facility.</p> <p>Review of the grievance written by Patient #11, dated 4/17/17, revealed "I got attacked by one of the staff ... [he/she] pushed me twice for no reason..."</p> <p>During an interview on 8/17/17 at 12:40-1:00pm, RSS #'s 1 and 2 were asked to provide a copy of the letter sent to Patient #11 notifying him/her of the facility's resolution, RSS #1 was unable to provide it. Furthermore RSS #1 stated the facility had not had an RSS in place for 4 months prior to him/her (RSS #1) starting the job in May.</p> <p>Further review of the same policy revealed, "...If attempted resolution takes longer than seven (7) days, the patient, or individual acting on patient's behalf, will be informed of the need for additional time. The written response is due no later than fourteen (14) business days post receipt of grievance."</p>	<p>A tracking log of all grievances and complaints will be maintained by the Recovery Support Specialist. An additional staff person has been assigned full time to the Quality Improvement Department to ensure all grievances are addressed in a timely manner.</p> <p>The tracking log will be accessible to the CEO, COO, DOP, QIC, and RSS. The RSS will coordinate responses of resolutions to patients per API P&P PRE-030-03 Patient Grievance Procedure. The coordination of the tracking log includes informing the CEO (or other department heads, for Level II responses) when resolution letters are due to the patient. The RSS will ensure all resolution letters contain the required elements to include the requirement for API to provide the patient written notice of its decisions regarding the patient's grievance, the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion.</p> <p>The tracking log will reflect the date a grievance was received, the person(s) responsible for the investigation and the date the resolution letter was delivered (or mailed, when a patient is discharged) to the patient.</p> <p>How: API will preserve patient's rights to due process and timely resolution of the grievance process. API will update and adhere to API P&P PRE-030-03 Patient Grievance Procedures. All staff will receive a copy of the updated policy and a summary of the contents for ease of understanding.</p> <p>Patient care department heads will review the policy with their staff during department meetings and document the information/training and attendance in the meeting minutes. New employees will receive training on the updated policy during new employee training.</p> <p>The tracking log of all grievances will be maintained and reviewed weekly by the RSS and QIC to ensure compliance with the timeframes set forth in the updated policy.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the RSS will send a monthly report of the total number of grievances received, their assigned "level" of resolution, and the number of patients who received (or were mailed) letters within the designated timeframe, per the updated API P&P PRE-030-03 Patient Grievance Procedure. The data will be a Performance Indicator for the RSS department and will be monitored monthly by the CEO and API Senior Management (ASM) team and reported quarterly to Governance.</p> <p>CEO Signature: </p>	
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<p>A 145</p>	<p>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</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, interview and policy review the facility failed to ensure: 1) all allegations of abuse, neglect or mistreatment were investigated in a timely and thorough manner for 1 patient (#3); 2) all incidents of potential abuse, neglect or mistreatment were reported to the state agency for 1 patient (#13); and 3) substantiated incidents of staff abuse, neglect or mistreatment by staff (Psychiatric Nurse Assistant) (PNA) #s 3 and 4) and Licensed Nurse (LN) #s 1 and 2) against patients (#s 2, 7, 14) had appropriate corrective, remedial and/or disciplinary action implemented. These failed practices placed vulnerable patients at risk for delayed investigations, further abuse or neglect, delayed responses to identified concerns, lack of supervision of staff and no state agency oversight.</p> <p>Findings:</p> <p>Record review was from 8/16-31/17. Investigation</p> <p>Record review revealed Patient #3 was admitted to the facility with a diagnosis that included Schizophrenia.</p> <p>During an interview on 8/17/17 at 12:40 pm -1:00 pm, Recovery Support Specialists (RSS) #'s 1 and 2 were asked for their log or list of patient grievances. RSS #1 said there was a log, but it was not current. He/she continued to say that there was a stack of written grievances in their office that had not been documented in the grievance log.</p> <p>Review of the stack of unlogged written grievances revealed Patient #3 had written 3 separate grievances/complaints.</p> <p>During the interview, RSS #1 was asked if the RSS had any grievances or complaints from Patient #3. RSS #1 stated, "No, I don't think so. That name does not ring a bell." After showing RSS #1 Patient #3's written grievances/complaints, he/she disclosed he/she had not seen them and confirmed</p>	<p>Who: The Quality Improvement Coordinator (QIC) is ultimately responsible for the corrective action as well as the overall and ongoing compliance.</p> <p>What: API will update API Policy and Procedure (P&P) PRE-030-03 Patient Grievance Procedure to include the requirement for API to provide patients with written notice of its decisions regarding the patient's grievance, the name of hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion. The letter will inform patients of their right to seek assistance from any advocacy agency if they disagree with the disposition of their grievance. The letter will also provide patients with the phone numbers of the Disability Law Center, the State Agency, Adult Protective Services, Office of Children's Services, and the State Ombudsman's Office.</p> <p>A tracking log of all grievances and complaints will be maintained by the Recovery Support Specialist. An additional staff person has been assigned full time to the Quality Improvement Department to ensure all grievances are addressed in a timely manner.</p> <p>The tracking log will be accessible to the CEO, COO, DOP, QIC, and RSS. The RSS will coordinate responses of resolutions to patients per API P&P PRE-030-03 Patient Grievance Procedure. The coordination of the tracking log includes informing the CEO (or other department heads, for Level II responses) when resolution letters are due to the patient. The RSS will ensure all resolution letters contain the required elements to include the requirement for API to provide the patient written notice of its decisions regarding the patient's grievance, the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the result (corrective actions taken by API, as appropriate) of the grievance process, and the date of completion.</p> <p>The tracking log will reflect the date a grievance was received, the person(s) responsible for the investigation and the date the resolution letter was delivered (or mailed, when a patient is discharged) to the patient.</p> <p>How: API will preserve patient's rights to due process and timely resolution of the grievance process. API will update and adhere to API P&P PRE-030-03 Patient Grievance Procedures. All staff will receive a copy of the updated policy and a summary of the contents for ease of understanding.</p>	<p>12/13/2017</p>

<p>they had not been reviewed or investigated. The 3 written grievances/concerns were:</p> <p>1. Dated 5/31/17 at 3:04 pm revealed, Patient #3 wrote "Too much abuse observed which are done by API staff..."</p> <p>Dated 6/1/17 at 8:45 pm revealed, "... [Another Patient's name]...located on [a unit] was left to suffer through agonizing pain with no emergency services/911 called...she is vomiting and shivering with gnashing teeth in obvious pain..." and</p> <p>Dated 6/2/17 at 6:45 am, revealed Patient #3 had concerns regarding his/her admission.</p> <p>During the interview on 8/17/17 at 12:40 pm - 1:00 pm RSS #'s 1 and 2 stated the patients can call, fill out a complaint form (located on the units) and/or verbally tell staff to file grievances for them. Furthermore, RSS #1 stated since starting in May, he/she had not been able to keep up with a log tracking the patients' grievances and resolutions. RSS #1 was unable to provide evidence Patient #3's grievances, 2 of which were allegations of abuse/and or neglect, had been investigated.</p> <p>Review of the facility's policy and procedure "No: PRE 030-03", dated 8/15/16, revealed "...LEVELS OF RESPONSE TO GRIEVANCES...an RSS, NSS or designee will...immediately report to the Chief Executive Officer (CEO) or designee any grievance that alleges abuse, neglect or serious staff misconduct...Sec to resolve with the patient...(immediately or within three business days)."</p> <p>Further review of the same policy revealed, "...If attempted resolution takes longer than seven (7) days, the patient, or individual acting on patient's behalf, will be informed of the need for additional time. The written response is due no later than fourteen (14) business days post receipt of grievance."</p> <p>Report Patient Neglect Incident</p> <p>Record review on 8/24/17 revealed Patient #13 was admitted to the facility with a diagnosis that included neurodevelopmental disorder with fetal alcohol effects. The Patient was admitted to the unit with close observation status scale (COSS) 1st degree (Patient is to be checked every 15 minutes x</p>	<p>Patient care department heads will review the policy with their staff during department meetings and document the information/training and attendance in the meeting minutes. New employees will receive training on the updated policy during new employee training.</p> <p>The tracking log of all grievances will be maintained and reviewed weekly by the RSS and QIC to ensure compliance with the timeframes set forth in the updated policy.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the RSS will send a monthly report of the total number of grievances received, their assigned "level" of resolution, and the number of patients who received (or were mailed) letters within the designated timeframe, per the updated API P&P PRE-030-03 Patient Grievance Procedure. The data will be a Performance Indicator for the RSS department and will be monitored monthly by the CEO and API Senior Management (ASM) team and reported quarterly to Governance.</p> <p>Who: The Chief Executive Officer (CEO) is ultimately responsible for the corrective action as well as the overall and ongoing compliance for Alaska Psychiatric Institute.</p> <p>What: API will update API P&P LD-020-13 Conduct Involving Patients to clarify that when API staff are alleged maltreatment patients, API will continue to remove staff from patient care and NOT return those staff to patient care until the investigation is fully resolved, and that, absent significant mitigating factors, termination will be API's response to serious and/or repeated substantiated allegations following API's internal investigation. The Director of Behavioral Health will authorize API to not use progressive discipline when serious patient abuse is determined to have occurred and termination is warranted.</p> <p>All API staff will receive a copy of the updated policy and a summary of the contents for ease of understanding. All patient care department heads will review and discuss the policy with their staff in department meetings. All new employees will receive training on the updated policy during new employee orientation.</p> <p>How: API will ensure patients are free from all forms of maltreatment. API will update and adhere to API P&P LD-020-13 Conduct Involving Patients. All staff will receive a copy of the updated policy and a summary of the contents for ease of understanding. All patient care department heads will review the policy with their staff in department meetings. All new employees will receive training on the updated policy during new employee training. API will notify the DBH Director of all Allegations of Abuse or Neglect and the recommended disposition for each case.</p>	
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<p>24 hours, and noted on the patient safety checklist).</p> <p>Review of a facility unusual occurrence report revealed an incident which occurred on 8/4/17 at 2200 (10:00 pm). Patient #13 was found sitting in a corner in his/her room with blood oozing from a self-inflicted laceration on his right upper arm, "possibly due to a punctured or lacerated Basilic vein. Patient conscious and coherent but pale ...It also appear that the patient may have banged the back of [Patient] head against the wall as some blood were present on the wall and on [Patient] head...the patient was transported to the ED at around 2225 [10:25 pm]."</p> <p>Review of the locator checks on the patient safety checklist, dated 8/4/17, revealed Patient #13 was checked every 15 minutes on 8/4/17, including the time of the incident.</p> <p>During an interview on 8/24/17 at 12:45 pm, the Quality Improvement Coordinator (QIC) said the verification of the 15 minute locator checks were reviewed by video. The documentation of the 15 minute locator checks on the patient safety checklist did not match what was seen on the video. The QIC said the 15 minute locator checks were falsified by the staff doing the checks. The Patient was not checked every 15 minutes. The times missed between checks ranged from 16 minutes up to 83 minutes.</p> <p>Review of the State survey agency's facility reported incidents log revealed a report regarding the neglect of Patient #13 had not been reported to the State agency.</p> <p>Disciplinary, Remedial, and/or Reeducation Action Did Not Occur</p> <p>PNA #3</p> <p>Record review on 8/17/17 revealed Patient #7 had diagnoses that included schizophrenia and a history of traumatic brain injury.</p> <p>Review of the State agency's facility's report of harm, dated 4/14/17, revealed a facility incident report of an allegation by PNA #3, which occurred on 4/12/17. The incident was reviewed on video by the Safety Officer/Risk Manager and the State survey team. The allegation stated PNA #3 restrained and escorted Patient #7 to the Oak Room (seclusion room). PNA #3 was observed preventing the Patient from leaving the seclusion room. After the second event of the PNA pushing the Patient, the</p>	<p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the CEO will provide the DBH Director with regular updates regarding API's Allegations of Patient Maltreatment findings.</p> <p>Who: The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and ongoing compliance for all staff assigned to the Nursing Department.</p> <p>What: When termination is not the warranted response to an instance of patient maltreatment, API will create a tracking log called "Nursing Department Tracking Log for Allegations of Abuse & Neglect" to ensure compliance with all recommendations (corrective, remedial and/or disciplinary) from the investigation(s). The log will assist with implementing recommendations and ensure the recommendations are monitored. The tracking log will reflect the Unusual Occurrence Report (UOR) number, date of incident, and recommendations from the investigation.</p> <p>All substantiated allegations of abuse or neglect recommendations will include a final face-to-face meeting between the DON and the staff member substantiated for maltreatment. During this meeting, the DON will ensure the staff person acknowledges abuse or neglect occurred, understands their role in the situation and assumes responsibility for changing their behavior. The DON will ensure accountability, review expectations and answer any further questions or concerns before the staff will be authorized to return to patient care.</p> <p>The tracking log will name the staff person providing any recommended supervision, date the weekly checks completed by the DON, show the date of the monthly report provided to the Quality Improvement (QI) Department, and show the date actions were finalized.</p> <p>How: A tracking log of all recommendations from investigations will be maintained and reviewed weekly by the DON and monitored monthly by the CEO.</p> <p>Education and guidance will be provided to the supervisors on their weekly submission of their supervision logs by the DON.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the DON will provide a monthly report to the API Senior Management (ASM) Team and provide a quarterly report to Governance. The CEO will review the tracking log in supervision, at least monthly with the DON.</p> <p>What: API will update the Nursing Department Procedure (NDP) C-1 last updated on 11/09/2016 to include instructions to staff to write the actual time of the check, rather than the</p>	
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<p>Patient could be heard on audio/video yelling at the PNA #3 "Stop hitting me, stop hitting me." During the Patient's time in the seclusion room Patient #7 urinated on the floor, due to the fact he/she was prevented from the leaving the seclusion room. Further review revealed the abuse towards Patient #7 was substantiated.</p> <p>Review of the medical record revealed no evidence Patient #7 had a physician's order or assessment for seclusion.</p> <p>Record review on 8/16-31/17 revealed a letter of warning (LOW), dated 6/14/17, was given to PNA #3 by the Interim CEO through the Assistant Director of Nursing. The LOW revealed "...determined that the allegations were substantiated and discipline is warranted...I am also directing you to attend a 1:1 session with the API Safety officer to review the differences between and protocols relating to time outs and seclusions; and continue with your weekly sessions with your clinical supervisor for the next six months." further review revealed no evidence of the weekly sessions with a clinical supervisor"</p> <p>Review of PNA #3's record on 8/17/16, revealed no evidence the PNA had received any weekly supervision visits with a supervisor after the abuse and illegal restraint had been substantiated by the facility.</p> <p>During an interview on 8/16/17 at 3:30 pm, when asked about the discipline and education of nursing staff, the Director of Nursing replied, the supervision was assigned to the clinical lead and she was "out of the loop."</p> <p>Review of an email, dated 8/22/17 at 10:51 am from the Director of Nursing to the Safety Officer/Risk Manager, revealed the weekly supervision had not started for PNA #3.</p> <p>Review of an email, dated 8/22/17 at 2:16 pm from the Director of Nursing to LN #1 and the Assistant Director of Nursing Ce'd, revealed "[PNA #3] will receive weekly clinical supervision for a period of six months. The clinical supervisor will provide Quality Improvement Coordinator/Safety Officer with a supervision plan; the clinical plan supervisor will provide written documentation of the clinical supervision, documentation the review of events, restraints and seclusions, assaults that occur:</p>	<p>current practice of checking a box, instructions on what to do if staff miss a check or conduct a check late. The NDP will set forth procedures for ensuring all original patient safety checklists are submitted each night to the Nursing Shift Supervisor for all three shifts. API will develop a web-based training, using actual examples, to train all nursing staff on the updated NDP.</p> <p>How: API will ensure all patients are checked for safety at least every 15 minutes. API will update and adhere to NDP C-1. All API Nursing Staff will receive a copy of the updated NDP and a summary of the contents for ease of understanding. Nursing Administration will review the policy with their staff during unit meetings and document the information and training and attendance in the meeting minutes. New nursing staff will receive training on the updated policy during new employee training.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, the Safety Officer will conduct monthly locator audits using API's CCTV system to ensure locator checks are completed per NDP C-1. The Safety Officer will report the findings of the monthly audits to the DON and ASM.</p> <p>CEO Signature: </p>	
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	<p>discussions of de-escalation techniques; discussions of specific patients and their illness, learning about symptoms, manifestations, treatment modalities, etc. Copies of the clinical supervisor notes will be provided to Quality Improvement Coordinator/Safety Officer for review on a monthly basis."</p> <p>PNA #4</p> <p>Record review revealed Patient #2 had diagnoses that included Autism spectrum disorder (a developmental disorder that affects a wide range of skills, symptoms, and disabilities) and mild-moderate retardation. The Patient had been discharged and readmitted to the facility several times.</p> <p>Review of an incident occurrence, dated 12/24/16, revealed PNA #4 was providing 1:1 observation for Patient #2. During the incident the Patient had aggressive behavior towards PNA #4. When the "Patient dropped the chair and fell to the floor...[PNA #4] charged at the Patient, tackling the patient to the ground. While restraining the Patient [PNA #4] pulled the Patient's hair, and moments later, during the fluid restraint, [PNA #4] right arm ended up around the Patient's neck and the Patient was placed briefly in a choke hold. [PNA #4] did not follow [his/her] training, physically responded to the patient when having other options." Further review revealed the use of more force than necessary against Patient #2, by PNA #4, was substantiated by the facility.</p> <p>PNA #4 returned to work on 1/28/17. Review of a letter revealed PNA #4 was to receive clinical supervision for at least 1 year with a clinical supervisor and meet regularly with his/her clinical supervisor for a minimum of 30 minutes per supervision session.</p> <p>Review of the "2015 Supervision Log", provided as evidence of PNA #4's supervision, revealed the PNA had supervisory visits, following the incident, conducted by LN #1 on 1/2/17; 1/7/17; 1/19/17; 1/21/17; and 2/2/17.</p> <p>No further information regarding PNA #4's supervisory visits since 2/2/17 was provided prior to the exit on 8/31/17.</p> <p>LN #1</p>		
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	<p>Review of the State agency's facility's report of harm, on 4/14/17, revealed a facility incident report of an allegation, by LN #1, of abuse/neglect/exploitation/serious staff misconduct, dated 4/12/17. This incident was the same one that PNA #3 was involved in. The incident was reviewed on video by the Safety Officer/Risk Manager and the State survey team. The allegation stated the LN #1 instructed Patient #7 to clean up her/his own urine from the Oak Room (seclusion room) and gave the Patient a towel to use to clean her/his urine. Patient #7 was not given any gloves or booties to cover his slippers when he/she was stepping on the towel to clean the urine off the floor. At no time was the Patient offered any help from the staff to assist in cleaning up the urine. The allegation of abuse was substantiated against LN #1. The facility's report stated LN #1 had received a letter of instruction (LOI) and resigned from API.</p> <p>Observation on 8/16/17 revealed LN #1 was currently working as a clinical lead with patients on 1 of the patient care units.</p> <p>During an interview on 8/16/17 at 9:50 am, LN #1 stated he/she was "clinical lead" and "nurse manager" and functioned as the "charge nurse" in the morning.</p> <p>Record review revealed LN #1 was a lead nurse on one of the units. There was no documentation found of the LN's LOI or any education, training or employee supervision after the allegation of abuse was substantiated against LN #1.</p> <p>During an interview on 8/23/17 at 12:45 pm, the Quality Improvement Coordinator (QIC) was asked about LN #1 LOI for the 4/12/17 incident. The QIC said there was no Letter of Instruction or Letter of Warning given to LN #1 for the 4/12/17 incident, but there should have been. The QIC stated that a letter was now being drafted (in process) for the 4/12/17 incident that LN #1 was involved in.</p> <p>LN #2</p> <p>During an interview on 8/16/17 at 2:14 pm - 2:45 pm, the Safety Officer (SO) stated the facility had substantiated LN #2 spit and yelled at Patient #14, 2 years ago (December 2013). The SO stated although the abuse was substantiated and although LN #2 was initially fired, the facility had to hire him/her back last year.</p>		
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	<p>During an interview on 8/24/17 at 9:00 am, the Quality Improvement Coordinator was asked for any retraining, action plans or oversight of LN #2 and PNA #4 after they were reinstated at the facility.</p> <p>The facility did not provide any information to the State survey agency prior to exit on 8/31/17.</p> <p>Review of the "Notice of Rights and Responsibilities" provided to patients on admission, last dated 8/17, and revealed "1. Receive personal dignity and services considerate and respectful of personal value and beliefs...8. To receive care in a safe setting...12. To be free from restraints or seclusion of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff."</p> <p>Review of the facility's policy, "Conduct Involving Patients", dated 8/15/17, revealed "All known or suspected incidents and all complaints of abuse, neglect, and other serious misconduct by API employees, student interns, or contractors towards patients must be reported and investigated...Physical abuse includes, but is not limited to: a. hitting, slapping, kicking, pinching, shoving, spitting on, or beating a patient; b. depriving a patient of a needed medical services or treatment, necessary biological needs...c. using more force than is reasonable for a patient's control, treatment, or management...d. the improper or illegal restraint or seclusion of a patient...4. Emotional abuse includes humiliation of a patient and threats of corporal punishment."</p>		
<p>A 167</p>	<p>482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION</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 policy in accordance with State law.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review, video review, interview and policy review the facility failed to ensure seclusion was implemented for 1 patient (#7) per the facility's policy. Specifically, facility staff implemented a Time-Out (a voluntary seclusion) that became seclusion for the patient (involuntary seclusion) when the facility staff denied the patient the right to exit the room. This failed practice caused the patient</p>	<p>Who: The Director of Nursing is ultimately responsible for the training and efficacy of patient care staff in following the hospital policies and procedures around seclusion and restraint. Hospital Education will communicate and provide education for resolving the deficiencies with regard to seclusion and restraint event reporting and documentation. The Quality Improvement Coordinator (QIC) is responsible for the documentation of ongoing compliance with hospital policies and procedures.</p> <p>What: API will update the Seclusion and /or Restraint, Time -Out Patient Safety Equipment (PSE) P&P SC-030-02.01b last updated on 08/15/2016 to include additional language in the section of definitions specifically further defining what is a seclusion and what is a time out. API will develop a web-based training, using actual examples, to train all nursing and LIP staff on the updated policy.</p>	<p>12/13/2017</p>

	<p>to be illegally detained in seclusion and created a risk for psychological harm. Findings:</p> <p>Record review on 8/16-17/17 revealed Patient #7 was admitted to the facility with diagnoses that included Schizophrenia (a brain disorder that causes one to suffer delusions and/or hallucinations) and Post Traumatic Brain Injury.</p> <p>Record review on 8/16/17 revealed the facility had conducted an investigation of an incident that occurred on 4/12/17 with Patient #7.</p> <p>Review of the 4/12/17 incident on the video, on 8/16/17 with the Safety Officer, revealed Patient #7 was observed launching across the nursing desk and then being escorted to the seclusion room (Oak room—a room with a bed, no windows, and a secure door capable of being locked) by PNA #3. The Patient was placed in the room and the door was left unlocked. During the review the Patient was observed attempting to exit the room 3 times. All 3 times the PNA prevented the Patient from exiting the room by pushing the Patient back into the room, the PNA then forcefully closed the door. At one point the Patient briefly looked around and voided in the corner. The seclusion lasted almost 15 minutes.</p> <p>Review of the "Seclusion & Restraint Initial Order Activity" revealed no physician's order for Patient #7 being placed in seclusion that day.</p> <p>During an interview on 8/16/17 at 9:50 am, Licensed Nurse #1 stated only a nurse could initiate seclusion or a restraint.</p> <p>During an interview on 8/16/17 at 3:30 pm, when asked about the incident, the Director of Nursing (DON) stated the Time-Out is voluntary and the patient needs to feel they can leave the room. The DON stated the incident with Patient #7 (on 4/12/17) should have been treated as seclusion.</p> <p>Review of the facility policy "Seclusion and or Restraint Time-Out, Patient Safety Equipment (PSE)", effective date 8/15/16, revealed "Seclusion: The involuntary confinement of a patient alone in a room or in an area whereas he/she is physically prevented from leaving that room or area. The room or area may be locked or unlocked..."</p>	<p>How: API will ensure the use of seclusion or restraint will be implemented in accordance with safe and appropriate techniques. API will update and adhere to Seclusion and/or Restraint, Time-Out Patient Safety Equipment (PSE) P&P SC-030-02.01b. All API nursing and LIP staff will receive a copy of the updated policy and a summary of the contents for ease of understanding. Nursing Administration and the Director of Psychiatry will review the policy with their staff during unit and team meetings and document the information and training and attendance in the meeting minutes. New nursing staff and new LIPs will receive training on the updated policy during new employee training</p> <p>API will re-emphasize the core conviction that 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.</p> <p>Seclusion and restraint events are carefully monitored by Alaska Psychiatric Institute in its commitment to reducing the rate of seclusion and restraint at the hospital. ASM will continue to review the metrics associated with seclusion and restraint including the amount of time in seclusion or restraint per 1,000 inpatient hours, the rate of events per 1,000 inpatient days, the proportion of clients secluded or restrained, and the breakdown for each patient care area as part of API's ongoing quality improvement initiative to reduce the use of seclusion and restraint with its acute inpatient population.</p> <p>Evaluation Method: ASM will continue to review the metrics associated with seclusion and restraint including the amount of time in seclusion or restraint per 1,000 inpatient hours, the rate of events per 1,000 inpatient days, the proportion of clients secluded or restrained, and the breakdown for each patient care area as part of API's ongoing quality improvement initiative to reduce the use of seclusion and restraint with its acute inpatient population.</p> <p>The API Clinical/Administrative Team will review episodes of seclusion & restraint in their weekly rounding providing education and feedback to each patient care unit and report on the rounding during ASM.</p> <p>CEO Signature: </p>	
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	<p>"Time-Out: A voluntary procedure used to assist the patient to regain emotional control. When a patient is physically prevented from leaving the Time-Out, or given the impression that they are no longer allowed to leave the intervention is no longer a Time-Out and instead becomes seclusion."</p> <p>"The following applies to any use of physical or mechanical restraint(s) or seclusion...Seclusion or physical or mechanical restraint will be documented on appropriate hospital forms."</p>		
<p>A 168</p>	<p>482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on record review, video review and interview the facility failed to ensure a Time-Out that became seclusion for patient #7, had physician orders for implementation. The failed practice placed the patient in seclusion without an order and denied the patient oversight of a providers care. Findings:</p> <p>Record review on 8/16-17/17 revealed Patient #7 was admitted to the facility with diagnoses that included Schizophrenia (a brain disorder that causes one to suffer delusions and/or hallucinations) and Post Traumatic Brain Injury.</p> <p>Record review on 8/16/17 revealed the facility had conducted an investigation of an incident that happened to Patient #7 on 4/12/17.</p> <p>Review of the 4/12/17 incident on video on 8/16/17 with the Safety Officer, revealed Patient #7 was observed launching across the nursing desk and then being escorted to the seclusion room (Oak room-a room with a bed, no windows, and a secure door capable of being locked) by PNA #3. The Patient was placed in the room and the door was left unlocked. During the review the Patient was observed attempting to exit the room 3</p>	<p>Who: The Director of Nursing is ultimately responsible for the training and efficacy of patient care staff in following the hospital policies and procedures around seclusion and restraint. Hospital Education will communicate and provide education for resolving the deficiencies with regard to seclusion and restraint event reporting and documentation. The Quality Improvement Coordinator (QIC) is responsible for the documentation of ongoing compliance with hospital policies and procedures.</p> <p>What: API update and provide additional training to support the Seclusion and /or Restraint, Time -Out Patient Safety Equipment (PSE) P&P SC-030-02.01b, specifically the RN Responsibilities Section, to ensure if a seclusion and/or restraint occurs there is a LIP order in place.</p> <p>How: API will ensure the use of seclusion or restraint will be implemented in accordance with safe and appropriate techniques. API will update and adhere to Seclusion and /or Restraint, Time-Out Patient Safety Equipment (PSE) P&P SC-030-02.01b. All API nursing and LIP staff will receive a copy of the updated policy and a summary of the contents for ease of understanding. Nursing Administration and the Director of Psychiatry will review the policy with their staff during unit and team meetings and document the information and training and attendance in the meeting minutes. New nursing staff and new LIPs will receive training on the updated policy during new employee training</p> <p>Evaluation Method: The API Clinical/Administrative Team will review episodes of seclusion & restraint in their weekly rounding providing education and feedback to each patient care unit.</p> <p>All nurses will receive information about NDP F-10 "24 Hour Night Nurse Audits" instructing them to track any variations in requirements of seclusion/restraint procedures including LIP orders. The Director of Psychiatry & Nursing Administration will be notified of any discrepancies.</p>	<p>12/13/2017</p>

	<p>times. All 3 times the PNA prevented the Patient from exiting the room by pushing the Patient back into the room, the PNA then forcefully closed the door. At one point the Patient briefly looked around and voided in the corner. The seclusion lasted almost 15 minutes.</p> <p>Review of the "Seclusion & Restraint Initial Order Activity" revealed there was no physician or nursing order for Patient #7 being placed in seclusion that day.</p> <p>During an interview on 8/16/17 at 3:30 pm, when asked about the incident, the Director of Nursing (DON) stated the Time-Out was considered voluntary and the patient needs to feel they can leave the room. The DON stated the incident (on 4/12/17) should have been treated as seclusion.</p> <p>Review of the facility policy "Seclusion and or Restraint Time-Out, Patient Safety Equipment (PSE)", effective date 8/15/16, revealed "Seclusion: The involuntary confinement of a patient alone in a room or in an area whereas he/she is physically prevented from leaving that room or area. The room or area may be locked or unlocked..."</p> <p>Review of the facility's procedure flow chart, "RN & LIP [licensed independent practitioner] Documentation & Monitoring", revised 3/22/12, revealed "At initiation of ES/R [go to] LIP written or [Telephone] order..."</p>	<p>CEO Signature: </p>	
<p>A 392</p>	<p>482.23(b) STAFFING AND DELIVERY OF CARE</p> <p>The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on interview, meeting minutes review and policy review the facility failed to have an adequate number of licensed nurses (LN) and psychiatric nurse assistants (PNA) available to meet the needs of the patients. This failed practice placed staff at risk for injury and/or burnout and placed patients at</p>	<p>Who: The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and ongoing compliance for all staff assigned to the Nursing Department.</p> <p>What: API will decrease the amount of overtime (either voluntary or mandatory) by updating Nursing Department Procedure (NDP) F-12 "Management of Overtime" to reflect the following: No employee will be allowed to work more than 22.5 hours of overtime in any given week (either voluntary or mandatory). When a staff member has worked a total of 22.5 overtime hours during the week, they are not to be scheduled again that week for overtime hours.</p> <p>How: API will ensure adherence to Nursing Department Procedure (NDP) F-12 "Management of Overtime" to provide a safe amount of overtime hours worked (either voluntary or mandatory).</p> <p>All nursing staff will be educated on the updated procedure in their unit meetings, and an e-mail notification of the change</p>	<p>12/13/2017</p>

	<p>risk for abuse and/or neglect. This had the potential to effect all patients residing in the facility. Findings:</p> <p>During an interview on 8/16/17 at 9:40 am, LN #1 stated staffing was a "big problem" at the facility and LN and PNAs were frequently mandated to work mandatory overtime. During the interview the LN stated some patients require closer monitoring because of their behaviors. LN #1 stated the staff can work 12 hour shifts, 14 hour shifts and/or 8 hour shifts.</p> <p>During an interview on 8/16/16 at 10:00 am, PNA #3 stated 1 patient in the facility had assaulted 24 different staff and some of the staff were currently out on medical leave.</p> <p>During an interview on 8/16/17 at 10:45 am, PNA #5 stated some facility staff work 12 hours and some work 8 hours. The PNA stated staff frequently end up working overtime.</p> <p>Review of the list overtime hours provided by the facility for the pay period ending 7/15/17 and 7/31/17 revealed several PNAs and LNs had worked upward of 20 hours to 135 hours beyond their regularly scheduled hours in the approximate 2 week time period.</p> <p>During a telephone interview on 8/22/17 at 10:10 am, Physician #1 stated the facility was often short staffed on the weekends. The Physician stated poor scheduling had contributed to some staff working 100 hours of overtime. During the interview, Physician #1 stated about 3 weeks ago, when there was not enough staff to help, a staff member was assaulted by a patient.</p> <p>Review of the Safety Committee Meeting, dated 1/18/17, revealed "Staff asleep during working." The "Discussion" was Staff who work NOC [night] shift are falling asleep when staff need to be alert and attentive to the patient;s and support one another's safety, and the safety of patients, is critical to the culture of safety." The "Action", revealed "...Discussion on how staff coverage may be affecting staff falling asleep when staff is working multi staff (14-16 [hour] shift s mandatory). Option: staff should be restricted when taking on extra shifts like every other day not every day."</p> <p>Review of the Safety Committee Meeting minutes dated 4/19/17. "Discussion about Susina; Discussion about the fact staffing is</p>	<p>will go out by the DON. All new nursing staff members will receive the updated NDP during orientation.</p> <p>Evaluation Method: The Nursing Office will track the Labor Tracking Analysis by Employee Overtime Hours Report to ensure compliance. The Administrative Assistant will print a current overtime record each weekday, listing hours of overtime (OT) worked by each employee for the previous two weeks. The NSS will use these printouts to determine whether an employee is eligible to work additional overtime.</p> <p>A log book will be kept with all Labor Tracking Analysis Reports and reviewed weekly by the Director of Nursing with the expectation if any employee goes over the 22.5 hours, there would be immediate notification by the NSS to the Director of Behavioral Health, the CEO, DOP and DON.</p> <p>What: API will increase efforts to fill vacant full-time and non-permanent Registered Nurse (RN) and Psychiatric Nursing Assistants (PNA) positions. API has the authority to recruit and hire as many non-permanent PNA positions as API needs to help reduce unit staffing shortages. Currently, approximately 24 positions are filled. All non-nursing Departments have been asked by the CEO to perform duties that support the Nursing Department as they are able.</p> <p>How: API will be in active recruitment, advertising all vacant and non-permanent RN and PNA positions in the Anchorage Daily Newspaper. Since 8/31/2017, API has hired 4 full time RNs and 4 non-permanent PNA positions, all who will begin orientation with API within 30 days. API's CEO will be reaching out to former non-permanent nursing staff to encourage them to return to API. API's CEO or DON will be sending regular emails recruiting for volunteers for extra shifts (without exceeding the 22.5 hour overtime limit).</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, API will review the vacancy rate for full-time and non-permanent nursing positions in the Nursing Department monthly during API Senior Management Meetings and the CEO will review the report with the DON at least monthly during supervision. The goal is a 10% decrease in vacancy rates per quarter.</p> <p>What: API will acquire a computerized scheduling program by 12/31/2017.</p> <p>How: API has selected a computerized scheduling program to assist in the management of overtime and data collection to demonstrate staffing needs. This scheduling program will be purchased by 12/31/2017.</p> <p>Evaluation Method: To ensure the plan of correction is effective and the deficiencies stay corrected, API will have a scheduling system where staff schedules can be tracked</p>	
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Alaska Psychiatric Institute Plan of Correction

	<p>too low with only three nurses and three PNA staffing."</p> <p>Review of the Safety Committee Meeting minutes, dated 8/2/17, revealed "Discussion about Susitna; Discussion about the fact staffing is to low with only three nurses and three PNA staffing."</p>	<p>electronically. This system will enable the CEO, COO, DOP and the DON to ensure staffing coverage is adequate to meet hospital needs.</p> <p>What: API will identify and enter into a contract with a local nursing temporary employee agency to fill nursing staff shortages due to vacancies or absences.</p> <p>How: The Division of Behavioral Health has authorized API to negotiate and enter into a contract with a nursing temporary employee agency to augment API's professional nursing staff. API will research the availability of such an agency and begin negotiations for providers by 10/13/2017. Temporary Nurses will be trained to work with API patients.</p> <p>Evaluation Method: API will demonstrate efforts to locate and enter into a contract with a nursing temporary employee agency to augment API's professional nursing staff. Once the temporary employee nurses are under contract and have been trained, API will increase the number of nurses available to work with patients to ensure a sufficient number of registered nurses are trained and able to meet patient needs.</p> <p>CEO Signature: </p>	
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