Health Facilities Certification & Licensing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	024002	A. BUILDING: _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA PSYCHIATRIC INSTITUTE	3700 PIPER STREET ANCHORAGE, AK 99508

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RR000	Initial Comments . During a State survey conducted at your facility on January 28-30, 2019, in conjunction with a Federal revisit survey to determine the State and Federal requirements for Medicare/Medicaid, the following deficient practices were noted. The sample size included 18 patients. The State Survey team determined the facility failed to ensure measures were in place to protect vulnerable patients per CFR 482.13(c)(3) Patient Rights: Free from Abuse/Harassment and Alaska Administrative Code 7 AAC 12.869 (1) Risk Management. This failure resulted in a patient at the facility receiving unwanted touching on his/her genital region by another patient on January 27, 2019 at 6:13 pm. After the incident, the facility did not 1) conduct a comprehensive investigation, 2) ensure measures were implemented to further protect this patient, or other patients residing on the Taku unit in the facility, from unsolicited sexual contact by the perpetrating patient, 3) determine the extent of psychological distress this patient may have experienced and treat any psychosocial instability associated with this unsolicited sexual contact, and 4) report the neglect to monitor the perpetrating patient as per Alaska AS 47.24.010 Report of Harm. Thses failed practices placed the patients residing on that unit in immediate jeopardy for potential unsolicited sexual touching and/or sexual assault with the potential to result in serious physical and/or psychological harm and/or death. The facility presented a plan to mitigate the immediate jeopardy to the health and safety of patients residing on the Taku unit on January 29, 2019 at 4:40 pm.	RR000		

Certification and Licensing
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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RR000	Continued From page 1 State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503 .	RR000		
RR360	7 AAC 12.670(a) - (b) Nursing Service Nursing service - (a) A licensed nurse shall write a patient care plan for each patient in consultation with other patient care personnel and the patient. (b) The patient care plan must reflect analysis of patient problems and needs, treatment goals, medication prescribed and, upon discharge, instructions given to the patient and the patient's family regarding medication management, including any risks, side effects, and benefits expected, and including any recommended activities and diet. This Rule is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the nursing care plan met the needs for appropriate pacemaker care for 1 patient (#3), out of 7 nursing care plans reviewed. Without appropriate and current care plans patients are at risk for not receiving the necessary and/or appropriate care and services. This failed practice placed the patient at risk for potential	RR360		

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cardiac complications which could impact the patient's health and overall well-being. Findings:

Record review on 1/28-30/19 revealed Patient #3 was admitted with diagnoses that included sick sinus syndrome (an uncommon heart rhythm disorder where the heart's sinus node, the heart's pacemaker, does not function properly) and Schizophrenia (A serious mental disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning, and can be disabling).

Review of the most recent "Nursing Care Plan Form," dated 1/26/19, revealed identified problem #3 as "Risk for decreased cardiac output [related to] mitral valve regurgitation and sick sinus syndrome with pacemaker." The long term goal for this problem was "[Patient] will report no symptoms related to cardiac output decreasing throughout the next 6 months." This goal was added on 1/26/19.

During an interview on 1/28/19 at 11:42 am, Registered Nurse (RN) #2 stated Patient #3 is not able to verbalize rational and clear statements due to his/her schizophrenia. RN #2 further stated the Patient would not be able to process signs and symptoms of cardia issues. After review of the nursing care plan long term goal, RN #2 stated the long term goal was not attainable by the Patient at this time.

When the State Surveyor inquired about pacemaker care and if a download of the pacemaker (an electronic transmittal of data to the cardiologist for review of the patient's cardiac status inbetween assessments/visits) had

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occurred recently, RN #2 stated he/she was not aware pacemaker downloading was something that needed to be done. RN #2 could not identify Patient #3's last cardiac appointment and did not know the recommended routine follow ups for Patient #3's cardiac care.

Review of the medical record on 1/28/19 revealed a "Consult Request & Emergency Treatment Form," dated 7/29/16 for a "pacemaker check." An appointment at Alaska Heart & Vascular Institute was scheduled for 8/5/16 at 2:00 pm. Additional review of the medical record revealed a copy of the original consult request form with a post-it note attached, dated 8/10/16, that read: "I'm guessing the Client refused appt. [appointment] or it was [checked] telephonic ..." The nursing staff could not confirm or deny Patient #3 attended this appointment.

On 1/29/19, the Physician's Assistant Certified (PA-C) #1 requested records from the Alaska Heart & Vascular Institute after RN #2 contacted PA-C #1 to inquire about Patient #3's pacemaker care. The records revealed the last pacemaker download occurred on 8/9/16 with a recommended follow-up in 3 months.

During an interview on 1/30/19 at 10:30 am, PA-C #1 stated he/she could not locate any paperwork in Patient #3's medical record about any pacemaker care after 8/9/16. He/she stated the Health & Physicals (H&Ps) do document the presence of the pacemaker, but no documentation associated with routine follow ups. PA-C #1 stated he/she placed an order for a cardiac consult based on the length of time it has gone unassessed.

Review of the H&Ps for Patient #3 revealed the

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RR360	Continued From page 4 "History & Physical (Dictated) Date of Admission," dated 4/20/16, which documents "presence of cardiac pacemaker." The "History & Physical (Dragon) Annuall H&P," dated 5/22/17, and the "History & Physical Annual H&P," dated 5/22/18, documented "Sick Sinus Syndrome patient has been asymptomatic since pacemaker implanted, will continue to monitor and treat as indicated." Further review of all H&Ps revealed no documentation associated with routine follow ups for cardiac monitoring or pacemaker downloads. Review of the facility's policy "Nursing Care Plan," dated 10/15/18, revealed: "A registered nurse will develop and keep current a nursing care plan for each patient, based on nursing assessments, re-assessments, and input from the patient/guardian and other relevant sources. A registered nurse will document patient progress toward nursing goals ...The nursing care plan will include planning for ...physiological ...factors ...The nursing care plan is based on the patient's needs and includes relevant nursing interventions." Review of the facility's "Nursing Department Procedure - Nurse Responsibilities," dated 4/6/2015, revealed: "Monitor each patient for signs and/or symptoms that suggest their physical status is deteriorating or at risk of evolving into a medical emergency." .	RR360		
RR510	7 AAC 12.860(1) Risk Management Risk management - A facility, with the exception of home health agencies and hospice agencies that do not provide inpatient care on agency premises, must have a risk management	RR510		

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RR510	Continued From page 5 program that has (1) provision for monitoring, evaluating, identifying, correcting, and reassessing care practices that negatively affect quality of care and services provided or result in accident or injury to a patient, resident, or staff, and provisions for documenting deficiencies found and remedial actions taken; This Rule is not met as evidenced by: . Based on record review, camera review and interview The facility failed to ensure an effective process was in place to receive and analyze adverse patient events and implement corrective actions and safety measures to protect patients. Specifically, the facility failed to ensure a process for accurate and timely review of Unusual Occurrence Reports (UORs) was effectively	RR510		

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being completed. This failed practice placed all patients at risk for prolonged exposure to an unsafe environment, following an event of staff neglect to a patient, due to a lack of review and implementation of safety measures by the facility. Findings:

Record review of the Taku (Forensic) unit 24 hour nursing report form, dated 1/28/19, revealed Patient #11 reportedly touched Patient #8's genital area while in the TV room on 1/27/19. Further review revealed the Taku unit census was 10 patients (including perpetrator).

Review of the medical record revealed Patient #11's had a "COSS [Close Observation Status Scale- level of observation and monitoring due to potential harm to that patient or others] Order", dated 12/3/18, for "2nd Milieu [one to one (1:1) level of staffing while outside of his/her room] / 1st Bed Area [level of monitoring that requires staff to observe the patient every 15 minutes while in his/her room] ...Secure Area Observational Level Danger to Others Unpredictable Behavior."

A camera review was conducted on 1/29/19 at 11:30 am, of the Taku unit for 1/27/19 starting at 5:56 pm. The observation consisted of Patient #11 and Psychiatric Nurse Assistant (PNA) #1, who was assigned as the Patient's 1:1 staff. During the camera review it was observed that Patient #11 was unattended and out of line of sight by his/her 1:1 multiple times. As a result, Patient #11 inappropriately touched Patient #8's genital area.

Review of the "Alaska Psychiatric Institute (API) - Unusual Occurrence Report (UOR)", dated 1/27/19 at 6:30 pm, revealed a sexual encounter

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occurred between Patient #8 (victim) and Patient #11 (perpetrator). The UOR did not indicate Patient #17 as a witness. The UOR further revealed no injury assessment or treatment type was conducted or identified. Review of the Immediate Supervisor/Nursing Shift Supervisor (NSS) Review, dated 1/27/19 at 7:25 pm, revealed Nursing Unit Manger #1 stated that Patient #8 did not want to press charges, no other patients were on the unit at the time of the event, no witnesses of the event and no staff were located in the TV room. The document had no indications that administration was notified of the event or what interventions were put in place to protect Patient #8 and/or other patients residing on the unit.

During an interview on 1/29/19 at 12:54 pm, the Chief Nursing Officer (CNO) and the Assistant Director of Nursing (ADON) stated they became aware of the 1/27/19 incident, between Patient #11 and Patient #8, when State Surveyors brought it to their attention on 1/29/19.

During an interview on 1/29/19 at 1:00 pm, Administrative Assistant (AA) #1 stated once a UOR has been created by floor staff and reviewed by a nursing supervisor the form comes to him/her. Once received AA #1 would review and log the incident and forward to a member of administration. In reference to the sexual event on 1/27/19 the AA stated he/she was not at work on 1/28/19 and wasn't sure what happened to the UOR because he/she was unaware of who reviews the UORs when he/she was out of the office.

During an interview on 1/29/19 at 1:01 pm, the Quality Assurance and Performance Improvement (QAPI) Director stated he/she

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picked up the UORs on 1/28/19 but the UOR pertaining to the 1/27/19 event that occurred between Patient #8 and #11 was not in the UORs. He/she further stated he/she received the UOR the morning of 1/29/19.

Review of the facility provided policy "Sentinel and Unanticipated Adverse Events," dated 10/8/13, revealed types of events to be considered sentinel events under this policy included event/occurrences that meet "Sexual Contact/Abuse/Assault occurs when there is sexual contact involving a patient and another patient ...while a patient is treated by, or on the premises of, API ...Sexual contact includes ...fondling of a patient's sex organ(s) by another individual's hand ..." The policy further stated all staff shall immediately report possible sentinel event to the NNS and a UOR will be completed. The NSS will first take any immediate actions necessary to prevent further harm to patients and then immediately notify the Medical Director, Chief Executive Officer, Chief Nursing Officer, Hospital Administrator, Clinical Director, Risk Manager, Safety Officer, Quality Improvement Coordinator or their designees.

Review of the facility's policy "Quality Assurance and Performance Improvement (QAPI) Program," dated 10/31/18, revealed an objective for the QAPI program was to "encourage an environment that promotes safety, encourages reporting of issues related to errors and safety related events ..." Further review revealed "QAPI program specifics include ...API utilized an Unusual Occurrence Reporting System (UOR) System to report identified safety events and near misses. Data from the UOR System is aggregate, analyzed and reported ...where safety risk mitigation plans will be developed, corrective

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RR510	Continued From page 9 action implemented, and tracked ...Patient safety events, including adverse events and sentinel events, are reported in accordance with all state and federal regulations ..." .	RR510		
RR550	7 AAC 12.890(a) Rights Rights of patients, clients, and residents - a) Except as otherwise provided in AS 47.30.825, a patient, client, or a nursing facility resident has rights that include the following: (1) to associate and communicate privately with persons of the patient's, client's, or resident's choice; (2) to have reasonable access to a telephone to make and receive confidential calls; (3) to mail and receive unopened correspondence; (4) to be informed of the facility's grievance procedure for handling complaints relating to patient, client, or resident care; (5) to be free from physical or chemical restraints except as specified in AS 47.30.825 or 7 AAC 12.258; (6) to be treated with consideration and recognition of the patient's, client's, or resident's dignity and individuality; (7) to confidentiality of the patient's, client's, or resident's medical records and treatment; (8) to be free from unnecessary or excessive medications; (9) to private visits by the patient's, client's, or resident's spouse, and to share a room if both spouses are patients, clients, or residents in the facility, unless medical reasons or space problems require separation; (10) to be informed in a language that the	RR550		

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patient, client, or resident understands, before or at the time of admission and during the stay, of services that are available in the facility and their cost, including any costs for services or personal care items not covered by the facility's basic per diem rate or not covered under 42 U.S.C. 1395 - 1396v (Titles XVIII or XIX of the Social Security Act);

(11) to be informed, in a language that the patient, client, or resident understands, of the patient's, client's, or resident's medical condition by the practitioner responsible for treatment;

(12) to refuse to participate in experimental research, psychosurgery, lobotomy, electroconvulsive therapy, or aversive conditioning;

(13) to participate in the development of a plan of care, or discharge plan, and to receive instructions for self-care and treatment that include explanation of adverse symptoms and necessary precautions, as appropriate;

(14) to be informed, in a language that the patient, client, or resident understands, of the rights listed in this subsection and of all the rules and regulations governing patient, client, or resident conduct and responsibility;

(15) to be informed of the professional training and experience of the practitioner responsible for treatment;

(16) to be informed by a practitioner of different options to the treatment recommended by the practitioner responsible for treatment, including the risks and benefits of each option.

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This Rule is not met as evidenced by:
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Based on record review, video review, interview, observation and facility policy review the facility failed to ensure one patient (#8) was treated with consideration and recognition of the patient's dignity and individuality after being sexually touched inappropriatly in the genital region as a result of negligence by a staff. This failed practice placed the patient at risk for psychosocial instability and pshycological distress. Findings:

Sexual Abuse & Neglect:

Record review of the Taku (Forensic) unit 24 hour nursing report form, dated 1/28/19, revealed Patient #11 reportedly touched Patient #8's genital area while in the TV room on 1/27/19. Further review revealed the Taku unit census was 10 patients (including perpetrator).

Review of a nurse's "Information Note", dated 1/27/19 at 6:49 pm, in Patient #11's medical record revealed "At approximately [6:15 pm] [Patient #8] ran out of the Taku TV room ... [Patient #8] stated that ...[Patient #11] touched [his/her] genital area. Staff shut the tv room doors

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to separate the patients. [Patient #8] walked back into the tv room while [Patient #11] stood by the nursing desk. [Patient #11] was asked to stay away from ...[Patient #8]...When the [Registered Nurse] asked [Patient #11] what happened the patient replied 'You guys told me to do it...Everyone in the world told me to do it.' RN spoke with [Patient #8] about the incident also. [Patient #8] stated [he/she] just walked up and reached for my [genitalia]. He touched me and I got up and ran out to you guys. RN asked if [Patient #8] wanted to press charges and [he/she] declined."

Patient #8

Review of Patient #8's medical record "Admission ASO Assessment", dated 8/23/18, revealed "has long history of sexual abuse ...has history of aggressive behavior." Further review revealed a nursing note dated 1/28/19 at 6:22 am, that stated "Patient was in an anxious mood do to another patient touching [him/her] inappropriately."

During an interview on 1/28/19 at approximately 11:50 am Patient #8 was asked about his/her day. The Patient immediately stated he/she was touched inappropriately by Patient #11 yesterday. During the interview Patient #8 became tearful and upset.

Patient #11

Review of Patient #11's medical record on 1/29-30/19 revealed the Patient had a history of schizophrenia, paranoid typed (A serious mental disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and

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extremely disordered thinking and behavior that impairs daily functioning, and can be disabling). Additional review revealed the Patient had a history of asking individuals about performing oral sex on himself/herself.

Review of "Treatment Plan Review", dated 1/24/19, revealed Patient #11 "Problem #2: Dangerous Behaviors...Patient remains dangerous." Specifically, the treatment plan stated the Patient engages in repeated assaultive behaviors and has made attempts to hit and bite others without any provocation.

Review of a "Nursing Care Plan", dated 12/3/18, revealed "Risk for other directed violence AEB [as evidenced by] hx [history] of assaultive bxs [behaviors] delusional though process." The "interventions" listed included "2/1 [degree] COSS [Close Observation Status Scale- level of observation and monitoring due to potential harm to that patient or others] protocol for safety ...Long Term Goal ...[Patient #11] will not engage in any unsafe behaviors (biting, hitting, etc.) for a period of 3 weeks."

Review of the medical record revealed Patient #11's had a "COSS Order", dated 12/3/18, for "2nd Milieu [one to one (1:1) level of staffing while outside of his/her room] / 1st Bed Area [level of monitoring that requires staff to observe the patient every 15 minutes while in his/her room] ...Secure Area Observational Level Danger to Others Unpredictable Behavior."

Review of Incident:

A camera review was conducted on 1/29/19 at 11:30 am, of the Taku unit for 1/27/19 from 5:56 pm to 6:23 pm. The observation consisted of

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RR550	Continued From page 14 Patient #8, Patient #11 and Psychiatric Nurse Assistant (PNA) #1, who was assigned as the Patient #11's 1:1 staff (one staff member assigned to one patient due to the patient's high risk for assaultive and/or sexualized behavior). During the 27 minute length of video, Patient #11 was left unattended by PNA #1 multiple times. Specifically, PNA #1 would go into various other rooms completely out of sight of Patient #11 and when present had his/her back to Patient #11. As a result, Patient #11 was observed to walk into the TV room and grabbed Patient #8's genital area. During this act, PNA #1 has his/her back to Patient #11. After the incident occured, Patient #8 was returned to the TV room without any intervention and left with Patient #11 outside in the hall still being unattended by his/her 1:1 staff. During the camera review on 1/29/19 at 11:30 am, Nursing Unit Manager #1, Nursing Unit Manager #2 and Non-Abusive Psychological and Physical Intervention (NAPPI - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructor #1 were present during the review. During an inteview on 1/29/18 at 11:30 am, Nursing Unit Manager #1 stated PNA #1 should not have left Patient #11 to go down the hall, into the kitchen, or into the Nurse's Station. He/she further stated that PNA #1 should not have positioned himself/herself by the Nurse's Desk counter when Patient #11 moved into the Dining Room, the PNA should have moved into the Dining Room with the Patient. During the camera review 1/29/19 at 11:30 am, the Non-Abusive Psychological and Physical Intervention (NAPPI - behavior assessment,	RR550		

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de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructor #1 stated a 1:1 staff should be in the same room as the Patient they are assigned to. He/she further stated PNA #1 should not have left Patient #11's sight at any time.

During an interview at 1/29/19 at 11:40 am, Nursing Unit Manager #2 stated Patient #11 was very dangerous with violent tendencies and requires a 1:1 supervision. Nursing Unit Manager #2 further stated the 1:1 staff was to be close to the Patient at all times. The Nursing Unit Manger stated PNA #1 was not conducting the appropriate 1:1 supervision by leaving the Patient alone multiple times.

During an interview on 1/29/19 at 12:54 pm, the Chief Nursing Officer (CNO) and the Assistant Director of Nursing (ADON) stated they became aware of the 1/27/19 incident, between Patient #11 and Patient #8, when State Surveyors brought it to their attention on 1/29/19. In addition, the CNO stated the facility had not implemented any safety measures to prevent further victimization.

The ADON further stated that Patient #11 had a near miss incident on 1/28/19 where his/her 1:1 staff prevented the Patient from inappropriately touching Patient #8 again.

During an interview on 1/29/19 at 1:15 pm, PNA #2 stated Patient #11 was admitted on 1:1 due to disorganized thinking, assaultive behavior, and trying to touch both staff and patients almost as soon as he/she entered the unit. PNA #2 identified Patient #11 as a threat to anyone near him/her and needed prevention intervention at all

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times. The 1:1 staff was supposed to provide this prevention by being between the Patient and everyone else at all times. PNA #2 also stated he/she has had to prompt 1:1 staff to remain close enough to intervene, should it be needed, multiple times.

During an interview on 1/30/19 at 9:35 am, the Chief of Psychiatry stated that Patient #8 did not receive any trauma informed care after the event that occurred on 1/27/19 and further stated the facility could have done better at provided follow up to the victims of such events. When asked about PNA #1's actions that led up to the sexual touching by Patient #11, the Chief of Psychiatry stated "The event was obvious negligence of [PNA #1]."

Review of the facility provided policy "Conduct Involving Patients," dated 10/13/17, revealed neglecting or endangering a patients is the failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any patient when that failure presents either imminent danger to the health, safety or welfare of a patient. The policy provided the following example "failure to provide adequate supervision to patients...or not providing the ordered supervision level of a patient.

Review of the facility provided policy "Response to Assaults," dated 6/1/15, revealed assaults are defined to include sexual acts toward others that cause emotional, mental or physical harm/injury. The policy stated patients are informed that API sexual and presumptively criminal behavior directed toward other patients is not tolerated. The policy further stated the NSS must immediately arrange for the continued monitoring and safety of the alleged assailant, victim, and

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milieu. When a patient to patient assault occurs the staff were to comfort and attend to any immediate physical and emotional needs of the victim who will be asked if he/she would like to have his/her support systems notified. Specifically, in the event of a sexual assault, staff must interact with the victim in a supportive way.

During an interview on 1/30/19 at 9:44 am, Psychiatrist #1 stated Patient #8 was anxious about talking to the police about the event. Psychiatrist #1 further stated Patient #8 stated he/she was upset and didn't understand why someone he/she doesn't know should not have touched him/her inappropriately. In addition, the Psychiatrist stated that Patient #11 was unpredictable and has had past occurrences where he/she attempted to reach out and touch others. Specifically, the Psychiatrist stated Patient #11 attempted to again touch Patient #8 the day after the event that occurred on 1/27/19. When asked about Patient #8's abuse history, Psychiatrist #1 stated Patient #8 had "profound sexual abuse since childhood."

Review of the "Alaska Psychiatric Institute (API) - Unusual Occurrence Report (UOR)", dated 1/27/19 at 6:30 pm, revealed a sexual encounter occurred between Patient #8 (victim) and Patient #11 (perpetrator). The UOR did not indicate Patient #17 as a witness. The UOR further revealed no injury assessment or treatment type was conducted or identified. Review of the Immediate Supervisor/Nursing Shift Supervisor (NSS) Review, dated 1/27/19 at 7:25 pm, revealed Nursing Unit Manger #1 stated that Patient #8 did not want to press charges, no other patients were on the unit at the time of the event, no witnesses of the event and no staff were located in the TV room. The document had no

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indications that administration was notified of the event or what interventions were put in place to protect Patient #8 and/or other patients residing on the unit.

Review of the facility provided policy "Sentinel and Unanticipated Adverse Events," dated 10/8/13, revealed types of events to be considered sentinel events under this policy included event/occurrences that meet "Sexual Contact/Abuse/Assault occurs when there is sexual contact involving a patient and another patient ...while a patient is treated by, or on the premises of, API ...Sexual contact includes ...fondling of a patient's sex organ(s) by another individual's hand ..." The policy further stated all staff shall immediately report possible sentinel event to the NNS and a UOR will be completed. The NSS will first take any immediate actions necessary to prevent further harm to patients and then immediately notify the Medical Director, Chief Executive Officer, Chief Nursing Officer, Hospital Administrator, Clinical Director, Risk Manager, Safety Officer, Quality Improvement Coordinator or their designees.

Review of the facility provided policy "Conduct Involving Patients," dated 10/13/17, revealed "Patients at API have the right to treatment in a setting that provides physical safety, emotional support, and freedom from abuse or inappropriate treatment ...Every API employee is responsible for monitoring the quality of care provided throughout the facility and for reporting any suspected or actual misconduct that involves patients." The policy identifies sexual abuse as any touching of a patient for a sexual purpose or in a sexual manner.

Additional review of the "Conduct Involving

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RR550	Continued From page 19 Patients" policy revealed neglecting or endangering a patients is the failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any patient when that failure presents either imminent danger to the health, safety or welfare of a patient. The policy provided the following example "failure to provide adequate supervision to patients...or not providing the ordered supervision level of a patient." .	RR550		
RR575	7 AAC 12.920 Applicable Laws and Regulations Applicable federal, state, and local laws and regulations - A facility must comply with all applicable federal, state, and local laws and regulations. If a conflict or inconsistency exists between codes or standards, the more restrictive provision applies. This Rule is not met as evidenced by: . Based on record review and interview the facility failed to comply with the parameters of a Court-Ordered Administration of Medication order for 1 patient (#2), out of 2 patients reviewed for	RR575		

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court-ordered medication orders. Specifically, the Health Practitioner (#1) exceeded the maximum daily dose of Lorazepam (Ativan - A benzodiazepine medication used to treat seizures and anxiety, and in this case the psychological diagnosis of catatonia) that was granted by the judge. This failed practice violated state laws and statutes. Providing treatment without the court-ordered, informed consent (after review and acceptance of the potential side effects and/or adverse reactions associated with the recommended doses of Lorazepam) placed the patient at risk for potential medication-induced complications. Findings:

Record review on 1/28-30/19 revealed that Patient #2 was admitted to the facility under an Ex Parte order (a court order for temporary custody for emergency psychiatric examination/treatment for up to 72 hours from the time the Ex Parte order is signed) due to grave disability (when a person's mental disorder prevents him/her from providing for his/her own basic life-sustaining needs, such as food, clothing, and shelter) and with a diagnosis of catatonic schizophrenia (a serious neurological and psychological condition in which two kinds of behaviors are typically displayed: stupor and motor rigidity or excitement. When people experience rigidity or stupor, they are unable to speak, respond or even move at times).

Review of Patient #2's medical record revealed a "LIP Psychiatric Progress Note," dated 1/7/19, which documented the need of medically-necessary, intramuscular (IM), administration of Lorazepam due to 1) the Patient received 10 milligrams (mg) of Lorazepam daily during a two-week stay at a hospital, prior to this facility's admission, to treat the catatonia being

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exhibited and 2) to prevent withdrawal symptoms that could potentially be life threatening, called acute withdrawal syndrome, due to the levels of Lorazepam the Patient regularly received prior to this admission and the Patient's refusal to accept the medication by mouth.

The note further documents a petition for a 30-day commitment, as well as, a request for involuntary medication administration was submitted to the courts on 1/7/19 for approval.

Review of a "LIP Psychiatric Progress Note," dated 1/17/19, revealed that the court case was heard on this day and the 30-day commitment, as well as, the petition for involuntary medication was granted.

Review of the "FINDINGS AND ORDER CONCERNING COURT-ORDERED ADMINISTRATION OF MEDICATION" court order, verbally granted on 1/17/19 and signed 1/28/19, revealed "API [Alaska Psychiatric Institute] seeks to administer daily the following medication in the stated range of dosage for the medication: Lorazepam (Ativan), daily total maximum dosage of 10mg, administered at least once per day, PO [by mouth] or IM (but not both in the same day)."

Review of Patient #2's "Medication Orders" log, dated 1/4-29/19, revealed that on 1/17/19, the day of the court-ordered approval, the LIP ordered Lorazepam 3mg by mouth, or IM if refuses, four times a day, for a total daily dose of 12mg a day.

Review of the "eMAR [electronic medication administration record] Administration Report," dated 1/18-28/19, revealed Patient #2 received a

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RR575	Continued From page 22 12mg total daily dose of Lorazepam on 11 separate days. Further review of the "Medication Orders" log, dated 1/4-29/19, revealed the LIP increased the Lorazepam dose on 1/29/19 to 4mg by mouth, or IM if refuses, four times a day, for a total daily dose of 16mg a day. Review of the "eMAR Administration Record" revealed Patient #2 received 15mg of Lorazepam on 1/29/19 as the dosage was changed after the morning 3mg dose of Lorazepam was given. This order remained active and this 16mg total daily dosage was administered throughout the rest of the survey. During an interview on 1/30/19 at 11:10 am, the Director of Psychiatry stated when a doctor petitions the court for involuntary medication administration, the doctor will ask for a dosage range. He/she stated if the doctor needs to deviate from that range they must first repetition the court for approval. During an interview on 1/30/19 at 11:40 am, Health Practitioner #1 stated he/she did request a daily dose of 10mg for Lorazepam and felt this was the total dose that he/she would need at the time to treat Patient #2's catatonia. He/she further stated that a higher dosage range should have been requested. He/she stated the current treatment for catatonia stated a dosage as high as 30mg a day could be used and this dosage range could potentially be needed to treat Patient #2's catatonia. During an interview on 1/30/19 at 11:58 am, the Alaska Psychiatric Institute legal representative stated the LIP should have requested a higher	RR575		

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RR575	Continued From page 23 dosage range in court before going over the 10mg range, or should have asked the court for the 30mg range during the first court appearance. During an interview on 2/4/19 at 12:00 pm, the Court Appointed Visitor for Patient #2 stated the LIP would provide the proposed recommended medications and doses to those medications in court during the hearing for approval of involuntary psychotropic medication administration. The Court Appointed Visitor also stated the LIP would need to repetition the court if the LIP wanted to change the medication or the dosage of medication outside of what was originally approved in court. Review of the facility's policy "Psychotropic Medications and Informed Consent," dated 6/1/2016, revealed: "INVOLUNTARY/COURT ORDERED-MEDICATIONS ..."(B) A court may determine that a patient lacks the capacity to give informed consent to the medication and may approve involuntary administration under [Alaska Statute] 47.30.839 (Court-ordered administration of medication.) ...(D) Emergency intramuscular medications or intramuscular back-up medications (IMBUs) may be ordered by the court subsequent to a petition by an LIP, provided the LIP is acting within the parameters of the court order." Review of Alaska Statute 47.30.839, last modified 11/15/2016, revealed: "(g) If the court determines that the patient is not competent to provide informed consent and, by clear and convincing evidence, was not competent to provide informed consent at the time of previously expressed wishes documented under (d)(2) of this section, the court shall approve the facility's proposed use of psychotropic medication."	RR575		

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