CORE ISSUES

Facility	License #	Physical Address	Phone Number
Montana State Hospital	12943	300 Garnet Way	406-693-7000
Administrator	City	Zip Code	Survey Date
	WARM SPRINGS	59756	09/08/2022
Survey Team Leader	Survey Type		Response Due
Wooten, Tara	Renewal Inspection		09/18/2022

Item #	Rule ()	Description
1	53-21-142-2 Rights of person admitted to facility	Facility inspection on June 14, 2022, June 15, 2022, and September 08, 2022. FINDINGS: The facility inspection of the SPRATT unit noted that all the patient room doors are locked from the outside. The doors are hinged to automatically close after being opened unless propped open. The rooms are only accessible by key, which the staff possess. Patients therefore must find and wait for staff to allow them into their personal rooms to access their personal belongings, lay down, or use the bathroom. During the inspection on September 8, 2022, a female patient was noted walking up and down the halls indicating she needed to use the bathroom and was needing a staff member to let her into her room to access a toilet. Another patient was seen sitting outside a room door in her wheelchair, resting her head in her hands, and appeared to be waiting on staff to allow her into the room.
2	37.106.302-2 MINIMUM STANDARDS OF CONSTRUCTION FOR A	Facility inspection on June 14, 2022, June 15, 2022, and September 08, 2022, staff interviews.

		FINDINGS: (1) The Facility inspection revealed that the call system throughout the facility is faulty. Per staff report: • In several rooms, the call system is not functional • Staff place patients in beds without ensuring that the system is operational • Several patients are unable to use the call system due to the location of the system on the wall. There are numerous patient rooms in which there is an "X" marked on the wall next to the call system. Staff indicate that these are the areas where a new call system is going to be installed and that a contractor marked the walls for identification. Several of these "X"-marked call systems were tested and were not functional. Call systems marked with an "X" specifically noted on the SPRATT unit: • S2 – Both call systems on the right side of the room • S3 – Both call systems on the right side of the room • S4 – Both call systems on the left side of the room • S5 – Both call systems on the left side of the room • S6 – Both call systems on the right side of the room • S10 – Both call systems on the right side of the room • S11 – First bed call system on the right side of the room • S12 – Both call systems on the left side of the room • S13 – First bed call system on the left side of the room • S14 – First bed call system on the right side of the room • S16 – Both call systems on the left side of the room AIA Guidelines chapter 4.1-8.3.7.4 (2) "The emergency call

		system shall be designed so that a call activated by a resident will initiate a signal distinct from the resident room call device and that can be turned off only at the resident's location." • In both the main facility, and on the SPRATT Unit, when the call system is activated by a patient, the call is answered by a phone within the nurse's station which they can talk to the patient over a speaker. When the phone is hung up, the call system turns off. Staff report they do not typically go to the patient rooms to check on the patient after they use the call system. (2) The emergency exit doors on all units on the main campus and on the SPRATT unit are not operational without a key.
3	37.106.320-3 MINIMUM STANDARDS FOR ALL HEALTH CARE FA	Facility Inspection June 14, 2022, June 15, 2022, and September 08, 2022. FINDINGS: Inspection of the main facility revealed: • The ligature free shower faucets that were installed in the handwashing sinks in the medical consultation rooms throughout the facility spray water across the room. • The pipes under the handwashing sink in medical exam room B154 were leaking. • The air exchange vents in all patient bathrooms throughout the facility had a buildup of dust and grime. • The hand washing sink located in the staffing area in Delta was not operational. Staff reported they have submitted several work orders for the repair and have not had a response from maintenance and management. • The electrical supply pipes located outside of the observation/seclusion rooms were not equipped with ligature free screws on all units.

		Inspection of the SPRATT unit revealed: • The sprinkler heads in the TV Room and cafeteria were not installed correctly. The cork board prevented the sprinkler head from being operational. • The smoke detector in the west courtyard hallway was partially detached from the ceiling. • The smoke detector in room S-14 had an orange foam sprayed in the vents preventing it from being operational. • Room S-8 the mounting screws holding the toilet to the floor were loose. • The air exchange vents in all patient bathrooms throughout the facility had a buildup of dust and grime. Inspection of the Learning Center revealed that: • The light fixture in the north women's bathroom was equipped with a non GFI electrical outlet located directly above the handwashing sink.
4	37.106.320-5 MINIMUM STANDARDS FOR ALL HEALTH CARE FA	Facility Inspection June 14, 2022, June 15, 2022, and September 08, 2022: Inspection of the facility revealed that: • The sheetrock was damaged on the wall by the sink room in room C134 in the main facility • Several of the ceiling tiles are damaged on the SPRATT Unit • Several of the ceiling tiles in the weight room of the Learning Center were damaged posing a fire hazard.
5	37.106.320-6 MINIMUM STANDARDS FOR ALL HEALTH CARE FA	Inspection of the SPRATT Unit June 14, 2022, June 15, 2022, and September 08, 2022. The facility had a pungent urine odor throughout the halls and in numerous rooms.
6	37.106.401-1 MINIMUM STANDARDS FOR A HOSPITAL: GENERA	§ 482.13 Condition of participation: Patient's rights. A hospital must protect and promote each patient's rights.

		Standard: Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff. (1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion - (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. (2) Training content. 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: (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. (ii) The use of nonphysical intervention skills. (iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition. (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); (v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary. (vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited

		to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. (3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors. (4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed. THE INTENT OF THIS RULE HAS NOT BEEN MET AS EVIDENCED BY: The surveyors review of 20 personnel records on 06/14/2022 – 06/15/2022 and 08/16/2022-08/24/2022 FINDINGS: Staff #2, #6, #7, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's personnel training records did not contain written documentation that staff successfully completed competency-based training pertaining to the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion. Staff #2, #12, #13, #17 and #20's personnel training records did not contain written documentation the staff had current and valid certification in the use of first aid techniques and cardiopulmonary resuscitation.

		_____ _____ §482.23(b)(4) - The hospital must ensure that the nursing staff develops and keeps current a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan. THE INTENT OF THE RULE IS NOT MET AS EVIDENCED BY: Review of patient files, interview with staff June 14, 2022, June 15, 2022, and September 08, 2022. The hospital did not have documentation of nursing care plans developed or kept current by the nursing staff that reflects the patients' goals and the nursing care that is provided to meet the patient's needs in 20 out of 20 files reviewed. _____ _____ § 482.42 Condition of participation: Infection prevention and control and antibiotic stewardship programs. The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the

		development and transmission of HAIs and antibiotic-resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program. Standard: Leadership responsibilities. (1) The governing body must ensure all of the following: (i) Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities. (ii) All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with hospital QAPI leadership. (2) The infection preventionist(s)/infection control professional(s) is responsible for: (i) The development and implementation of hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines. (ii) All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities. (iii) Communication and collaboration with the hospital's QAPI program on infection prevention and control issues. (iv) Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of infection prevention and control guidelines, policies, and procedures. (v) The prevention and control of HAIs, including auditing of adherence to infection prevention and control policies and

		procedures by hospital personnel. (vi) Communication and collaboration with the antibiotic stewardship program. THE INENT OF THIS RULE HAS NOT BEEN MET AS EVIDENCED BY: The surveyors review of 20 personnel records on 06/14/2022 – 06/15/2022 and 08/16/2022-08/24/2022 FINDINGS: (1) 20 out of 20 personnel training records do not contain written documentation that the staff successfully completed competency-based training pertaining to the practical applications of infection prevention and control guidelines, policies, and procedures. (2) Surveyors observed soiled laundry containers in the patient hallways in main facility and SPRATT unit. The containers are not impervious to moisture. Staff report containers are emptied but not removed from hallways or cleaned throughout the day. _____ § 482.61 Condition of participation: Special medical record requirements for psychiatric hospitals. The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. Standard: Treatment plan.

		(1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities. The written plan must include - (i) A substantiated diagnosis; (ii) Short-term and long-range goals; (iii) The specific treatment modalities utilized; (iv) The responsibilities of each member of the treatment team; and (v) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out. (2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included. THE INTENT OF THE RULE HAS NOT BEEN MET AS EVIDENCED BY: The surveyor's review of 20 current patient records on 06/14/2022 – 06/15/2022 and 08/16/2022-08/24/2022 FINDINGS: Patient's #1, #2, #3, #4, #5, #6, #8, #9, #10, #12, #13, #14, #15 and #17 treatment plans did not have written documentation of the active treatment received by the patient. Each treatment plan required patients to attend 1-15 groups per week but did not include a specific written intervention on what group each patient should attend and how it relates to the treatment plan. The treatment plan updates did not include written documentation of patient progress, an evaluation of goals/interventions, and modifications made to

		the treatment plan as a result. _____ § 482.61 Condition of participation: Special medical record requirements for psychiatric hospitals. The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. (d) Standard: Recording progress. Progress notes for the patient must be documented, in accordance with applicable State scope-of-practice laws and hospital policies, by the following qualified practitioners: Doctor(s) of medicine or osteopathy, or other licensed practitioner(s), who is responsible for the care of the patient; nurse(s) and social worker(s) (or social service staff) involved in the care of the patient; and, when appropriate, others significantly involved in the patient's active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan. THE INTENT OF THE RULE HAS NOT BEEN MET AS EVIDENCED BY: The surveyor’s review of 20 current patient records on 06/14/2022 – 06/15/2022 and 08/16/2022-08/24/2022

		FINDINGS: On September 14, 2022, the department requested written progress notes pertaining to group participation and active treatment. Fourteen patient records were received and reviewed and did not contain written documentation why the patient was selected for the group, what the purpose of the group was, and the progress the patient made as a result of the group. The group progress notes only documented if the patient attended the group or not. _____ § 482.61 Condition of participation: Special medical record requirements for psychiatric hospitals. The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. (e) Standard: Discharge planning and discharge summary. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge. THE INTENT OF THE RULE HAS NOT BEEN MET AS EVIDENCED BY: The surveyor’s review of 10 discharged patient records on 06/14/2022 – 06/15/2022 and 08/16/2022-08/24/2022

		FINDINGS: (1) Patient's #21, #23 and #29 written discharge summaries did not contain written documentation of the following required information: - A recapitulation of the patient's hospitalization and active treatment received - Recommendations from appropriate services concerning follow-up or aftercare - A brief summary of the patient's condition on discharge. _____ 482.62 Condition of participation: Special staff requirements for psychiatric hospitals. The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning. (g) Standard: Therapeutic activities. The hospital must provide a therapeutic activities program. (1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. (2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program. THE INTENT OF THIS RULE HAS NOT BEEN MET AS EVIDENCED

		BY: The surveyor's review of 20 current patient records, group schedules for Units A, B, D, E and Spratt on 06/14/2022 - 08/24/2022 and interviews with staff on 6/14/2022, 09/08/2022, and 09/15/2022. FINDINGS: (1) The hospital does not have adequate numbers of qualified professional, support staff and consultants to provide comprehensive therapeutic activities consistent with each patient's active treatment program. The hospital currently has two licensed addiction counselors and one certified recreational therapist to meet the therapeutic needs of 122 patients. Recreational technicians that provide the majority of the active treatment to patients are not specifically trained in recreational based treatment programs and group facilitation. (2) The hospital has not implemented a program that is appropriate to the needs and interests of the patients that is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. The majority of the active treatment provided to patients consist of recreational groups that are not consistent with each patient's active treatment program. Recreational groups are scheduled 3-5 hours per day mostly consist of leisure/recreational activities such as gym/exercise time, taking a walk, community coffee, social hour, crafts and playing games. Group enrollment is determined by the social worker or the recreational therapist based on the Recreational Therapy Assessment and which level the patient is on. The patient needs to demonstrate compliance with programming to move up the levels. Patients are schedule for as little as 30 minutes of group per week up to

		10 hours per week. Psychiatric technicians and nurses working the unit do not know what groups each patient is assigned to attend. Patients are not required to attend groups nor are they encouraged to attend if they choose not to participate. (3) Surveyor observation and staff interviews found patients spend the majority of their time in the common area of the unit playing cards, games, walking the hallways of the unit, talking to other patients, etc. Staff interviewed stated patients are bored and feel that there is a lack of scheduled activities. Staff also reported they do not have enough clinical staff to provide individualized mental health treatment for each patient. (4) Surveyor observed 2 different schedules posted on the B wing; neither of which was the updated schedule. The updated schedule was provided by a recreational technician. Per recreational staff; two of the groups on the schedule for the day were not provided. (5) The hospital did not have written documentation that they provided comprehensive therapeutic activities. (a) 17 of 17 patient records did not have written documentation that the patients were offered a therapeutic activities program and mental health treatment outside of medication management. (b)17 out of 20 patient records did not include written documentation that the patients were offered and/or provided individual and/or family therapy.
7	37.106.430-2 MINIMUM STANDARDS FOR A HOSPITAL: PSYCHI	AND 482.62 Condition of participation: Special staff requirements for psychiatric hospitals.

		The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning. (a) Standard: Personnel. The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to: (1) Evaluate patients; (2) Formulate written individualized, comprehensive treatment plans; (3) Provide active treatment measures; and (4) Engage in discharge planning. The surveyor's review of 20 personnel records on 06/14/2022 – 06/15/2022 and 08/16/2022-08/24/2022 and hospital staff roster submitted to the department on 06/14/2022. FINDINGS: The hospital does not have adequate numbers of qualified therapists/professional staff to evaluate patients, formulate written individualized comprehensive treatment plan, provide active treatment measures, and engage in discharge planning. The hospital currently employs only 2 Licensed Addictions Counselors to provide restorative and rehabilitative services to 122 patients. The hospital currently does not employ any Licensed Mental Health Professionals.
8	37.106.2905-1 DOCUMENTATION IN RESIDENT'S MEDICAL RECO	AND (2) When a restraint or safety device is used, the following items must be documented in the resident's record:

		(a) frequency of monitoring in accordance with documented facility policy; (b) assessment and provision of treatment if necessary for skin care, circulation and range of motion; and (c) any unusual occurrences or problems. AND (3) During a quarterly re-evaluation, a facility must consider: (a) using the least restrictive restraint or safety device to restore the resident to a maximum level of functioning; (b) causes for the medical symptoms that led to the use of the restraint or safety device; and (c) alternative safety measures if a restraint or safety device is removed. Before removing a restraint or safety device, the resident or the authorized representative and the attending physician must be consulted. THE INENT OF THIS RULE HAS NOT BEEN MET AS EVIDENCED BY: Facility inspection and review of patient files June 14, 2022, June 15, 2022, and September 08, 2022. It was observed on the SPRATT unit that patients #12, #13, #18, #19, and #20 were using geriatric or "Broda" chairs. Interview with unit staff indicate that for Patient #13 and #18, the chairs are being used for safety purposes to prevent or reduce falls. • Patient#13 has order for "Broda chair" but does not have evidence of 1(a), 1(b), (2) or (3) located in the patient file • Patient #18 does not have an order for a wheelchair or the use of the Broda chair and does not have evidence of 1(a), 1(b), (2) or (3) located in the patient file.