Provider ID: 024002	Name of Provider: Alaska Psychiatric Institute	Department of Health and Human Services Centers for Medicare and Medicaid Services	Date Survey Completed: 3/29/2018
ID Prefix Tag	Summary Statement	Alaska Psychiatric Institute's Plan of Correction	Completion Date
A 115	**PATIENT RIGHTS CFR(s): 482.13** A hospital must protect and promote each patient's rights. 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: **A123**- Failed to ensure one patient (#2) had received written notice of the steps taken and resolution of his/her written complaint/grievance; **A143** - Failed to ensure one patient (#1) was provided psychiatric care in a manner that preserved physical privacy. **A144** - Failed to ensure one patient (#1) was provided with an emotionally safe environment during seclusion events. **A145** – Failed to ensure one patient (#1), out of 8 patients reviewed for restraints/time-out/seclusion, was free from potential verbal, emotional and physical abuse during care and treatment **A162** - Failed to identify seclusion for three patients (#s 1, 12 and 13) who were prevented from leaving a room or area. Specifically, the facility implemented a Time-Out (a voluntary	**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. **A123** – **Who:** The Quality Improvement Coordinator (QIC) is ultimately responsible for the corrective action and overall, ongoing compliance. **What:** API will develop a desk procedure establishing protocols for how Recovery Support Services (RSS) staff are to process and document complaints and grievances. **How:** API will ensure RSS staff members receive training in the protocols noted in the RSS desk procedure. **Evaluation Method:** To ensure the plan of correction is effective and the deficiencies stay corrected, the QIC or designee will, on a weekly basis for the first 60 days following implementation of the RSS desk procedure, review a sample of the complaints and grievances received in that week to ensure all required protocols are being followed. If deficiencies are noted, additional training or other remedial action(s) will take place. If no deficiencies are noted within the first 60 days of review, the frequency of review will change to a monthly review of a sample of the complaints and grievances received by RSS within that month. Reviews for the prior month will be conducted no later than by COB seven working days after the prior month's end.	6/15/2018

	seclusion) that became a seclusion (involuntary) for the patients. **A167** - Failed to ensure one patient (#1) was safely and appropriately restrained and/or secluded during two separate events. **A174** - Failed to ensure one patient (#1) was released from seclusion in a timely manner in conjunction with the absence of immediate or imminent destructive and/or harmful behavior. **A175** - Failed to ensure the monitoring of 1 patient (#6) included offering fluids during multiple seclusion events **A178** - Failed to ensure one patient (#6) was evaluated face-to-face within one hour after the initiation of a restraint and seclusion. 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.	**A143 -** **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. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) to include a statement directing patient care staff involved in the management of a patient in the Oak Room who requires the removal of clothing for safety, toileting etc. will be provided dignity measures (use of blanket, towel etc. at the RNs discretion). **How**: API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method:** By June 15, 2018, API will train patient care staff, including LIPs, RNs, PNAs, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive additional training and pass a situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the pass rate monthly for each department to the API Senior Management Team (ASM). **A144-** **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. **What:** API will update and adhere to API P&P SC-030-02.02a Management of Patient Behavior to emphasize that all patients will be treated with dignity and respect while being offered choices in the management of their behavior. **How:** API will update and adhere to API to API P&P SC-030-02.02a Management of Patient Behavior. Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method**: By June 15, 2018, API will train patient care staff, including LIPs, RNs PNAs, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive training and pass a situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the pass rate monthly for each department to the API Senior Management Team (ASM). Additionally, the RN III Unit Supervisors, or their designee will conduct monthly mini-seminars on Dignity and Respect issues. These seminars will be recorded in each unit's unit meeting minutes and verified by the Director of Nursing. **A145-** **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. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) to emphasize individualized behavior plans (IBP) do not	

direct a patient to be put in seclusion or restraint and the importance of using only NAPPI approved techniques for physical intervention.

How: API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding.

Evaluation Method: By June 15, 2018, API will train patient care staff, including LIPs, RNs PNAs, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive training and pass a situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the pass rate for each department to the API Senior Management Team (ASM).

A162 –

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.

What: API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically removing Time-Out from the policy and create a new policy which focuses solely on time-out for patients to emphasize the difference between seclusion & time out procedures.

How: API will update and adhere to the update of API P&P SC-030-02.01b and the new Time-Out Policy.

Evaluation Method: By June 15, 2018, API will train patient care staff, including LIPs, RNs PNAs, Unit Clerks, Social Workers, and

Clinical Services Staff. These staff will receive online training and pass situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the pass rate for each department to the API Senior Management Team (ASM).

What: API will request funding and procurement (CCTV) System to reflect the addition of the on-duty Nursing Shift Supervisor Office having access to view incidents in a confidential manner in the Nursing Office.

How: API will request a purchase, provide installation of the system and create a strict protocol for viewing, create a desk procedure for conducting per-shift NSS audits and documenting the findings on the debriefing forms.

Evaluation Method: By June 15, 2018, API will train Nursing Shift Supervisors in the management and confidential nature of reviewing CCTV to include teaching to review S/R incidents for adherence to TIC and policy. They will be required to complete an online training and pass situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the rate for designated supervisors to the API Senior Management Team (ASM). Additionally, each NSS will conduct a CCTV enabled audit of a behavioral incident that occurred on their shift and document the audit on the updated debriefing form.

A167 –

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.

		What: API Hospital Education Department will provide an updated Trauma Informed Care (TIC) training for new employee orientation and hospital wide. **How**: API Hospital Education Department will complete the Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma Informed Care (TIC) one-day train the trainer course & the State of Alaska Division of Behavioral Health sponsored Trauma 101 Training. **Evaluation Method:** By June 15, 2018, API will have the Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma Informed Care train the trainer program completed. The Hospital Education Department will create and rollout TIC training for new employee orientation by July 15, 2018. The Hospital Education Department will complete an updated Trauma Informaed Care (TIC) training for all employees by October 15, 2018. **What:** API Hospital Education Department and the Nurse Unit Supervisor will complete monthly mock behavioral drills reviewing the flow of events, emphasizing hospital P& P being followed while responding to code grays, seclusion, restraint events and debriefing process rotating each month to a different unit/location in the hospital. **How:** API Hospital Education Department and the Nurse Unit Supervisor will collaborate to complete mock guidelines and scenarios for the monthly mock drills. HED and Nurse Unit Supervisor will meet to assign roles and responsibilities for each unit prior to the units training rotation.	

Evaluation Method: By June 15, 2018, API Hospital Education and a Nurse Unit Supervisor will have completed one mock code drill with a patient care unit choice providing feedback to patient care staff and providing a written evaluation of the exercise with suggestions for improvement, what went well and any suggestions or themes presenting. The information will be reported to the ASM Team and Nursing Administration where the information will be reviewed in the monthly unit meetings with staff by the RN III Unit Supervisors. The Hospital Education Department will track and maintain records of compliance for monthly drills reporting to the API Senior Management Team (ASM).

A174 -

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.

What: API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically RN Responsibilities/Notification to the NSS when a patient has an seclusion or restraint event the RN will be required to call the on-duty Nursing Shift Supervisor (NSS) q 30 minutes for the duration of the event providing rational for the continuation of the S/R event.

How: API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding.

Evaluation Method: By June 15, 2018, API RNs will receive additional training and pass

		situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the rate for each department to the API Senior Management Team (ASM). **A175 –** **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. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically PNA responsibilities to reflect the PNA monitoring the S/R Face to Face Flow Sheet will confirm that the offer of fluids q60 minute & PRN, offer bathroom q 120 minute & PRN, offer food & personal hygiene at least once every 8 hours and as needed has been documented. **How:** API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method:** By June 15, 2018, API will train all patient care staff including LIPs, RNs PNAs, Unit Clerks, Social Workers, and Clinical Services staff. These staff will receive additional training and pass a situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the rate for each department to the API Senior Management Team (ASM). The NSS per-shift CCTV audit guidelines will direct each NSS to audit at least one S/R event with a	

duration of 61 minutes or longer (where there was an event of that duration), to verify that fluids and other patient care needs were met at appropriate intervals and documented accurately. Any falsification of records will be subject to disciplinary action.

A178 –

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.

What: API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically RN Responsibilities/Notification to the NSS requiring the RN releasing the patient from S/R episode to call the on-duty Nursing Shift Supervisor to ensure the face to face is completed on time.

How: API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding.

Evaluation Method: By June 15, 2018, API RNs will receive additional training and pass situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the rate for each department to the API Senior Management Team (ASM).

CEO Signature:

A 123	**PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION** **CFR(s): 482.13(a)(2)(iii)** At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on record review, interview, and policy review the facility failed to ensure one patient (#2) out of 2 patients reviewed that had filed grievances in the facility, had received written notice of the steps taken and resolution of his/her written complaint/grievance. This failed practice denied the patient written knowledge of the steps and actions taken on his/her behalf. Findings: Patient #2 Record review on 3/27-29/18 revealed Patient #2 was admitted to the facility with diagnoses that included	**Who:** The Director of Qualuty Improvement (QID) is ultimately responsible for the corrective action as well as the overall and ongoing compliance for Alaska Psychiatric Institute. **What:** API will develop a desk procedure establishing protocols for how Recovery Support Services (RSS) staff are to process and document complaints and grievances. **How:** API will ensure RSS staff members receive training by the QID in the protocols noted in the RSS desk procedure. **Evaluation Method:** To ensure the plan of correction is effective and the deficiencies stay corrected, the QID or designee will, on a weekly basis for the first 60 days following implementation of the RSS desk procedure, review a sample of the complaints and grievances received in that week to ensure all required protocols are being followed. If deficiencies are noted, additional training or other remedial action(s) will take place. If no deficiencies are noted within the first 60 days of review, the frequency of review will change to a monthly review of a sample of the complaints and grievances received by RSS within that month. Reviews for the prior month will be conducted no later than by COB seven working days after the prior month's end. **CEO Signature:**	6/15/2018

traumatic brain injury and diabetes mellitus type 2.

During an interview on 3/27/18 at 2:30 pm, Patient #2 stated he/she had filed "16" grievances while at the facility.

Review on 3/29/18 of Patient #2's written complaints/grievances revealed a concern "No#. 18-119" dated 3/5/18. The complaint/grievance had 2 concerns written on it. The first concern was documented by the Protective Services Specialist (PSS) as resolved: "Notified unit staff who said they would take care of request." The second concern was, "Have a grievance with...2 staff members that [harass] me...This has been going on about 80 % of the time I been here since 2-16-18." The second concern was not addressed.

During an interview on 3/29/18 at 10:40 am, the PSS confirmed the 2nd complaint/grievance had not been addressed.

Review on 3/29/18 of the facility's policy and procedures "Patient Complaint and Grievance Procedures" last revised 10/13/17, revealed "Patient Grievance: A concern or complaint filed by a patient ...that is unable to be resolved within three (3) business days." Additional review revealed,

	"...Level II grievances include, but are not limited to ...staff demeanor...Within seven (7) calendar days, provide the RSS [Recovery Support Services/Protective Services Specialist] staff with a written response...The final written response is due to the patient no later than fourteen (14) business days post receipt of the grievance."		
A143	**PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1)** The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on record review, video review and interview the facility failed to ensure one patient (#1), out of 13 sampled patients, was provided psychiatric care in a manner that preserved physical privacy. This failed practice placed the patient at risk for psychosocial harm and trauma. Findings: Record review on 3/27-29/18 revealed Patient #1 was admitted to the facility with a diagnosis of developmental delay (a condition which represents a significant delay in the process of development),	**Who:** The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) to include a statement directing patient care staff involved in the management of a patient in the Oak Room who requires the removal of clothing for safety, toileting etc. will be provided dignity measures (use of blanket, towel etc. at the RNs discretion). **How:** API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method:** By June 15, 2018, API will train patient care staff, including LIPs, RNs, PNAs, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive additional training and a pass situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education	6/15/2018

	mild mental retardation, cognitive disorder and anoxic brain injury (injury to the brain due to lack of oxygen). Seclusion: 3/5/18 Video review of the seclusion event on 3/5/18 at 10:46 am revealed LN (licensed nurse) #1 providing release criteria for Patient #1 who was in a 5-point mechanical restraint (straps that hold each wrist, each ankle and one over the torso that holds patient to a bed). The LN noted the patient had urinated while in the 5-point restrain. The LN told the patient to stand up and "drop them" while pointing to the patient's pants. The patient took off his/her pants resulting in him/her to be naked from the waist down. The LN then instructed the patient to walk out of the Oak Room (a room with a restraint bed and a secure door capable of being locked) and go to the bathroom in the next room. Multiple staff were present while the partially nude patient walked from the Oak Room to the bathroom. During an interview on 3/28/18 at 4:00 pm, the Quality Improvement Coordinator (QIC) stated the LN should have illustrated a more respectful method while having the patient undress. During an interview on 3/29/18 at	Department will track and report the pass rate monthly for each department to the API Senior Management Team (ASM). **CEO Signature:**	

	10:15 am the Director of the facility stated the staff should have provided a towel in efforts to provide more privacy and dignity to the patient while undressing. Record review of the seclusion documentation for the event on 3/5/18 revealed a note dated 3/7/18 that described the events of the seclusion and mechanical restraint. The noted stated "[Patient] was release from restraints so [he/she] can shower after urinating on [himself/herself] while in restraints." Next, the patient took a shower. The note continued to state "[Patient] following direction but per behavioral plan was placed back into seclusion to reinforce that urinating on [himself/herself] will not result in release from restraint/seclusion." Review of Patient's behavioral plan, dated 3/27/18, revealed no indication or approval to place back into seclusion after urinating on self. During an additional interview on 3/28/18 at 4:10 pm, the Quality Improvement Coordinator (QIC) stated there was not clinical indication or justification for the Patient to go back into seclusion after the shower.		

	During an interview on 3/28/18, Psychologist #1 stated the Oak Room should never be used as punishment.		
A 144	**PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)** The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: . Based on record review, video review and interview the facility failed to ensure one patient (#1), out of 7 patients reviewed that had been placed in seclusion and/or time-out, was provided with an emotionally safe environment during seclusion events. This failed practice placed the patient at risk for emotional instability and psychosocial harm. Findings: Record review on 3/27-29/18 revealed Patient #1 was admitted to the facility with a diagnosis of developmental delay (a condition which represents a significant delay in the process of development), mild mental retardation, cognitive disorder and anoxic brain injury (injury to the brain due to lack of oxygen). Seclusion: 3/5/18	**Who:** The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What:** API will update and adhere to API P&P SC-030-02.02a Management of Patient Behavior to emphasize that all patients will be treated with dignity and respect while being offered choices in the management of their behavior. **How:** API will update and adhere to API to API P&P SC-030-02.02a Management of Patient Behavior. Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method**: By June 15, 2018, API will train patient care staff, including LIPs, RNs PNAs, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive training and pass a situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the pass rate for each department to the API Senior Management Team (ASM). Additionally, the RN III Unit Supervisors, or their designee will conduct monthly mini-seminars on Dignity and Respect issues. These seminars will be recorded in each unit's unit meeting minutes and verified by the Director of Nursing.	6/15/2018

Video review of the seclusion event on 3/5/18 at 10:46 am revealed LN (licensed nurse) #1 providing release criteria for Patient #1 who was in a 5-point mechanical restraint (straps that hold each wrist, each ankle and one over the torso that holds patient to a bed). The LN noted the patient had urinated himself/herself while in the 5-point restraint. The LN told the patient to stand up and "drop them" while pointing to the patient's pants. The patient took off his/her pants resulting in him/her to be naked from the waist down. The LN then instructed the patient to walk out of the Oak Room (a room with a restraint bed and a secure door capable of being locked) and go to the bathroom in the next room. Multiple staff were present while the partially nude patient walked from the Oak Room to the bathroom.

During an interview on 3/28/18 at 4:00 pm, the Quality Improvement Coordinator (QIC) stated the LN should have illustrated a more respectful method while having the patient undress.

During an interview on 3/29/18 at 10:15 am the Director of the facility stated the staff should have provided a towel in efforts to provide more privacy and dignity to the patient while undressing.

Seclusion: 3/13/18

CEO Signature:

3/29/18

	Video review of the seclusion event on 3/13/18 at approximately 11:00 am revealed Patient #1 was having a difficult time on the milieu, opening doors and attempting to touch others. Staff instructed the patient to go to the Oak Room. Patient #1 verbally and physically indicated he/she didn't want to go. Staff assisted the Patient to the Oak Room indicating he/she needed a voluntary time out. Once in the Oak Room PNA #4, standing over the patient, punitively stated that he/she would bring the patient back and lock the door if the patient touched anyone else. During an interview on 3/28/18 at 4:15 pm, the Quality Improvement Coordinator (QIC) stated staff should not tower over patients and use the Oak Room as a punitive measure. Seclusion: 3/15/18 Video review of the seclusion event on 3/15/18 revealed Patient #1 was being guided to the Oak Room by multiple staff. Once in the Oak Room, LN #2 proceeded to give medication to the Patient at 5:56 pm. During medication administration the LN reprimanded the patient by standing over him/her and punitively stated he/she would give the Patient a shot if he/she refused to take the medication by mouth. Patient #1 began to become emotional. The LN stated "You can cry then." The LN continued to indicate if the patient does not		

	comply then he/she would be locked in the Oak Room. During an interview on 3/28/18 at 4:15 pm, the Quality Improvement Coordinator (QIC) stated the staff member in the video appeared to be scolding and threatening with the use of a shot and seclusion. During an interview on 3/28/18, Psychologist #1 stated the Oak Room should never be used as punishment. Review of the facility's policy "Management of Patient Behaviors," effective date 8/15/17, revealed the facility " ...will provide the least restrictive and non-violent therapeutic environment for the care of its patients, will treat all patients with dignity and respect, and will ensure the safety and well-being of all patients ..."		
A 145	**PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT** **CFR(s): 482.13(c)(3)** The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: . Based on record review, video review and interview the facility failed to ensure one patient (#1), out of 8	**Who:** The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) to emphasize individualized behavior plans (IBP) do not direct a patient to be put in seclusion or restraint and the importance of using only NAPPI approved techniques for physical intervention.	6/15/2018

	patients reviewed for restraints/ time-out/ seclusion, was free from potential verbal, emotional and physical abuse during care and treatment. Specifically, the facility failed to ensure the patient free from improper physical handling, unreasonable confinement, verbally belittled and threatening of punishment by means of seclusion and injections. This failed practice placed the patient at risk for physical injury, emotional distress, less that optimal psychosocial well-being. Findings: Record review on 3/27-29/18 revealed Patient #1 was admitted to the facility with a diagnosis of developmental delay (a condition whicb represents a significant delay in the process of development), mild mental retardation, cognitive disorder and anoxic brain injury (injury to the brain due to lack of oxygen). Seclusion #1: 3/5/18 Review on 3/28/18, of the 3/5/18 video revealed the Patient was in his/her bedroom at 8:36 am. The patient began to leave the room when PNA (Psychiatric Nursing Assistant) #4 stepped behind the Patient and pulled him/her back into the room by the backside collar of the Patient's top. During an interview on 3/28/18, during the video review, the Assistant Director of Nursing (ADON) stated the use of the patient's collar to pull the Patient back into room was not the appropriate way to direct him/her. The ADON stated the PNA should have approached the patient from the front.	**How:** API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method**: By June 15, 2018, API will train patient care staff, including LIPs, RNs PNAs, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive training and pass a situation-based test. The Hospital Education Department will track and report the pass rate for each department to the API Senior Management Team (ASM). **CEO Signature:**	

	Further review of the video from 3/5/18 at 8:40 am revealed the patient, standing in doorway of room, began to kick at the PNA. Next, the PNA directed the patient back into the room with an open hand on the front chest/shoulder area. When the Patient attempted to leave the bedroom, the PNA used his/her foot to block the bedroom door from opening more than 6 inches. The patient made multiple attempts to squeeze through the small opening. During an interview on 3/28/18 at 3:30 pm, the Quality Improvement Coordinator (QIC) stated the patient was secluded in his/her bedroom. The QIC further stated secluding a patient in a bedroom could be approved if the behavior plan indicated it necessary. The QIC continued to state, placing the patient in a facility approved physical hold and the use of a gurney for transportation would have been a safer and more appropriate method of handling the patient's behaviors. Review of Patient's behavioral plan, dated 3/27/18, revealed no indication or approval to use his/her bedroom as a place for seclusion. Physical Hold: 3/5/18 Additional review of the video from 3/5/18 revealed the patient was moved into the Oak Room (a room with a restraint bed and a secure door capable of being locked). While in the Oak Room the Patient began to bang head on the locked door. At approximately 8:55 am two staff members came into the Oak Room and placed the Patient		

abdomen first against the corner of two walls. The Patient, while standing, was held against the corner until the bed restraints were in place.

During an interview on 3/29/18 the Medical Officer stated staff should not have placed the Patient face forwards into a wall.

During an interview on 3/29/18 at 10:00 am the Protective Service Specialist of the facility stated the staff should have used a more appropriately NAPPI (Non-Abusive Psychological and Physical Intervention) technique such a capture wrap (a physical hold technique that 1 or 2 people place a hug-like hold on the patient).

During an interview on 3/29/14 at 2:07 the NAPPI Trainer stated a one arm body wrap would have been the most appropriate physical hold. The NAPPI Trainer further stated placing patients against the wall is not an approved NAPPI technique nor is that type of hold taught in the NAPPI certification class.

Review of the facility's policy "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE)," effective date 10/27/17, revealed "..Only NAPPI approved techniques for physical intervention will be used."

Review of the NAPPI Trainers Manual, provided by the facility on 3/29/18, revealed placing a patient face-forward into a wall was not an approved NAPPI technique.

Seclusion #2: 3/5/18

	Video review of the seclusion event on 3/5/18 at 10:46 am revealed LN (licensed nurse) #1 providing release criteria for Patient #1 who was in a 5-point mechanical restraint (straps that hold each wrist, each ankle and one over the torso that holds patient to a bed). The LN noted the patient had urinated while in the 5-point restraint. The LN told the patient to stand up and "drop them" while pointing to the patient's pants. The patient took off his/her pants resulting in him/her to be naked from the waist down. The LN then instructed the patient to walk out of the Oak Room (a room with a restraint bed and a secure door capable of being locked) and go to the bathroom in the next room. Multiple staff were present while the partially nude patient walked from the Oak Room to the bathroom. When the shower was completed at 11:08 am, Patient #1 was returned to seclusion with no imminent behaviors to self or others being displayed. At 11:22 am the Patient approached the door and knocked calmly to gain the attention of the observer, PNA #5. No obvious acknowledgement of the patient was noted. Patient #1 was released at 11:52 am. Record review of the seclusion documentation for the event on 3/5/18 revealed a note dated 3/7/18 that described the events of the seclusion and mechanical restraint. The noted stated "[Patient] was release from restraints so [he/she] can shower after urinating on [himself/herself] while in restraints." Next, the patient took a shower. The note continued to state "[Patient] following direction but per behavioral plan was placed back into		

seclusion to reinforce that urinating on [himself/herself] will not result in release from restraint/seclusion."

Review of Patient's behavioral plan, dated 3/27/18, revealed no indication or approval to place back into seclusion after urinating on self.

During an interview on 3/28/18 at 4:00 pm, the Quality Improvement Coordinator (QIC) stated the LN should have illustrated a more respectful method while having the patient undress. The QIC further stated there was no clinical indication or justification for the Patient to go back into seclusion after the shower and the re-seclusion was unnecessary.

During an interview on 3/28/18, Psychologist #1 stated the Oak Room should never be used as punishment.

During an interview on 3/29/18 at 10:15 am the Protective Service Specialist of the facility stated the staff should have provided a towel in efforts to provide more privacy and dignity to the patient while undressing.

Seclusion: 3/13/18

Video review of the seclusion event on 3/13/18 at approximately 11:00 am revealed Patient #1 was having a difficult time on the milieu, opening doors and attempting to touch others. Patient #1 was asked by a staff to go to the Oak Room for a time-out. The patient sat down and replied "I don't want to go." As the Patient was being walked to the Oak Room, he/she began to yell "No Oak Room! No Oak Room!

	No Oak Room!" Staff assisted the Patient to the Oak Room indicating he/she needed a voluntary time out. At 11:03 am multiple staff physically stood in doorway of the Oak Room. As a result this created a physical wall that prevented Patient #1 from exiting the room. Once in the Oak Room PNA #4, standing over the patient, punitively stated that he/she would bring the patient back and lock the door if the patient touched anyone else. Further video review until 11:12 am revealed the patient was in the Oak Room alone with the door appearing to be shut. Medication was administered at 11:12 am by LN (licensed nurse) #1. Next, the Patient calmly asked if he/she could leave the Oak Room immediately after 11:12 am. The LN denied the request and the Patient sat in the Oak Room from 11:12 to 12:14 with no signs of threatening behaviors. Review of the Seclusion Face to Face Flow Sheet, dated 3/13/18, revealed the staff documented Patient #1 was quietly sitting and/or lying down from 11:30 am to 12:14 pm. During an interview on 3/28/18 at 3:30 pm, the Quality Improvement Coordinator (QIC) stated staff did not follow protocol. When asked to describe the violent and/or destructive behavior, the QIC stated no immediate violent or destructive behavior warranted the seclusion During a second interview on 3/28/18 at 4:15 pm, the Quality Improvement Coordinator stated staff should not tower over patients and use the Oak Room as a punitive measure.		

Seclusion: 3/15/18:

Video review of the seclusion event on 3/15/18 revealed Patient #1 was being guided to the Oak Room by multiple staff. Once in the Oak Room, LN #2 proceeded to give medication to the Patient at 5:56 pm. During medication administration the LN reprimanded the patient by standing over him/her and punitively stated he/she would give the Patient a shot if he/she refused to take the medication by mouth. Patient #1 began to become emotional. The LN stated "You can cry then." The LN continued to indicate if the patient does not comply then he/she would be locked in the Oak Room.

During an interview on 3/28/18 at 4:15 pm, the Quality Improvement Coordinator (QIC) stated the staff member in the video appeared to be scolding and threatening with the use of a shot and seclusion.

During an interview on 3/28/18, Psychologist #1 stated the Oak Room should never be used as punishment.

Review of the facility's policy "Management of Patient Behaviors," effective date 8/15/17, revealed the facility " ...will provide the least restrictive and non-violent therapeutic environment for the care of its patients, will treat all patients with dignity and respect, and will ensure the safety and well-being of all patients..."

Review of the facility's policy "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE)," effective date of 10/27/17, revealed the policy defined a seclusion as "The

	involuntary confinement of a patient alone in a room or an area whereas he/she is physically prevented from leaving that room or area. The room or area may be unlocked or locked ...[Alaska Psychiatric Institute] only uses restraints or seclusion when a patient's behavior results in an imminent risk of patient harming himself or herself or other ...when safety issues require an immediate physical response to prevent harm." Review of the facility's policy "Conduct Involving Patients," effective date 10/13/17, revealed "All patients will be treated in a respectful an culturally sensitive manner at all times ...[API - Alaska Psychiatric Institute] prohibits any harmful exchanges by employees towered patients at any time during and after hospitalization ...Physical abuse includes ...using more force than reasonable for a patient's control, treatment or management ...defined as the appropriate use of [NAPPI] techniques ...the improper or illegal restraint of seclusion of a patient; including the use of restraint or seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff ...Verbal abuse includes use of oral or written words ...or statements that belittle, goad, sneer at, condemn, or threaten a patient with bodily harm ...pattern of disrespectful verbalizations ...also meet the definition of abuse ...Emotional abuse includes humiliation of a patient and threats of corporal punishment."		
A 162	**PATIENT RIGHTS: RESTRAINT OR SECLUSION** **CFR(s): 482.13(e)(1)(ii)**	**Who:** The Director of Nursing (DON) is ultimately responsible for the corrective	6/15/2018

	Seclusion is the involuntary confinement of a 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. This STANDARD is not met as evidenced by: Based on record review, interview and video review the facility failed to identify seclusion for three patients (#s 1, 12 and 13) out of 7 patients placed in situation that prevented them from leaving a room or area. Specifically, the facility implemented a Time-Out (a voluntary time that allowed patients to be in a low stimulus area) that resulted in the patients inability to move freely about the unit. This failed practice resulted in the patients to be inadvertently secluded and created a risk for psychological harm. Findings. Patient #1 - Seclusion #1 on 3/5/18 Record review on 3/27-29/18 revealed Patient #1 was admitted to the facility with a diagnosis of developmental delay (a condition which represents a significant delay in the process of development), mild mental retardation, cognitive disorder and anoxic brain injury (injury to the brain due to lack of oxygen). Review on 3/28/18, of the 3/5/18 video revealed the Patient was in his/her bedroom at 8:36 am. The patient began to leave the room when PNA (Psychiatric Nursing Assistant) #4 stepped behind the patient and pulled	action as well as the overall and on-going compliance. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically removing Time-Out from the policy and create a new policy which focuses solely on time-out for patients to emphasize the difference between seclusion & time out procedures. **How:** API will update and adhere to the update of API P&P SC-030-02.01b and the new Time-out Policy. **Evaluation Method:** By June 15, 2018, API will train patient care staff, including LIPs, RNs PNAs, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive training and pass a situation-based test. The Hospital Education Department will track and report the pass rate for each department to the API Senior Management Team (ASM). **Who:** The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What:** API will request funding for procurement of an additional closed circuit television (CCTV). The on-duty Nursing Shift Supervisor will have access to view incidents in a confidential manner in the Nursing Office in close proximity to the event or in real time. **How:** API will request to purchase and install the CCTV system and create a strict written protocol for viewing, create a desk procedure for conducting per-shift NSS audits and documenting the findings on the debriefing forms.	

him/her back into the room by the backside collar of the patient's top.

During an interview on 3/28/18, during the video review, the Assistant Director of Nursing (ADON) stated the use of the patient's collar to pull patient back into room was not the appropriate way to direct him/her. The ADON then stated the PNA should have approached the patient from the front.

Further review of the video from 3/5/18 at 8:40 am revealed Patient #1 while standing in doorway of room, began to kick at the PNA. Next, the PNA directed the patient back into the room with an open hand on the front chest/shoulder area. The Patient attempted to leave the bedroom. The PNA used his/her foot to block the bedroom door from opening more than 6 inches. The Patient #1 made multiple attempts to squeeze through the small opening.

During an interview on 3/28/18 at 3:30 pm, the Quality Improvement Coordinator (QIC) stated the patient was secluded in his/her bedroom.

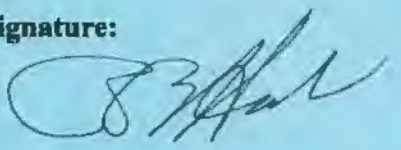
Record review revealed no seclusion paperwork or indication was located in Patient #1's medical record for the event that occurred with PNA #4 and the Patient in the bedroom on 3/5/18.

Patient #1 - Seclusion: #2 on 3/5/18

Video review of the seclusion event on 3/5/18 at 10:46 am revealed LN #1 providing release criteria for Patient #1 who was in a 5-point mechanical restraint (straps that hold each wrist, each ankle and one over the torso that holds patient to a bed). The LN noted

Evaluation Method: By June 15, 2018, API will train Nursing Shift Supervisors in the management and confidential nature of reviewing CCTV to include teaching to review S/R incidents for adherence to TIC and policy. NSSs will be required to complete an online training and pass situation-based test. The Hospital Education Department will track and report the rate for designated supervisors to the API Senior Management Team (ASM). Additionally, each NSS will conduct a CCTV enabled audit of a behavioral incident that occurred on their shift and document the audit on the updated debriefing form.

CEO Signature:



the patient had urinated himself while in the 5-point restraint. The LN then instructed the patient to walk out of the Oak Room (a room with a restraint bed and a secure door capable of being locked) and go to the bathroom in the next room.

Record review of the seclusion documentation for the event on 3/5/18 revealed a note dated 3/7/18 that described the events of the seclusion and mechanical restraint. The noted stated "[Patient] was release from restraints so [he/she] can shower after urinating on [himself/herself] while in restraints." Next, the patient took a shower. The note continued to state "[Patient] following direction but per behavioral plan was placed back into seclusion to reinforce that urinating on himself will not result in release from restraint/seclusion."

Review of Patient's behavioral plan, dated 3/27/18, revealed no indication or approval to place back into seclusion after urinating on self.

During an interview on 3/28/18 at 4:10 pm, the Quality Improvement Coordinator (QIC) stated there was no clinical indication or justification for the Patient to go back into seclusion after the shower. The QIC further stated the re-seclusion was unnecessary.

Patient #1 - Time-Out 3/13/18

Review of an "Emergency Seclusion" document, dated 3/13/18, revealed Patient #1 was directed to the Oak Room for "voluntary timeout." after throwing liquids on facility staff.

	Review on 3/28/18, of the 3/13/18 video revealed Patient #1, near his/her room, was asked by a staff to go to the Oak Room (a room with a restraint bed and a secure door capable of being locked) for a time-out at 11:00 am. The patient sat down and replied "I don't want to go." As the Patient was being walked to the Oak Room, he/she began to yell "No Oak Room! No Oak Room! No Oak Room!" At 11:03 am multiple staff physically stood in doorway of the Oak Room and created a physical wall that prevented Patient #1 from exiting the room. From 11:03 am to 11:12 am the Patient was in the Oak Room alone with the door appearing to be shut. After medication was administered to the Patient, at 11:12 am, by LN (Licensed Nurse) #1. Next, the Patient calmly asked if he/she could leave the Oak Room. The LN denied the request and the Patient sat in the Oak Room from 11:12 to 12:14 with no signs of threatening behaviors. Review of the Seclusion Face to Face Flow Sheet, dated 3/13/18, revealed the staff did not document the seclusion until 11:18 am. During an interview on 3/28/18, Psychologist #1 stated the Oak Room should never be used as punishment. During an interview on 3/28/18 at 3:30 pm, the QIC stated staff did not follow protocol. When asked to describe the violent and/or destructive behavior, the QIC stated no violent or destructive behavior warranted the seclusion. Patient #12 - Time-Out Record review on 3/27-29/18 revealed Patient		

	#12 was admitted to the facility with a diagnosis of schizophrenia. During an interview on 3/27/18 at 2:15 pm, Patient #12 stated he/she had been in a Time-Out the previous Saturday (3/24/18). Review of the seclusion/restraint log for the date of 3/24/18 revealed no seclusion was documented for Patient #12. Review of Patient #1's medical record revealed no documentation of a seclusion on 3/24/18. The only seclusion documented in the medical record was dated 3/20/18. Review on 3/29/18 at 1:15 pm, of the 3/24/18 video revealed the Patient went to the seclusion room at 4:07 pm, voluntarily. At 4:21 pm the Patient stated "I want to go in my room". The Patient came out of the Oak Room and proceeded to escalate his/her behaviors towards the staff. The staff then escorted the Patient back to the Oak Room at 4:25 pm and closed the door. During an interview on 3/29/18 at 1:15 pm, the QIC stated for a time-out the Staff should have informed the Patient that the door was unlocked. Patient #13 - Time-Out Record review on 3/27-29/18 revealed Patient #13 was admitted to the facility with diagnoses that included schizophrenia and antisocial personality disorder. During an interview on 3/27/18 at 2:30 pm, Patient #13 stated he/she had been in a voluntary "Time-Out" on 3/26/18.		

Review of the medical record revealed no documentation of a Time-Out or seclusion on 3/26/18. Review of the seclusion log for 3/26/18 revealed no seclusions were documented for Patient #13.

Review on 3/29/18 at 1:30 pm, of the 3/26/18 at 1:11 pm video revealed the Patient was walking down the hall with PNA #1. The PNA stated to the Patient "Do you think I want to agitate you?" The Patient started swearing and the PNA called a code gray (a behavior emergency-where additional staff respond quickly). Other staff responded and the Patient was taken to the Oak Room. The Patient was then patted down and the door was closed.

During an interview on 3/29/18 at 1:30 pm, the QIC confirmed the placement of the Patient in the Oak Room was a seclusion, not a time-out.

During an interview on 3/27/18 at 2:20 pm, PNA
#3, stated the facility did not use time-outs.

During an interview on 3/27/18 at 1:45 pm, PNA
#2 stated time-outs were voluntary and usually occurred in the patient's bedroom. The PNA stated the patient could also go into the Oak Room to yell and scream, but then they would be on 1:1 (one staff member to one patient) observation.

During a subsequent interview on 3/28/18 at 11:45 am PNA #2 stated the facility policy explained when and what a Time-Out was. The PNA stated the facility always documented Time-

	Outs when a patient was in their room, because the patient would then be on 15 minute checks. Review of the facility's policy and procedure (P&P) "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) dated 10/27/17 revealed "TIME-OUT: A voluntary procedure used to assist the patient to regain emotional control. Use of a staff-approved area ...for time alone, for any period of time and from which the patient is not prevented from leaving nor given the impression that they are not allowed to leave. When a patient is physically prevented from leaving the Time-Out, or given the impression that they are not allowed to leave, the intervention is no longer a Time-Out, and instead becomes a seclusion. Further review of the P&P revealed the definition for seclusion was "The involuntary confinement of a patient alone in a room or an area whereas he/she if physically prevented from leaving that room or area. The room or area may be unlocked or locked."		
A 167	**PATIENT RIGHTS: RESTRAINT OR SECLUSION** **CFR(s): 482.13(e)(4)(ii)** [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. This STANDARD is not met as evidenced by: .	**Who:** The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What**: API Hospital Education Department will provide updated robust and ongoing Trauma Informed Care (TIC) training for all employees. **How**: API Hospital Education Department will complete the Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma Informed Care (TIC) one-day Train the Trainer course & the State	6/15/2018

	Based on record review, interview and video review the facility failed to ensure one patient (#1), out of 7 patients reviewed for restraint/seclusion, was safely and appropriately restrained and/or secluded according to facility approved standards of practice, during two separate events. This failed practice place the patient at risk for injury, trauma and psychological harm. Findings: Record review on 3/27-29/18 revealed Patient #1 was admitted to the facility with a diagnosis of developmental delay (a condition which represents a significant delay in the process of development), mild mental retardation, cognitive disorder and anoxic brain injury (injury to the brain due to lack of oxygen). Review on 3/28/18, of the 3/5/18 video revealed the Patient was in his/her bedroom at 8:36 am. The patient began to leave the room when PNA (Psychiatric Nursing Assistant) #4 stepped behind the Patient and pulled him/her back into the room by the backside collar of the Patient's top. During an interview on 3/28/18, during the video review, the Assistant Director of Nursing (ADON) stated the use of the patient's collar to pull the Patient back into room was not the appropriate way to direct him/her. The ADON stated the PNA should have approached the patient from the front. Further review of the video from 3/5/18 at 8:40 am revealed the patient, standing in doorway of room, began to kick at the PNA. Next, the PNA directed the patient back into the room	of Alaska Division of Behavioral Health sponsored Trauma 101 training. **Evaluation Method:** By June 15, 2018, API will have the Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma Informed Care train the trainer program completed. The Hospital Education Department will create and roll out TIC training for new employee orientation by July 15, 2018. New employees will be required to pass a situation-based test to reflect their understanding of TIC. The Hospital Education Department will complete an updated Trauma Informaed Care (TIC) training for all employees by October 15, 2018. All employees will be required to pass a situation-based test to reflect their understanding of TIC. **What:** API Hospital Education Department and the Nurse Unit Supervisor will complete monthly mock behavioral drills reviewing the flow of events, emphasizing hospital P& P being followed while responding to code grays, seclusion, and/or restraint events and debriefing process rotating each month to a different unit/location in the hospital. **How:** API Hospital Education Department and the Nurse Unit Supervisor will collaborate complete mock guidelines and scenarios for the monthly mock drills. HED and the RN III Supervisor will meet to assign roles and responsibilities for each unit prior to the units training rotation. **Evaluation Method:** By June 15, 2018, API Hospital Education and a Unit Supervisor will have completed one mock code drill with a patient care unit choice providing feedback to patient care staff and providing a written	

	with an open hand on the front chest/shoulder area. When the Patient attempted to leave the bedroom, the PNA used his/her foot to block the bedroom door from opening more than 6 inches. The patient made multiple attempts to squeeze through the small opening. During an interview on 3/28/18 at 3:30 pm, the Quality Improvement Coordinator (QIC) stated the patient was secluded in his/her bedroom. The QIC further stated secluding a patient in a bedroom could be approved if the behavior plan indicated it necessary. The QIC continued to state, placing the patient in a facility approved physical hold and the use of a gurney for transportation would have been a safer and more appropriate method of handling the patient's behaviors. Review of Patient's behavioral plan, dated 3/27/18, revealed no indication or approval to use his/her bedroom as a place for seclusion. Additional review of the video from 3/5/18 revealed the patient was moved into the Oak Room (a room with a restraint bed and a secure door capable of being locked). While in the Oak Room the Patient began to bang head on the locked door. At approximately 8:55 am two staff members came into the Oak Room and placed the Patient abdomen first against the corner of two walls. The Patient, while standing, was held against the corner until the bed restraints were in place. During an interview on 3/29/18 the Medical Officer stated staff should not have placed the Patient face forwards into a wall.	evaluation of the exercise with suggestions for improvement, what went well and any suggestions or themes presenting. The information will be reported to the ASM Team and Nursing Administration where the information will be reviewed in the monthly unit meetings with staff by the RN III Supervisors. The Hospital Education Department will track and maintain records of compliance for monthly drills reporting to the API Senior Management Team (ASM). **CEO Signature:**	

	During an interview on 3/29/18 at 10:00 am the Director of the facility stated the staff should have used a more appropriately NAPPI (Non-Abusive Psychological and Physical Intervention) technique such a capture wrap (a physical hold technique that 1 or 2 people place a hug-like hold on the patient). During an interview on 3/29/14 at 2:07 the NAPPI Trainer stated a one arm body wrap would have been the most appropriate physical hold. The NAPPI Trainer further stated placing patients against the wall is not an approved NAPPI technique nor is that type of hold taught in the NAPPI certification class. Review of the facility's policy "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE)," effective date 10/27/17, revealed "...Only NAPPI approved techniques for physical intervention will be used." Review of the NAPPI Trainers Manual, provided by the facility on 3/29/18, revealed placing a patient face-forward into a wall was not an approved NAPPI technique.		
A174		**Who:** The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically RN Responsibilities/Notification to the NSS when a patient has an seclusion or restraint event the RN will be required to call the on-duty Nursing Shift Supervisor (NSS) q 30 minutes for the duration of the event providing rational for the continuation of the S/R event.	6/15/2018

		How: API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method**: By June 15, 2018, API RNs will receive additional training on the policy and pass a situation-based test. The Hospital Education Department will track and report the pass rate for each department to the API Senior Management Team (ASM).	
A175	**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: Based on record review, interview and policy review the facility failed to ensure the monitoring of 1 patient (#6), out of 7 patients reviewed for seclusion/restraints, included offering fluids during multiple seclusion events. These failures placed the Patient at risk not receiving the needed fluids and dehydration. Findings: Patient #6:	**Who:** The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically PNA responsibilities to reflect the PNA monitoring the S/R Face to Face Flow Sheet will confirm that the offer of fluids q60 minute & PRN, offer bathroom q 120 minute & PRN, offer food & personal hygiene at least once every 8 hours and as needed has been documented. **How:** API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method:** By June 15, 2018, API will train all patient care staff including LIPs, RN's PNA's, Unit Clerks, Social Workers, and Clinical Services Staff. These staff will receive additional training and pass a situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the rate for	6/15/2018

	Record review on 3/27-29/18 revealed Patient #6 was admitted to the facility with a diagnosis that included schizophrenia. Further review revealed the Patient had numerous seclusion/restraint episodes since admittance. Review of the following "Seclusion Face to Face Flow Sheet" in the medical record review revealed missing documentation related to fluids offered to the Patient at least every hour : - 3/10/18 at 7:42 pm to 9:43 pm - no documentation of fluids provided and/or offered were documented until 9:15 pm; - 3/22/18 at 8:13 pm to 4:30 am - no documentation of fluids provided and/or offered at least hourly; - 3/23/18 at 12:40 am to 7:42 am - no documentation of fluids were provided and/or offered until 6:35 am; and - 3/24/18 at 10:23 am to 12:55 pm - no documentation of fluids provided and/or offered. During an interview on 3/29/18 at 2:15 pm, the Quality Improvement Coordinator confirmed the above seclusion flow sheets were missing documentation of the Patient receiving fluids, or offered fluids while secluded. Review of the facility's policy and procedure "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) dated 10/27/17, revealed "D. Psychiatric Nursing Assistant (PNA) responsibilities ...Face to Face Flow Sheet will be documented in real time by staff member observing the patient to include documentation	each department to the API Senior Management Team (ASM). The NSS per-shift CCTV audit guidelines will direct each NSS to audit at least one S/R event with a duration of 61 minutes or longer (where there was an event of that duration), to verify that fluids and other patient care needs were met at appropriate intervals and documented accurately. Any falsification of records will be subject to disciplinary action. **CEO Signature:**	

	...of fluids q [every] 60 minute & PRN [as needed]...Staff must write a comment on Flow Sheet to clinically justify any required patient assessment/assistance that is not offered or performed ...6. Staff must note any patient refusals for care on the S/R Flow Sheet ..."		
A178	**PATIENT RIGHTS: RESTRAINT OR SECLUSION** **CFR(s): 482.13(e)(12)** When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a- - - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: . Based on record review, interview and policy review the facility failed to ensure one patient (#6), out of 7 patients reviewed for restraints/seclusion, was evaluated face-to-face within one hour after the initiation of a restraint and seclusion. The failure to complete the evaluation	**Who**: The Director of Nursing (DON) is ultimately responsible for the corrective action as well as the overall and on-going compliance. **What:** API will update API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) specifically RN Responsibilities/Notification to the NSS requiring the RN releasing the patient from S/R episode to call the on-duty Nursing Shift Supervisor to ensure the face to face is completed on time. **How:** API will update and adhere to API P&P SC-030-02.01b Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE). Patient care staff will receive a copy of the updated policy and summary of the contents for ease of understanding. **Evaluation Method:** By June 15, 2018, API RNs will receive additional training and pass a situation-based test. If staff do not pass the test, they will be retrained until they are successful. The Hospital Education Department will track and report the rate for each department to the API Senior Management Team (ASM). **CEO Signature:**	6/15/2018

	within one hour placed the Patient at risk for a negative outcome from the restraint and seclusion. Findings: Record review on 3/27-29/18 revealed Patient #6 was admitted to the facility with a diagnosis that included schizophrenia. Further review revealed Patient #6 was on Close Observation Status Scale (COSS-a system of increased vigilance and monitoring) with 2nd degree in the milieu (continuous, strict visual monitoring by assigned staff within arm's length), and 1st degree in bed area (15 minute observation and engagement checks). Review of the medical record revealed the Patient was secluded on 3/25/18 at 10:23 pm and released from seclusion on 3/26/18 at 12:27 am. At the initiation of the seclusion the Patient was restrained by a "Brief Manual Restraint" (BMR). Further review of the medical record revealed the facility did not document a 1-hour face-to-face. The face-to-face was completed on 3/26/18 at 4:38 am, which was greater than 6 hours since the start of the BMR and seclusion.		

	During an interview on 3/29/18 at 12:25 pm the Quality Improvement Coordinator (QIC) confirmed the face-to-face evaluation was not completed within 1 hour. During an interview on 3/29/18 at 2:00 pm, the QIC, stated all the RNs received specialty training as a Special Procedures Nurse (SPN) in order to be trained in 1 hour face-to-face evaluations. Review of the facility's policy and procedure "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE) dated 10/27/17, revealed "III. INITIATING, IMPLEMENTING, MONITORING AND DOCUMENTING SECLUSION/RESTRAINT: ...G. Assess the patient, in person face-to-face, within one (1) hour of initiating the use of restraint (including manual and gurney restraint) and seclusion. The assessment will be documented at the time of the assessment using the in-person one (1) HR [hour] Face-to-Face Assessment ...h. A Special Procedures Nurse (SPN) may perform this function if an		

	LIP [Licensed Independent Practioner] is not on site "...The SPN must follow the same assessment guidelines."		