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A 000	INITIAL COMMENTS . An Federal complaint survey (AK3614) was conducted at Alaska Psychiatric Institute (API) in conjunction with a State licensure revisit survey from 4/8-11/19. The survey found API was not in substantial compliance with Center for Medicare and Medicaid Services (CMS) requirements for hospitals. During Federal complaint survey, API was found to not in substantial compliance with CMS requirements for hospitals as evidence by an immediate jeopardy under CFR 482.13: Patient Rights. The sample included 10 patients. The following deficiencies were noted during an Federal complaint survey. 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	A 000		
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: . Based on record review, observations and interviews the facility failed to ensure the hospital	A 115		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/10/2019

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A 115	Continued From page 1 met the Condition of Participation for Patient Rights. The hospital failed to ensure patients' rights were protected and promoted. Due to the severity of deficient practices at CFR 482.13, an immediate jeopardy was called under CFR 482.13 Patient Rights. Findings: A-144: The facility failed to ensure a patient (#6) on one to one (1:1) supervision was supervised according to facility 1:1 supervision policy and failed to follow procedures for monitoring the safety of units that housed patients on 1:1 supervision. This failed practice placed all patients (based on a census of 21) at risk for exposure to an unsafe environment. A-167: The facility failed to ensure the safe application of mechanical restraints during 3 out of 3 restraint episodes reviewed for 1 patient (#3). Specifically, the facility failed to: 1) Recognize improper fitting of restraints and 2) Identify the risk of improper restraint application and implement interventions for safety. This failed practice placed the patient in immediate jeopardy for serious harm and/or death while restrained. Findings: The immediate jeopardy was brought to the attention of the facility's administration on April 10, 2019 at 4:40 pm, at which time the facility was notified of the deficient practice and high risk to patients. The immediacy was removed by the facility on April 10, 2019 at 5:55 pm by ensuring Patient #3 would not be placed in mechanical restraints until an appropriate size was determined and obtained. In addition, he facility stated they would use brief manual restraints	A 115		

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A 115	Continued From page 2 (BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely), as an alternative form of restraint for Patient #3. A-202: The facility failed to ensure restraint training included how to: 1) recognize improper fitting of restraints and 2) identify the risk of improper restraint application and implement interventions for safety for 1 patient (#3), during 3 out of 3 episodes reviewed. This failed placed the patient at risk for injury when self-harm behavior, by head banging, was not responded to by staff to ensure the patient's safety and well-being.	A 115		
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, camera review and interview the facility failed to ensure a patient (#6) on one to one (1:1) supervision was supervised according to facility 1:1 supervision policy and failed to follow procedures for monitoring the safety of units that housed patients on 1:1 supervision. This failed practice placed all patients (based on a census of 21) at risk for exposure to an unsafe environment. Findings: Record review from 4/8-10/19 revealed Patient #6 was admitted with a history of self-care deficits, harming behaviors to self and others, delusions,	A 144		

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sexualized behaviors and aggressive behaviors. Further review revealed documented occurrences of unsafe behaviors while on the unit.

Record review of Patient #6's medical record revealed a "Type: DAR COSS/Degree Assmt. of Risk" note made by RN #9 on 4/5/19 at 6:27 pm. The entry revealed "[Patient] was attempting to masturbate and urinate while in day room this [morning]. [Patient's] [male/female] peer was [complaining of] ...feeling traumatized by [Patient's] inappropriate sexual [behavior].

During an interview on 4/9/18 Unit Manager (UM) #2 identified the peer referenced in the 4/5/19 note as Patient #8.

During an interview on 4/10/19 at 9:00 am Patient #8 stated he/she was present during the 4/5/19 event with Patient #6. The Patient stated he/she was exposed to Patient #6's nudity and sexualized behaviors. When asked how the event made him/her feel, Patient #8 stated he/she was bothered by the event because he/she shouldn't have to be exposed to Patient #6's sexualized behaviors.

Record review of Patient #6's medical record revealed an urgent COSS (Close Observation Status Scale - level of observation and monitoring due to potential harm to that patient or others) order, dated 4/5/19 at 9:50 am, for the patient to be on 2nd degree (see definition below) while in the milieu. Further review revealed justification for order was documented at danger to self, danger to other and unpredictable behavior.

Review of the facility provided document "Close Observation Status Scale (COSS) Guidelines,"

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revision date 6/1/18, revealed the COSS level 2nd degree indicated "1:1 must maintain continuous visual focus & be in the same room at all times ...must retain primary attention on assigned patient."

During a camera review on 4/9/18 at 9:51 am, the initiation of 1:1 status and coverage was observed for Patient #6 on 4/5/19 from 9:51 am to 11:14 am. The following was observed:

- 9:51 am: As Patient #6 was in the fish bowl (a small room with windows across and to the left of the Psychiatric Nurses Assistant (PNA) desk). PNA #3 can be heard talking to the staff about the initiation of the 1:1 status for Patient #6. PNA #11 verbally assumed responsibility for the 1:1 at that time.

- 9:52 am: PNA #11 was observed to position himself/herself with his/her back leaned against the outer wall and window of the fish bowl. PNA #11 was not able to see Patient #6 as his/her back was to the Patient.

- 10:07 am: PNA #11 was observed to look back over his/her shoulder to view Patient #6 quickly, then resume looking outward with his/her back to the Patient.

- 10:17 am: PNA #11 moved to stand beside the PNA desk (a central counter/desk within the unit that is manned by a PNA at all times), turned to face the fish bowl, with the ability to view Patient #6 one minute later.

- 10:19:25 am: PNA # 11 left the PNA desk and entered the nurse's station (an office next to the PNA desk. This office door is closed and the

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view into the fish bowl is obstructed). Patient #6 remained in the fish bowl at this time.

- 10:21:56 am: PNA #11 was observed to enter the area behind the PNA desk (access to this area is from a separate door in the nurse's station).

- 10:22:16 am: PNA #11 re-entered back into the nurse's station.

- 10:22:26 am: PNA #11 resumed his/her position beside the PNA desk.

- 10:22:56 am: PNA #11 left the nurses station and went into the unit kitchen (a closed-door room with no windows).

- 10:23:59 am: PNA #11 resumed his/her position beside the PNA desk.

- 10:24:10 am: PNA #11 left the PNA desk and walked down a hallway (away from the fish bowl and Patient #6).

- 10:25:28 am: PNA #11 resumed his/her position beside the PNA desk.

- 10:25:34 am: PNA #11 left the PNA desk and moved down a hallway to the general storage room area (away from the fish bowl and Patient #6).

- 10:26:20 am: PNA #11 resumed his/her position beside the PNA desk.

- 10:31:02 am: PNA #11 left the PNA desk and entered the nurse's station.

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- 10:31:50 am: PNA #11 left the nurse's station and resumed position at the PNA desk.

- 10:32:34 am: PNA #11 left the PNA desk and walked down a hallway to open another patient's room.

- 10:33:00 am: PNA #11 resumed his/her position at the PNA desk.

- 10:33:34 am: PNA #11 left the PNA desk and entered the nurse's station.

- 10:41:41 am: PNA #11 exited the nurse's station and resumed his/her position at the PNA desk.

- 10:46:35 am: PNA #11 left the PNA desk and re-entered the nurse's station.

- 10:50:27 am: PNA #11 entered the PNA desk area from the nurse's station.

- 10:50:40 am: PNA #11 re-entered the nurse's station, then exited the nurse's station with the unit locator (a clipboard where all patient's locations are documented in timed intervals) and began walking the unit to locate patients.

- 10:54:12 am: PNA #12 took over the 1:1 for Patient #6 and positioned himself/herself beside the PNA desk facing the fish bowl where Patient #6 remained.

- 11:08:20 am: PNA #12 entered the dining room area to retrieve Patient #6's dinner tray, took it to the Patient in the fish bowl and resumed his/her position beside the PNA desk.

- 11:08:52 am: PNA #12 left the PNA desk and

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entered the kitchen.

- 11:09:53 am: PNA #12 resumed his/her position beside the PNA desk.

- 11:14:10 am: PNA #12 remained at the PNA desk to observe Patient #6 in the fish bowl.

Review of the facility provided training roster entitled "1:1 [Patient] Contact Training," dated 4/8/19, revealed PNA #11 and PNA #12 received training on 1/30/19.

During an interview on 4/9/19 at 10:15 am, NAPPI (NAPPI - Non-Abusive Psychological and Physical Intervention - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructor #1 and Director of Nursing (DON) both stated PNA #11 should not have left Patient #6 while he/she was the Patient's 1:1 staff for any reason unless the PNA verbally asked another PNA to take over for him/her. During the camera review, both NAPPI Instructor #1 and the DON stated they never observed or heard PNA #11 verbally asked another PNA to watch Patient #6 during the times he/she left the area.

During an interview on 4/9/19 at 10:20 am, DON stated that all PNAs and nurses recently received training on appropriate 1:1 coverage and observation. He/she stated PNA #11's behavior while on 1:1 was not appropriate and increased the risk for Patient #6 to expose other patients to sexually inappropriate behavior.

During an interview on 4/10/19 at 11:52 am, NAPPI Instructor #1 stated a PNA on a 1:1 should never have his/her back to the 1:1 patient. Going

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into another room away from the 1:1 patient and not being able to see that patient is not proper 1:1 protocol

Facility Based 1:1 Monitoring Process - WEKA Contracted Service

During an interview on 4/10/19 at 11:06 am WEKA (contracted security service) Staff #1 stated the two WEKA contracted staff were posted in a room with monitors to watch live video feed of the units. WEKA Staff #1 further stated the WEKA contracted staff were tasked with monitoring 1:1 patients to ensure adequate supervision was being conducted. When asked what is the process to ensure the WEKA contracted staff are made aware of patients that required 1:1 supervision, WEKA Staff #1 stated that nursing previously sent up a list of patients on 1:1 status; however that stopped for an unknown reason. WEKA Staff #1 further explained that the WEKA contracted staff rotate out of the live video observation duties with other WEKA contracted staff that were assisting on the nursing units every two hours. As a result, when the first rotation occurs (after the first two hours of a shift) the oncoming WEKA contracted staff would be aware of the 1:1 supervisor patients because they were on the floor for the first two hours of the rotation as opposed to the WEKA contracted staff who were on live video observation duty without any confirmation of patients on 1:1 supervision.

During an interview on 4/10/19 at 1:35 pm, WEKA Staff #2 was asked by Surveyors how he/she knew if a patient was on a 1:1 while performing camera reviews. He/she stated "we see staff following someone around, see them following a

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patient." He/she further stated that nurses previously printed off a 1:1 sheet and gave it to WEKA staff but they don't do that anymore.

During an interview on 4/10/19 at 4:32 pm DQRM stated he/she was unaware that WEKA contracted staff conducting the live video observations did not regularly receive notification of which patients were on 1:1 supervision.

During an interview on 4/11/19 at 8:34 am WEKA Staff #3 stated the purpose of WEKA staff observing the live video feed was to monitor for imminent issues of concern and safety. When asked about the process of reporting sexualized behavior, WEKA Staff #3 stated that a patient walking around naked does not need immediate action but masturbating in public area would require intervention. When asked about the process of knowing and monitoring patients on 1:1 supervisor, WEKA Staff #3 stated the WEKA staff were to monitor patients on 1:1 supervision via the live video observation, however the WEKA staff used to receive a list of patients on 1:1 supervision but no longer received that information from the facility. WEKA Staff #3 further stated that it could be up to two hours, at staff rotation, before the WEKA staff monitoring the live video feed would have been made aware of patients on 1:1 supervision.

During an interview on 4/11/19 at 9:30 am, Unit Manager #1 stated there is no 1:1 sheet or information provided to WEKA staff to inform them of who is on 1:1 status.

Review of the facility provided policy "PC-060-14 Close Observation Status Scale (COSS)," effective date 3/21/19, revealed 2nd degree

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A 144	Continued From page 10 COSS is described as "1:1 continuous, strict visual monitoring by assigned staff ...the assigned staff must be in the same room as the patient ...staff may talk to other patients but must retain primary attention on the assigned 1:1 patient.	A 144		
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: . Based on record review, camera review, interview, and policy review the facility failed to ensure the safe application of mechanical restraints during 3 out of 3 restraint episodes reviewed for 1 patient (#3). Specifically, the facility failed to: 1) Recognize improper fitting of restraints and 2) Identify the risk of improper restraint application and implement interventions for safety. This failed practice placed the patient in immediate jeopardy for serious harm and/or death while restrained. Findings: The immediate jeopardy was brought to the attention of the facility's administration on April 10, 2019 at 4:40 pm, at which time the facility was notified of the deficient practice and high risk to patients. The immediacy was removed by the facility on April 10, 2019 at 5:55 pm by ensuring Patient #3 would not be placed in mechanical	A 167		

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restraints until an appropriate size was determined and obtained. In addition, he facility stated they would use brief manual restraints (BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely), as an alternative form of restraint for Patient #3.

Record review on 4/8-11/19 revealed Patient #3 was admitted to the facility with a diagnosis of catatonic schizophrenia (A specific type of schizophrenia that is characterized by delusions, hallucinations and disruptions in a person's movement, called stupor - long periods where the person moves very little and does not respond to instructions, conversations, or the environment around them).

Review of the facility's "[Alaska Psychiatric Institute] Seclusions, Restraints Manual Holds" log, dated 2/1/19 - 4/8/19, revealed Patient #3 had required 53 BMR, from 2/2/19 to 3/13/19, to administer court ordered medication by injection to treat the catatonic schizophrenia. A mechanical restraint (when a patient is physically secured to a restraint bed [an immovable rectangular box-shaped block that is coated with a durable rubber material] within a secured room using mechanical wrist, ankle, and/or chest restraints [a wide durable strap that is positioned across the patient's chest, with the ends of the strap going under the arms, and those ends secured to the bed. If not properly applied, a patient could sit up while in wrist/ankle restraints, it could also place the patient at risk for strangulation] that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely) was required on 3/13/19 due

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to unsafe behavior. An additional 3 mechanical restraints were required between 3/20-21/19 due to unsafe behavior.

Restraint Review
Episode #1

Review of Patient #3's medical record revealed a 5-point restraint (2 wrist restraints, 2 ankle restraints, and one chest restraint are applied to the patient's body while lying on the restraint bed) occurred 3/20/19 at 11:35 pm.

Camera review on 4/10/19 at 2:38 pm, of the 3/20/19 restraint episode revealed that at 12:32 pm, while in 5-point restraints, Patient #3 was able to sit straight up and throw his/her body back forcefully against the restraint bed, and in the same motion, hit his/her head against the bed. It was observed that Patient #3 hit his/her head in this manner 15 times in a row. Registered Nurse (RN) #1 was present and witnessed this self-harm behavior, however no interventions were initiated to stop the behavior. Further observation revealed the 5th point restraint (the chest strap) was resting low on the Patient's abdomen.

During an interview on 4/10/19 at 3:20 pm, the Director of Nursing (DON) stated staff should prevent restrained patients from hitting their head against the restraint bed.

Review of the "Violent/Self Destructive Restraint/Seclusion Audit Tool," (An audit tool nursing shift supervisors used to audit the event from start to finish to ensure all interventions were applied and appropriate: used for quality improvement and educational purposes) of the

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3/20/19 restraint episode revealed the auditor documented "Restraints were properly applied per hospital policy and verified by RN." This was not consistent with the camera review completed by the Surveyor and DON.

Episode #2

Review of Patient #3's medical record revealed a 5-point restraint occurred on 3/21/19 at 7:38 am.

Camera review on 4/9/19 at 10:37 am, of the 3/21/19 restraint episode revealed that 2 minutes after restraints were applied, and staff moved away, Patient #3 was able to sit up and threw himself/herself back against the bed, hitting his/her head 6 times in a row. Staff immediately initiated physical control of Patient #3's body and attempted to reposition the 5th point restraint, however stopped and moved away when Patient #3 started spitting at them. Once the staff moved away, Patient #3 sat up and repeated the head banging behavior 18 times in a row. Further observation revealed the 5th point restraint was observed to be resting low on Patient #3's abdomen.

Further camera review revealed Assistant Director of Nursing (ADON), Nursing Shift Supervisor (NSS) #1, RN #2, RN #1, Psychiatric Nurse Assistant (PNA) #1, and PNA #2 all observed Patient #3's head banging behavior and did not attempt to re-initiate physical control or use other interventions to stop the self-harm behavior.

During an interview on 4/9/19 at 11:05 am, the NAPPI (NAPPI - Non-Abusive Psychological and Physical Intervention - behavior assessment,

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de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructor #1 and DON both stated head banging in restraints should not be allowed and Patient #3 was at imminent risk for a head or neck injury from the head banging during this restraint. They stated interventions to keep the Patient safe should have been attempted.

Continued camera review of the 3/21/19 restraint episode revealed that at 7:51 am, Patient #3 sat up and threw himself/herself back and banged his/her head against the restraint bed 13 more times in a row. At 7:52 am, Patient #3 repeated the self-harm behavior 4 times in a row. The ADON, NSS #1, and Unit Manager #1 all witnessed the head banging behavior and did not attempt to initiate interventions to stop the self-harm behavior.

During an interview on 4/9/19 at 11:15 am, the ADON stated the 5th point restraint could have been repositioned for better control of Patient #3's movements to prevent the self-harm behavior, however this was not done because the Patient doesn't like to be touch and would have re-escalated him/her.

Additional camera review revealed a release from restraints was attempted at 8:11 am, however Patient #3 immediately began assaulting staff. Staff gained physical control of Patient #3 and placed him/her in 4-point restraints (2 wrist restraint and 2 ankle restraints are applied to the patient's body while lying on the restraint bed). Once staff moved away, Patient #3 sat up and threw himself/herself back, banging his/her head against the restraint bed 3 times in a row. Staff immediately initiated physical control of Patient

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#3's body and applied the 5th point restraint across his/her chest and adjusted the strap to fit across his/her chest more securely. The 5th point restraint became loose after time however and at 8:42 am, Patient #3 sat up and threw himself/herself back, banging his/her head against the restraint bed 3 times in a row again. This was witnessed by PNA #3 and reported the head banging to Psychiatrist #1.

Review of the "Violent/Self Destructive Restraint/Seclusion Audit Tool," of the 3/21/19 restraint episode revealed the auditor documented "Restraints were properly applied per hospital policy and verified by RN." This was not consistent with the camera review completed by the Surveyor and DON.

Episode #3

Review of Patient #3's medical record revealed a 4-point restraint occurred on 3/21/19 at 9:06 pm.

Camera review on 4/11/19 at 11:48 am, of the 3/21/19 restraint episode revealed Patient #3 sat up and threw himself/herself back against the bed, hitting his/her head a total of 7 times throughout the restraint. Further review revealed RN #3, RN #4, and PNA #4 witnessed this head banging behavior and did not attempt to initiate interventions to stop the self-harm behavior.

Review of the "Violent/Self Destructive Restraint/Seclusion Audit Tool," of the 3/21/19 restraint episode revealed the auditor documented "Restraints were properly applied per hospital policy and verified by RN." This was not consistent with the camera review completed by the surveyor and DON.

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During an interview on 4/10/19 at 2:18 pm, NSS #1 stated the chest strap for Patient #3 was too big for his/her body size and he/she was able to get out of restraints at times. When asked about methods to correct poorly fitted restraints on Patient #3, he/she stated it would be best to hold the patient down to prevent injury but then staff would get hurt. NSS #1 further stated the Patient's "out of control" behaviors were a possible result from withdraw symptoms from a decrease of Ativan.

During an interview on 4/10/19 at 2:38 pm, when asked about interventions to correct poorly fitted restraints for Patient #3, the ADON stated touching the patient is a psychological trigger and the staff should not touch him/her to correct the poorly fitted restraints.

During an interview on 4/10/19 at 3:20 pm, when asked about Patient #3 recurrent use of mechanical restraints and the concern with poorly fitting chest restraints, Unit Manager #2 stated staff should have held him/her for safety because the mechanical restraints did not fit Patient #3 appropriately. Unit Manager #2 stated that the increase in Patient #3's behaviors was contributed to the previous rapid taper of the medication Ativan. In addition, Unit Manager #2 stated the Patient was currently undergoing a second taper attempt at a slower rate because he/she is sensitive to aggressive tapering of Ativan.

Review of "LIP [Licensed Independent Practitioner] Psychiatric Progress Note," dated 3/14/19, revealed Patient #3 had undergone a medication taper (decreasing a medication's

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dosage incrementally to eventually discontinue the medication) of Lorazepam (Ativan - a benzodiazepine and antianxiety medication) which was a court ordered medication (a medication ordered in a court of law due to the Patient's inability to make sound decisions on his/her behalf) from 2/11/19 to 3/12/19.

Further review of the 3/14/19 "LIP Psychiatric Progress Note" revealed that on the evening of 3/13/19, Patient #3 was taken to the emergency room for "bizarre and erratic behavior, as well as, elevated vital signs including temperature. Patient was diagnosed with a suspected delirium possibly due to benzodiazepine discontinuation syndrome [withdrawal syndrome which is typically characterized by sleep disturbance, irritability, increased tension and anxiety, panic attacks, hand tremors, and sweating which can manifest 1-4 days after stopping the medication]."

Review of the "ED [Emergency Department] Provider Note," dated 3/13/19, revealed Patient #3's behavior was "likely related to overly aggressive benzodiazepine tapering." The Provider's recommendation was that the "tapering from these medications be done more slowly."

On 3/14/19, the LIP at the facility restarted Patient #3 on Lorazepam.

Review of a "LIP Psychiatric Progress Note," dated 3/18/19, revealed that Patient #3's behavior on 3/13/19 was documented by the nurses as "running up and down the hallway, tongue protruding, began rolling around on floor and progressed to ramming body forcefully into wall and banging [his/her] head. While in the Oak room [the secured room used for restraints], the

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A 167	Continued From page 18 patient continued to bang [his/her] head on bed while restrained and would sit [himself/herself] up and forcefully slam head back down on bed." Review of "LIP Psychiatric Progress Note--Draft," dated 4/8/19, revealed a medication taper of Lorazepam was reinitiated again on 4/5/19. Review of Patient #3's "Treatment Plan Review," dated 3/25/19, revealed the treatment team did not document review of the 3 restraints between 3/20-21/19. There was documentation that indicated the Patient was "improving with increased Ativan dose." Review of Patient #3's "Nursing Care Plan Form," last revised 4/6/19, revealed no documentation of the medication taper that started 4/5/19. The previous revision to the nursing care plan, dated 3/23/19, did not address the 3 restraints between 3/20-21/19. During an interview on 4/10/19 at 3:03 pm, RN #2 stated that Patient #3 had no changes to behavior plan or care plan after previous repeat mechanical restraint use. When asked about risk of loosely fitted mechanical chest restraints, RN #2 stated there is a risk for choking. When asked what interventions could be done for a patient whose mechanical chest restraint became loose and the patient was able to sit up, RN #2 stated staff should hold the shoulders of the patient for refitting of restraint or general safety of the patient. During an interview on 4/10/19 at 3:03 pm RN #11 stated that Patient #3 had no changes to behavior plan or care plan after previous repeat mechanical restraint use. When asked about risk	A 167		

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of loosely fitted mechanical chest restraints, RN #11 stated loose restraints are unsafe and create the risk of blocking the patient's airway.

During an interview on 4/11/19 at 10:19 am, the DON stated the facility trains all RNs and PNAs annually to ensure they are competent to care for the patients admitted. Part of this training included restraint application and techniques.

Review of the "Nursing Skills Fair Check Off - PNA" (the check off list used during annual training) revealed a section entitled "Seclusion & Restraint" and included training in:

- "Knows location of supplies & circumstances of use;"
- "Demonstrates proper set up/attachment of restraints to bed;" and
- "Demonstrates proper placement of restraints on person/mannequin"

During an interview on 4/11/19 at 10:30 am, Nursing Skills Fair Instructor #1 stated the training included practicing restraint placement on a bed and applying the restraints to a mannequin under his/her observation. He/she stated the main purpose of the 5th point restraint was to prevent a patient from sitting up and bucking back onto the bed. For the 5th point restraint training, he/she went over the correct application of the 5th point (under one arm, over the chest, and under the other arm) and that the 5th point should rest above the breast line area, leaving a hand space under it so as to not constrict breathing.

Additional interview revealed Nursing Skills Fair Instructor #1 stated the training did not cover the

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A 167	Continued From page 20 re-adjustment of the 5th point strap if not applied correctly or if dislodged from its appropriate placement. He/she further stated there is a risk for injury if a patient is able to sit up and buck back onto the bed. During an interview on 4/11/19 at 10:41 am, Nursing Skills Fair Instructor #2 stated he/she taught the staff to get the RN immediately if restraints are not working or misplaced at any time. Both Nursing Skill Fair Instructors stated if the restraint situation is unsafe, staff need to address it despite the risk of re-traumatizing a patient by touching them. Review of the facility's policy "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE)," dated 10/27/17, revealed: "Those who apply the restraint, receive the training, and demonstrate the safe use of restraint ...and the application and removal of mechanical restraints." Further review revealed: "Those authorized to provide monitoring or 15-minute assessments are competent and demonstrate competence in ...signs of incorrect application of restraints ...and recognizing the need to contact medical personnel for further evaluation." Additional review revealed: "RN Responsibilities ...personally ensure and document that restraints are applied properly." .	A 167		
A 202	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(2)(iv)	A 202		

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A 202	Continued From page 21 [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia). This STANDARD is not met as evidenced by: . Based on record review, camera review, interview, and policy review the facility failed to ensure restraint training included how to: 1) recognize improper fitting of restraints and 2) identify the risk of improper restraint application and implement interventions for safety for 1 patient (#3), during 3 out of 3 episodes reviewed. This failed placed the patient at risk for injury when self-harm behavior, by head banging, was not responded to by staff to ensure the patient's safety and well-being. Findings: Record review on 4/8-11/19 revealed Patient #3 was admitted to the facility with a diagnosis of catatonic schizophrenia (A specific type of schizophrenia that is characterized by delusions, hallucinations and disruptions in a person's movement, called stupor - long periods where the person moves very little and does not respond to instructions, conversations, or the environment around them). Review of the facility's "[Alaska Psychiatric Institute] Seclusions, Restraints Manual Holds" log, dated 2/1/19 - 4/8/19, revealed Patient #3	A 202		

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had required 53 brief manual restraints (BMR - a method where one or more staff physically hold a patient to immobilize or reduce the ability of a patient to move his/her arms, legs, body, or head freely), from 2/2/19 to 3/13/19, to administer court ordered medication by injection to treat the catatonic schizophrenia. A mechanical restraint (when a patient is physically secured to a restraint bed [an immovable rectangular box-shaped block that is coated with a durable rubber material] within a secured room using mechanical wrist, ankle, and/or chest restraints that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely) was required on 3/13/19 due to unsafe behavior. An additional 3 mechanical restraints were required between 3/20-21/19 due to unsafe behavior.

Restraint Review
Episode #1

Review of Patient #3's medical record revealed a 5-point restraint 2 wrist restraints, 2 ankle restraints, and one chest restraint [a wide durable strap that is positioned across the patient's chest, with the ends of the strap going under the arms, and those ends secured to the bed. When properly applied the chest strap prevents a patient from sitting up to freely move the upper torso of the body] are applied to the patient's body while lying on the restraint bed) occurred 3/20/19 at 11:35 pm.

Camera review on 4/10/19 at 2:38 pm, of the 3/20/19 restraint episode revealed that at 12:32 pm, while is 5-point restraints, Patient #3 was able to sit straight up and throw his/her body back forcefully against the restraint bed, and in the same motion, hit his/her head against the bed. It

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was observed that Patient #3 hit his/her head in this manner 15 times in a row. Registered Nurse (RN) #1 was present and witnessed this self-harm behavior, however no interventions were initiated to stop the behavior. Further observation revealed the 5th point restraint (the chest strap) was resting low on the Patient's abdomen.

During an interview on 4/10/19 at 3:20 pm, the Director of Nursing (DON) stated staff should prevent restrained patients from hitting their head against the restraint bed.

Review of the "Violent/Self Destructive Restraint/Seclusion Audit Tool," (An audit tool nursing shift supervisors used to audit the event from start to finish to ensure all interventions were applied and appropriate: used for quality improvement and educational purposes) of the 3/20/19 restraint episode revealed the auditor documented "Restraints were properly applied per hospital policy and verified by RN." This was not consistent with the camera review completed by the Surveyor and DON.

Episode #2

Review of Patient #3's medical record revealed a 5-point restraint occurred on 3/21/19 at 7:38 am.

Camera review on 4/9/19 at 10:37 am, of the 3/21/19 restraint episode revealed that 2 minutes after restraints were applied, and staff moved away, Patient #3 was able to sit up and threw himself/herself back against the bed, hitting his/her head 6 times in a row. Staff immediately initiated physical control of Patient #3's body and attempted to reposition the 5th point restraint,

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however stopped and moved away when Patient #3 started spitting at them. Once the staff moved away, Patient #3 sat up and repeated the head banging behavior 18 times in a row. Further observation revealed the 5th point restraint was observed to be resting low on Patient #3's abdomen.

Further camera review revealed Assistant Director of Nursing (ADON), Nursing Shift Supervisor (NSS) #1, RN #2, RN #1, Psychiatric Nurse Assistant (PNA) #1, and PNA #2 all observed Patient #3's head banging behavior and did not attempt to re-initiate physical control or use other interventions to stop the self-harm behavior.

During an interview on 4/9/19 at 11:05 am, the NAPPI (NAPPI - Non-Abusive Psychological and Physical Intervention - behavior assessment, de-escalation, and defusing skills for humane and effective response to violent and/or unsafe patient behavior) Instructor #1 and DON both stated head banging in restraints should not be allowed and Patient #3 was at imminent risk for a head or neck injury from the head banging during this restraint. They stated interventions to keep the Patient safe should have been attempted.

Continued camera review of the 3/21/19 restraint episode revealed that at 7:51 am, Patient #3 sat up and threw himself/herself back and banged his/her head against the restraint bed 13 more times in a row. At 7:52 am, Patient #3 repeated the self-harm behavior 4 times in a row. The ADON, NSS #1, and Unit Manager #1 all witnessed the head banging behavior and did not attempt to initiate interventions to stop the self-harm behavior.

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A 202	Continued From page 25 During an interview on 4/9/19 at 11:15 am, the ADON stated the 5th point restraint could have been repositioned for better control of Patient #3's movements to prevent the self-harm behavior, however this was not done because the Patient doesn't like to be touch and would have re-escalated him/her. Additional camera review revealed a release from restraints was attempted at 8:11 am, however Patient #3 immediately began assaulting staff. Staff gained physical control of Patient #3 and placed him/her in 4-point restraints (2 wrist restraint and 2 ankle restraints are applied to the patient's body while lying on the restraint bed). Once staff moved away, Patient #3 sat up and threw himself/herself back, banging his/her head against the restraint bed 3 times in a row. Staff immediately initiated physical control of Patient #3's body and applied the 5th point restraint across his/her chest and adjusted the strap to fit across his/her chest more securely. The 5th point restraint became loose after time however and at 8:42 am, Patient #3 sat up and threw himself/herself back, banging his/her head against the restraint bed 3 times in a row again. This was witnessed by PNA #3 and reported the head banging to Psychiatrist #1. Review of the "Violent/Self Destructive Restraint/Seclusion Audit Tool," of the 3/21/19 restraint episode revealed the auditor documented "Restraints were properly applied per hospital policy and verified by RN." This was not consistent with the camera review completed by the Surveyor and DON. Episode #3	A 202		

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A 202	Continued From page 26 Review of Patient #3's medical record revealed a 4-point restraint occurred on 3/21/19 at 9:06 pm. Camera review on 4/11/19 at 11:48 am, of the 3/21/19 restraint episode revealed Patient #3 sat up and threw himself/herself back against the bed, hitting his/her head a total of 7 times throughout the restraint. Further review revealed RN #3, RN #4, and PNA #4 witnessed this head banging behavior and did not attempt to initiate interventions to stop the self-harm behavior. Review of the "Violent/Self Destructive Restraint/Seclusion Audit Tool," of the 3/21/19 restraint episode revealed the auditor documented "Restraints were properly applied per hospital policy and verified by RN." This was not consistent with the camera review completed by the Surveyor and DON. During an interview on 4/10/19 at 2:18 pm, NSS #1 stated the chest strap for Patient #3 was too big for his/her body size and he/she was able to get out of restraints at times. When asked about methods to correct poorly fitted restraints on Patient #3, he/she stated it would be best to hold the patient down to prevent injury but then staff would get hurt. During an interview on 4/10/19 at 2:38 pm, when asked about interventions to correct poorly fitted restraints for Patient #3, the ADON stated touching the patient is a psychological trigger and the staff should not touch him/her to correct the poorly fitted restraints. During an interview on 4/10/19 at 3:20 pm, when asked about Patient #3 recurrent use of	A 202		

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mechanical restraints and the concern with poorly fitting chest restraints, Unit Manager #2 stated staff should have held him/her for safety because the mechanical restraints did not fit Patient #3 appropriately.

During an interview on 4/10/19 at 4:36 pm, PNA #5 stated the hospital had 2 sizes of restraints, small and large.

During an interview on 4/11/19 at 10:19 am, the DON stated the facility trains RNs and PNAs annually to ensure they are competent to care for the patients admitted. Part of this training included restraint application and techniques.

Review of the "Nursing Skills Fair Check Off - PNA" (the check off list used during annual training) revealed a section entitled "Seclusion & Restraint" and included training in:

- "Knows location of supplies & circumstances of use;"
- "Demonstrates proper set up/attachment of restraints to bed;" and
- "Demonstrates proper placement of restraints on person/mannequin"

During an interview on 4/11/19 at 10:30 am, Nursing Skills Fair Instructor #1 stated the training included practicing restraint placement on a bed and applying the restraints to a mannequin under his/her observation. He/she stated the main purpose of the 5th point restraint was to prevent a patient from sitting up and bucking back onto the bed. For the 5th point restraint training, he/she went over the correct application of the 5th point (under one arm, over the chest, and under the other arm) and that the 5th point

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should rest above the breast line area, leaving a hand space under it so as to not constrict breathing.

Additional interview revealed Nursing Skills Fair Instructor #1 stated the training did not cover the re-adjustment of the 5th point strap if not applied correctly or if dislodged from its appropriate placement. He/she further stated there is a risk for injury if a patient is able to sit up and buck back onto the bed.

During an interview on 4/11/19 at 10:41 am, Nursing Skills Fair Instructor #2 stated he/she taught the staff to get the RN immediately if restraints are not working or misplaced at any time.

Both Nursing Skill Fair Instructors stated if the restraint situation is unsafe, staff need to address it despite the risk of re-traumatizing a patient by touching them.

Review of the facility's policy "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSE)," dated 10/27/17, revealed: "Those who apply the restraint, receive the training, and demonstrate the safe use of restraint ...and the application and removal of mechanical restraints."

Further review revealed: "Those authorized to provide monitoring or 15-minute assessments are competent and demonstrate competence in ...signs of incorrect application of restraints ...and recognizing the need to contact medical personnel for further evaluation."

Additional review revealed: "RN Responsibilities ...personally ensure and document that restraints

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A 202	Continued From page 29 are applied properly." .	A 202		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: . Based on record review and interview the facility failed to identify and analyze causes of an adverse patient event involving sexualized behavior and provide feedback and learning to improve facility performance. This failed practice placed 10 patients located on the Katmai unit (based on a current census of 11) at risk for	A 286		

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exposure to an unsafe environment. Findings:

Record review from 4/8-10/19 revealed Patient #6 was admitted with a history of self-care deficits, harming behaviors to self and others, delusions, sexualized behaviors and aggressive behaviors. Further review revealed documented occurrences of unsafe behaviors while on the unit.

During a camera review observation on 4/9/18 from 10:00 am to 10:21 am, the following inappropriate sexual behavior was observed that occurred on 4/5/19 from 8:15 am to 9:02 pm:

- Patient #6 entered the TV Room of the Katmai unit and began masturbating while sitting on the couch. Psychiatric Nursing Assistant (PNA) #3, PNA #7, and PNA #8 entered the TV Room and redirected Patient #6 to go to his/her room.

- Patient #6 came out of his room 15 minutes later with his/her pants around ankles, holding his/her genitals. It was observed on camera that PNA #9 only verbally redirected the Patient to pull his/her pants up.

- Patient #6 continued to walk the hall of the unit to the TV room still exposed. PNA #8 could be heard on the camera review to verbally redirect Patient #6 to pull his/her pants up, but did not follow patient into the TV Room to redirect behavior.

- Patient #5 was in the TV Room at the time Patient #6 entered, and was seated on the right side of a 3 seat length couch. Patient #6 walked over, in front of Patient #5 and sat on the left side of the couch. His/Her pants were still around his/her ankles and he/she began to masturbate.

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PNA #10 was observed standing outside the TV Room window facing the Patient but did not redirect him/her.

- Patient #6 pulled up his/her pants about a minute later. New clothes were offered to Patient #6 by PNA #3 Patient #6 went to the bathroom, changed clothes, and then returned to the TV room.

During an interview on 4/9/19 at 10:21 am, Director of Nursing (DON) stated that if it was documented other patients were upset by Patient #6's behavior, it should be written in an Unusual Occurrence Report (UOR) and investigated. After viewing the event on camera, the DON stated a UOR should have been done for this event.

Review of the facility's " ...Unit Nursing Communication Report," dated 4/8/19 revealed the patient was prompt to stop masturbating in the TV room on 4/5/19. In addition the report stated "Other [patients] were very upset by [Patient #6's] disruptive [behavior] and nudity and inappropriate sexual [behavior] in milieu."

Record review of Patient #6's medical record revealed a "Type: DAR COSS/Degree Assmt. of Risk" note made by Registered Nurse (RN) #9 on 4/5/19 at 6:27 pm. The entry revealed "[Patient] was attempting to masturbate and urinate while in day room this [morning]. [Patient's] female peer was [complaining of] ...feeling traumatized by [Patient's] inappropriate sexual [behavior]."

During an interview on 4/9/18 Unit Manager (UM) #2 identified the female peer referenced in the 4/5/19 note as Patient #8.

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A 286	Continued From page 32 During an interview on 4/10/19 at 9:00 am Patient #8 stated he/she was present during the 4/5/19 event with Patient #6. The Patient stated he/she was exposed to Patient #6's nudity and sexualized behaviors. When asked how the event made him/her feel, Patient #8 stated he/she was bothered by the event because he/she shouldn't have to be exposed to Patient #6's sexualized behaviors. Review of the facility provided document entitled "Nursing Shift Report," dated for the 24 hour period of 4/5/19 at 8:00 am to 4/6/19 at 7:59 am revealed no documentation of the 4/5/19 sexual behavior incident with Patient #6 was reviewed, reported via the nursing shift report or a UOR was completed. During an interview on 4/9/19 at 10:32 am the Director of Quality/Risk Manager confirmed that no UOR had been completed for the sexualized behavior conducted by Patient #6 on 4/5/19. During an interview on 4/9/19 at 11:45 am UM #2 stated he/she had spoken with Patient #8 about the 4/5/19 incident. UM #2 stated the event was traumatizing for Patient #8. During an interview on 4/9/19 at 1:31 Wellpath Senior Vice President of Hospitals stated that the team was unaware of the sexual event with Patient #6. During an interview on 4/11/19 at 11:01 am the Acting Chief Executive Officer stated more work needed to be done related to the UOR process. Review of the facility's policy " ...Unusual	A 286		

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A 286	Continued From page 33 Occurrence Reporting," effective date 3/21/19 revealed "Occurrences to be reported include, but not limited to: ...Sexual behavior ..." Further review revealed "The [Risk Manager]/designee will complete the UOR process and seek clarification for discrepancies identified in final review ...The [Risk Manager]/designee will determine if an investigation is required and will take appropriate actions to initiate ...[Director of Nursing] or designee will conduct a validation of the UORs for timeliness, proper completion and report/notification ...Deficiencies identified during the incident and UOR reviews will be addressed daily, during the Morning Briefing meeting with API leadership, in order to ensure the identified outstanding UORs and any required notifications to a State Agency are completed without delay ...The [Risk Manager]/designee will report closed UORs and investigations to API Senior Management."	A 286		
A 309	. QAPI EXECUTIVE RESPONSIBILITIES CFR(s): 482.21(e)(1), (e)(2), (e)(5) The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address	A 309		

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A 309	Continued From page 34 priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: . Based on record review and interview the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) program addressed priorities for improved quality of care and patient safety and develop improvement actions to be evaluated. This failed practice reduced the likelihood of sustained improved hospital practices which placed all patients (based on a census of 21) at risk for receiving care and services in a less than optimal healthcare setting. Findings: The Survey Agency noted multiple systematic failures and/or repeat noncompliance in the areas of patient rights through observations, interviews, and record review from 4/8-11/19. A review of the QAPI program was requested, specifically to QAPI's identification, analysis and evaluation of noncompliance in the areas listen above. During an interview on 4/11/19 at 12:37 pm Wellpath Director of Performance Improvement and Risk Management (PIRM) stated collected data had started to be reviewed, however the QAPI program was being rearranged. The PIRM further stated a review of compliance from previously identified deficiencies should have been conducted sooner.	A 309		

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A 309	Continued From page 35 Documentation related to the QAPI's identification, analysis and evaluation of noncompliance was requested on 4/11/19. No documentation was provided. During an interview on 4/11/19 at 12:37 pm Wellpath Compliance Consultant (CC) #1 stated the collection and analyzation of compliance data had not completed and the QAPI program was just getting started. As a result, no documentation or evaluation of action items were available for review. The CC #1 further stated he/she began to collect compliance data last week. In addition, the CC #1 stated noncompliance with systematic failures should have been recognized earlier by the facility if QAPI functions were in place at an earlier time.	A 309		
A 396	. NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: . Based on record review and interview, the facility failed to develop accurate and up-to-date nursing care plans for 5 patients (#1, 4, 7, 9, & 10), out of 8 sampled patients. This failed practice placed residents at risk for not receiving the necessary and/or appropriate care and services. Findings: Patient #1	A 396		

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Record review on 4/8-11/19 revealed Patient # 1 was admitted to the facility with diagnoses that included Intellectual Developmental Disorder (below average intelligence and set of life skills present before age 18).

Review of Patient #1's "History and Physical," dated 3/28/19, revealed an "Active Problem List" that included hypertension (high blood pressure), and vitamin D deficiency. Further review revealed the "Impression/Plan" section which documented: "Hypertension, NOS [not otherwise specified], Patient to continue Inderal 10mg 3 times a day. Vitamin D Deficiency. Vitamin D3 1000 unites daily ordered."

Review of Patient #1's "Nursing Care Plan Form," dated 3/28/19, revealed a nursing diagnosis of "Knowledge Deficit related to appropriate behaviors in the community." Further review revealed no nursing diagnosis or interventions for hypertension or vitamin D deficiency.

During an interview on 4/10/19 at 7:25 am, RN #8 stated care plans may be done in the electronic health record (EMR), in the "Weekly RN Assess. & TX [treatment] Plan Review," as well as the paper nursing care plan in the chart. He/she stated that the update dates should be the same on both. RN #8 stated the most current nursing care plan for Patient #1 was in the EMR, dated 4/4/19.

Review of Patient #1's "Weekly RN Assess. & TX [treatment] Plan Review," dated 4/4/19, revealed a review of the care plan for the current nursing diagnosis. Further review revealed no nursing diagnosis or interventions for hypertension or

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A 396	Continued From page 37 vitamin D deficiency. Patient #4 Record review on 4/8-11/19 revealed Patient #4 was admitted to the facility with diagnoses that included unspecified dementia with behavioral disturbances (a decline in intellectual functioning, including problems with memory, reasoning and thinking with aggressive/violent behavior) and paranoid schizophrenia (a chronic mental illness; individuals with paranoid schizophrenia hold untrue beliefs (delusions) or hear things others don't hear (auditory hallucinations). Review of Patient #4's "LIP [Licensed Independent Practitioner] Progress Note," dated 2/6/19, revealed an "Active Problem List" that included COPD (Chronic Obstructive Pulmonary Disease - a chronic lung disorder resulting in blocked air flow in the lungs) and chronic foot pain due to a history of a transmetatarsal right foot amputation (removing the front part of the foot, to include the toes and all knuckle joints of the toes). Further review revealed a "Treatment/Intervention Plan" that included Albuterol (Ventolin Hfa) (aerosol medication used to help open airways when constricted) 2 puffs every 4 hours as needed for shortness of breath or wheezing and Ibuprofen 400mg every 6 hours as needed for pain. Review of an "MOS [Medical Officer Specialist] Progress Note," dated 3/8/19, revealed Patient #4 was started on Gabapentin (a nerve pain medication) 100mg 3 times a day for chronic foot pain that is not relieved by current as needed pain medication.	A 396		

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Review of Patient #4's "Nursing Care Plan Form," dated 4/6/19, revealed a nursing diagnosis of "altered health maintenance: chronic foot pain, COPD, tobacco use. [history] [right] foot amputation, [history] alcohol use disorder, severe." Review of the goals and interventions for the diagnosis revealed the Albuterol and Gabapentin were not documented as interventions.

During an interview on 4/10/19 at 7:10 am, RN #7 stated nursing care plans are updated by typing new information on the "Nursing Care Plan Form," print it off, and place in the paper chart. RN #7 stated the most current nursing care plan for Patient #4 was dated 4/6/19.

Patient #7

Record review on 4/8-11/19 revealed Patient #7 was admitted to the facility with diagnoses that included intermittent explosive disorder (behavior disorder characterized by explosive outbursts of anger and violence, often to the point of rage, that are disproportionate to the situation at hand).

Review of Patient #7's "History and Physical," dated 3/27/19, revealed a "Surgical History" of a splenectomy (removal of the spleen with an order placed "If [patient] complains of fever or illness of any sort contact MOS [medical office specialist] by phone."

Review of Patient #7's "Nursing Care Plan Form," dated 4/7/19, revealed no documentation of asplenia (absence of normal spleen function: removal of Patient's spleen) or the doctor's order for contact if patient complains of being ill was in the nursing care plan.

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During an interview on 4/10/19 at 7:25 am, RN #8 stated the most current nursing care plan for Patient #7 was 4/7/19.

Patient #9

Record review on 4/8-11/19 revealed Patient #9 was admitted to the facility with diagnosis of psychotic disorder (a mental illness that causes abnormal thinking and perceptions. Psychotic illnesses alter a person's ability to think clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately).

Review of Patient #9's "History and Physical," dated 9/19/18, revealed no active medical problems at the time of admission.

Review of Patient #9's medical record revealed multiple medical issues identified and treated since admission:

- Patient was seen by the medical provider on 2/1/19 for occasional right foot pain during gym activity. Ibuprofen 800mg by mouth every 8 hours as needed for pain was encouraged. Further review Patient #9 used Ibuprofen 14 times from 2/1-21/19.

- Patient was seen by the medical provider on 2/6/19 for mild facial acne. Benzoyl Peroxide 10% topical face wash twice a day was ordered. Further review revealed Patient #9 used Benzoyl Peroxide 33 times and refused 68 times from 2/6/19 to 4/10/19.

- Patient was seen by the medical provider on

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2/25/19 for intermittent stomach upset. The medical provider suspected the cause was lactose intolerance or possibly an underlying GERD issue. Patient #9's diet was changed to low lactose diet with lactase (a pill taken before eating to help aid in the digestion of dairy products) 9,000 units by mouth three times a day with meals and ordered Pantoprazole 40mg by mouth every bedtime for 14 days. Further review revealed Patient #9 complied with Lactase taken at meals, he/she only refused Lactase 19 times since 2/26/19. He/she complied with the Pantoprazole.

- Patient was seen by the medical provider on 3/12/19 for a sore throat associated with a runny nose. The medical provider changed a nasal spray from as needed medication to a scheduled medication, Deep Sea Nasal Spray 2 sprays each nostril every bedtime. Further review revealed Patient #9 used the nasal spray 11 times and refused 19 times from 3/12/19 to 4/10/19.

- Patient was seen by the medical provider on 4/1/19 for continued intermittent stomach upset. The medical provider ordered lab test and encouraged continued Gelusil (Maalox) use as needed. Further review revealed Patient #9 used Gelusil twice since 4/1/19.

- Patient was seen by the medical provider on 4/9/19 for left ear pain times 2 days. The medical provider diagnosed left otitis media (a middle ear infection) and ordered Amoxicillin (an antibiotic) 500mg by mouth twice daily for 7 days and Ibuprofen 400mg every 8 hours as needed for pain. Further review revealed Patient #9 complied with Amoxicillin for the 7 day course. He/she did not use the Ibuprofen.

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A 396	Continued From page 41 Review of Patient #9's "Nursing Care Plan Form," revealed this nursing care plan has not been updated since 1/22/19. During an interview on 4/10/19 at 7:25 am, RN #8 stated the most current nursing care plan for Patient #9 was in the EMR, dated 4/9/19. Review of Patient #9's "Weekly RN Assess. & TX [treatment] Plan Review," dated 4/9/19, revealed a review of the nursing care plan's current nursing diagnosis of "Disturbed Thought Process [as evidenced by] Inaccurate interpretation of [his/her] environment, auditory hallucinations, laughing to [himself/herself]. Further review revealed no nursing diagnoses or interventions were added to the care plan for any of the medical issues identifies and treated since admission. Patient #10 Record review on 4/8-11/19 revealed Patient #10 was admitted to the facility with diagnosis of unspecified schizophrenia (a severe mental disorder characterized by delusions [false beliefs], hallucinations [perception of sights, sounds, etc. that are not actually present], incoherence and physical agitation). Review of Patient #10's "History and Physical," dated 2/7/19, revealed no active medical problems at the time of admission. Review of Patient #10's medical record revealed additional psychiatric interventions and multiple medical issues identified and treated since admission:	A 396		

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A 396	Continued From page 42 - Patient #10 required crisis medication (a situation requiring immediate use of psychotropic medication to preserve the life of, or prevent significant physical harm to, the patient or another patient, as determined by a licensed physician or RN. The order is valid for 24 hours and may be renewed for a total of 72 hours, including the initial 24 hours, only after an in-person assessment is completed to determine if crisis remains) on 2/10/19 due to agitation, aggression, and homicidal threats. Medication administered: Haldol (an antipsychotic medication) 5mg intramuscular (IM - given by shot) every 4 hours as needed may give for acute affective arousal (behavior characterized by anxiety, frustration, anger, tension, and agitation); Lorazepam (an antianxiety medication) 2mg IM every 4 hours as needed for agitation; and Benadryl 50mg IM every 4 hours as needed for extrapyramidal side effects (EPS - drug-induced movement disorders that affect a person's ability to move extremities, facial muscles, and/or torso. Can become permanent issues if not treated promptly). Further review Patient #10 received this crisis medication on 2/10/19; 2/16/19; 2/18/19; and 2/20/19 and received Lorazepam 2mg IM, Benadryl 50mg IM, and Chlorpromazine (Thorazine: An antipsychotic medication) 50mg IM crisis medication on 3/18/19. - Patient was seen by the medical provider on 2/19/19 for lower back pain. Tylenol 650mg by mouth as needed for pain was ordered. Further review revealed Ibuprofen 400mg by mouth was ordered for breakthrough pain that Tylenol doesn't cover. Patient #10 received Tylenol 10 times from 2/18-26/19 and Ibuprofen 8 times from 2/19/19 to 3/22/19.	A 396		

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- Patient was seen by the medical provider on 3/11/19 for indigestion. Gelusil (Maalox) chewable tablet (an antacid chewable tablet with Simethicone, an anti-gas medication) by mouth every 4 hours was ordered as needed. Patient #10 received Gelusil (Maalonx) 8 times from 3/19/19 to 4/6/19.

- Patient was seen by the medical provider on 3/20/19 for ongoing indigestion. Suspected diagnosis was GERD (Gastric Reflux Disease - a digestive disease in which the stomach acid or bile irritates the esaphogus, or food pipe, lining) and a trial of pantoprazole medication was ordered for 21 days.

- Patient was seen by the medical provider on 3/26/19 for a headache. Tylenol 650 mg by mouth as needed for pain was ordered. Patient #10 received Tylenol for a headache 3 times from 3/3-19/19 and Ibuprofen 400mg by mouth on 3/25/19.

Review of Patient #10's "Nursing Care Plan Form," dated 3/4/19, revealed no documentation of the crisis medication used. Additional review revealed no nursing diagnosis, goals, or interventions for lower back pain, indigestion, or headaches.

During an interview on 4/10/19 at 7:25 am, RN #8 stated the most current nursing care plan for Patient #10 was in the EMR, dated 4/4/19.

Review of Patient #10's "Weekly RN Assess. & TX [treatment] Plan Review," dated 4/4/19, revealed no documentation of the crisis medication used. Additional review revealed no

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nursing diagnosis, goals, or interventions for lower back pain, indigestion, or headaches.

During an interview on 4/9/19 at 9:10 am, Unit Manager #1 stated nurse managers are supposed to audit nursing care plans weekly and turn in results to the DON.

During an interview on 4/10/19 at 10:10 am, the Wellpath Divisional Director of Nursing stated that the facility's care plans have been an ongoing issue and staff were having difficulty developing and maintaining care plans. He/she further stated that the facility's care plan policy didn't provide adequate guidance on how nurses should handle care plans. In addition, Wellpath Divisional Director of Nursing stated the new care plan policy was approved on 3/14/19 but he/she just recently received notification of its approval. When asked where the care plans should be located, Wellpath Divisional Director of Nursing stated staff were trained to use the paper form of care plans in the paper charts. When informed that nursing staff had been observed to use paper form care plans and electronic based care plans, Wellpath Divisional Director of Nursing stated a reevaluation of the care planning process training needed to be conducted.

During an interview on 4/10/19 at 10:19 am, the DON stated the current care plans should only be found in the paper chart because the facility was still developing an electronic form of the care plans.

Review of the facility's policy "Nursing Care, Planning," dated 3/14/19, revealed: "The nursing care plan must be consistent with the medical plan of care ...The plan for nursing care shall

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A 396	Continued From page 45 include nursing interventions and goals that support, prescribed medical care and/or restore, maintain or promote the patient's well-being ...Goals for nursing care shall be consistent with the therapy prescribed by the responsible medical practitioner." Further review revealed: "Nursing interventions include, but are not limited to: Nursing treatments, including health promotion, education, and counseling. Physician-prescribed treatments. Medication administration and assessment of medication adverse effects and side effects." .	A 396		