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{A 000}	INITIAL COMMENTS A revisit survey was completed on 5/29/19 for all previous deficiencies cited on 2/1/19. One deficiency was cited.	{A 000}		
{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 interviews and document review the facility failed to track contraband on 3 of 3 patient care units. Additionally, the facility failed to follow their admission criteria process and admitted a patient who met hospital identified exclusion criteria (Patient #19). Findings include: Facility policy: The policy, Environmental Unit Rounds read, Environmental Unit rounds will be performed to establish and maintain patient safety. The frequency of rounds is dictated by patient acuity, and unit concerns, and is performed five times every shift by MHT's. The MHT's will check and monitor for: Patient rooms are free of any contraband (sharps, aerosol cans, belts, ties, mirrors, razors, glass containers, strings, sporks, plastic bags of any size, caps for juice, soda or water bottles). All community areas are free of contraband that can potentially be used for self-harm. Nurse on the unit is made aware by the MHT of any increased patient acuity and/or unit concerns. The above rounds are documented on the Unit Environmental Checklist.	{A 144}		

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

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The policy, Unit Searches read, when staff has reason to believe contraband is present they will notify the Charge RN and measures will be taken to reveal and dispose of potential danger. Staff identify contraband may be present on the unit. Staff notifies Charge RN. Staff will thoroughly search the room and patient's belongings for contraband.

According to the Clinical Guidelines for Inpatient Psychiatric Admissions, patient admissions were categorized by green, yellow, red and black zones. Patients with medical conditions identified in the "yellow zone" require an admission review by a minimum of a house supervisor or designee. Yellow zone conditions included transfer from a medical facility. Patients with medical conditions identified in the "black zone" are considered "absolute exclusionary criteria; no admission". Medical conditions in the black zone included uncontrolled diabetes.

References:

The Leadership Patient Safety Checklist read, Instructions: This is a patient-focused review. For each patient care shift, complete an assessment of the following parameters. Summarize results and submit findings to the Chief Operating Officer for compilation. Safety: Environment of Care Observations, any loose pencils seen in patient areas unsupervised by staff.

1. The facility failed to track pencils, which were identified as contraband, used by patients.

a. On 5/29/19 at 10:46 a.m., a tour was conducted of the 300 Unit. During the tour an interview was conducted with the mental health

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technician (MHT #10) at 11:30 a.m. MHT #10 stated she counted pencils every morning when she started her shift and documented this in the pencil log. MHT #10 stated pencils were to be counted at the beginning of each shift, including day shift and night shift. MHT #10 stated it was important for staff to know the baseline inventory at the beginning of the shift, and account for all pencils to keep patients and staff safe. MHT #10 stated it was important to track contraband and pencils were considered contraband and they could be used by patients to hurt themselves or someone else.

b. Review of the document staff referred to as the Pencil Log, for the 300 Unit revealed from 5/1/19 through 5/28/19 (a total of 56 shifts) there were 38 shifts missing a pencil inventory count. As example,

On 5/1/19, there was no documentation an initial pencil count was completed. There was no count of pencils until 5/3/19, day shift, when 10 pencils were logged. The was no inventory count for night shift on 5/3/19. On 5/4/19, day shift, there was an inventory of eight pencils. Following 5/4/19, day shift, there were five shifts with missed inventory counts. The next count was on 5/7/19, day shift, where five pencils were logged. There was no documentation as to why there were three missing pencils.

i. Review of an Incident Report, dated 5/9/19 at 3:53 a.m., revealed an incident occurred on 5/9/19 at 1:44 a.m. The incident noted a walker pouch was searched in room 308 (on unit 300) and found three pencils, three sporks, and three apple juice caps. House Supervisor (Supervisor) #14 documented staff signed out one of the

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pencils close to shift change and the pencil sign out sheet had not been utilized. Supervisor #14 documented she provided training to the MHTs that had worked the last couple of days.

However, following the incident report and subsequent training inventory of pencils continued to be inconsistent. For example,

On 5/9/19 day shift a pencil count was completed. The next count was not done until night shift on 5/11/19, four shifts with no count.
On 5/11/19 night shift 6 pencils were logged. There was no further inventory of pencils until day shift 5/15/19,six shifts with no count.
On 5/18/19 day shift a pencil count was completed. The next count was not done until day shift on 5/22/19, seven shifts without a pencil inventory.
On 5/26/19 day shift a pencil count was completed where 7 pencils were noted. The next count was not completed until day shift 5/29/19, where six pencils were logged, five shifts with no inventory.

As noted above, there were 38 shifts during the month of May 2019 in which a pencil inventory was not logged.

c. On 5/29/19 at 11:30 a.m., during the tour of the 300 Unit, MHT #10 reviewed the Pencil Log, MHT #10 stated she logged the count at the beginning of her shift, on 5/29/19, and there were six pencils. MHT #10 stated she was unable to explain the discrepancy for the missing pencil from 5/26/19, when seven pencils were logged, because there was no documentation to explain what happened to the missing pencil. MHT #10 stated there had been an issue with logging

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pencils on the 300 Unit but she was unsure of who to speak with regarding her concerns. MHT #10 stated it was important to accurately log pencils for inventory because it ensures everyone on the unit was safe and it was important to know which patients had pencils in their possession.

d. On 5/29/19 at 11:23 a.m., an interview was conducted with the registered nurse (RN #9) on 300 Unit. RN #9 stated when pencils were missing it was dangerous because pencils were a sharp pointy object that patients could use to harm themselves or others and were unsafe.

e. On 5/29/19 at 11:50 a.m., an interview was conducted with the lead mental health tech (MHT #11) on the 300 Unit. MHT #11 stated it was important to decrease contraband on the unit for patient safety. MHT #11 stated tracking pencils was important so staff knew who had the pencils. Upon review of the document, referred to as the Pencil Log for the 300 Unit, MHT #11 stated on her prior shift there were 3 MHT's and none of the MHT's documented a pencil count. MHT #11 stated she was unsure why they had not documented the count, and stated sometimes it may have been overlooked. MHT #11 stated not tracking pencils was a risk to patient safety and patients could use pencils to stab someone, or themselves, or patients could eat them.

f. On 5/29/19 at 12:20 p.m., a tour was conducted of the 400 Unit. During the tour the 400 Unit Pencil Log was reviewed. Findings revealed, from 5/1/19 through 5/28/19 (a total of 56 shifts) there were 17 shifts missing a pencil inventory count. As example,

From 5/1/19 night shift until 5/5/19 night shift

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there was no pencil inventory documented on the night shifts, 5 shifts with no count.
From 5/15/19 night shift until 5/19/19 night shift there was no pencil inventory documented on the night shifts, 5 shifts with no count.

g. On 5/29/18 at 12:07 p.m., a tour was conducted of the 600 Unit. During the tour the 600 Unit Pencil Log was reviewed. Findings revealed, from 5/1/19 through 5/28/19 (a total of 56 shifts) there were 26 shifts missing a pencil inventory count. As example,

On 5/6/19 day shift a pencil count was completed. The next count was not done until day shift on 5/9/19, five shifts with no count.
On 5/16/19 day shift a pencil count was completed. The next count was not done until day shift on 5/19/19, five shifts with no count.
On 5/22/19 day shift 14 pencils were logged. There was no further inventory of pencils until day shift 5/24/19 when 12 pencils were logged, three shifts with no count. There was no documentation to explain why there were two missing pencils.

h. On 5/29/19 at 12:07 p.m., during the tour, an interview was conducted with the 600 Unit mental health tech (MHT #16). On review of the 600 Unit Pencil Log MHT #16 stated she was unsure of what may have happened to the 2 pencils which were unaccounted for from 5/22/19 to 5/24/19. MHT #16 stated maybe the pencils had been lost or broken. MHT #16 stated the pencils were to be counted at the beginning of every shift to verify the count was the same. MHT #16 stated the entries should be dated and initialed by staff.

i. On 5/29/19 at 12:29 p.m., an interview was conducted with the 600 Unit registered nurse (RN

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#17). RN #17 reviewed the 600 Unit Pencil Log for 5/22/19 to 5/24/19. RN #17 stated she was unable to tell what happened with the 2 pencils from reviewing the log. RN #17 stated pencils were a big safety issue because they were sharp objects and the pencils could be used by patients to harm themselves or others. RN #17 stated she had received contraband training from the facility but was unsure if pencils had been included in the training. RN #17 stated the mental health techs were responsible for tracking pencils so they did not get misplaced.

j. On 5/29/19 at 2:59 p.m. an interview was conducted with the director of compliance, quality, and risk (Director #5). Director #5 stated she had never reviewed the pencil logs on the three units. Director #5 stated she was unaware of any policies or guidelines for staff to use for the pencil sign in and sign out process. Director #5 stated she had provided training for staff on contraband but did not include pencils in her training. Director #5 stated the pencils could be used by patients to harm themselves or others. Director #5 was unable to provide a policy or procedure that outlined the process for pencil sign in and sign out, or a procedure for pencil inventory, for staff to reference.

2. The facility failed to follow their patient admission criteria process and admitted a patient who met hospital identified exclusion criteria.

a. A revisit was conducted on 5/20/19 after the facility was cited for failing to follow their admission criteria process and admitted a patient who met hospital identified exclusion criteria.

Similar findings were found on the revisit, in

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which Patient #19 who, prior to admission from the transferring outside facility, was documented to have uncontrolled diabetes, which met the hospital identified exclusion criteria.

b. According to the Clinical Guidelines for Inpatient Psychiatric Admissions, patient admissions were categorized by green, yellow, red and black zones. The yellow zone noted the patient's medical condition must be reviewed by a minimum of a house supervisor or designee. Listed as conditions to be reviewed were transfers from medical care units from another facility. The black zone noted these were absolute exclusionary criteria; and the patient would not be admitted. Listed conditions included open and or non-healing wounds and uncontrolled diabetes.

c. Review of Patient #19's medical record revealed the patient was admitted to the facility on 5/16/19 from an outside medical facility. On review of the referral packet, which had been reviewed by an admissions and referral (A&R) specialist (Specialist #21) and a house supervisor (Supervisor #14) prior to his admission, included documentation the patient's medical conditions included uncontrolled diabetes, medication noncompliance, high blood pressure and a chronic right foot stump wound.

Review of the Open Call Listing, documented by A&R staff on 5/15/19 at 11:39 p.m., showed Supervisor #14 called the outside medical facility and determined the patient had no open wounds. House Supervisor #14 was documented to be ok with Patient #19 medically. At 11:41 p.m., Medical Director (Physician) #8 accepted the patient for admission. There was no documentation in which staff addressed the documented uncontrolled

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diabetes.

This was in contrast to the clinical guidelines for inpatient psychiatric admission, which indicated the patient's uncontrolled diabetes fell into the black zone of absolute exclusion criteria.

d. On 5/29/19 at 12:01 p.m., an interview was conducted with Director of Compliance, Quality and Risk (Director) #5. Director #5 stated the facility had provided admission criteria training to include the Clinical Guidelines for Inpatient Psychiatric Admission. Director #5 stated she had not provided training on how staff should proceed if a patient had been admitted who meet exclusion criteria, because those patients should not be admitted. The training, according to Director #5 had been provided to the A&R staff, nurses and house supervisors, to include Specialist #21 and Supervisor #14.

Director #5 provided and reviewed the clinical guidelines for inpatient psychiatric admissions and stated the facility had admission exclusion criteria because patients who fell into the exclusion criteria were patients the facility determined could not be cared for safely with the nurses and medical equipment the facility had available. Director #5 stated if a patient was admitted who fell into the exclusion criteria, it put the patient at risk for inappropriate care.

Director #5 stated audits had been done on every admission since 5/1/19 to ensure the admission criteria policy had been followed. Director #5 stated she was unaware of any patients who were admitted since then, which met exclusion criteria.

e. Director #5 reviewed Patient #19's medical

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record and confirmed faxed information, from the outside transferring hospital, had been received prior to accepting the patient for admission and prior to the patient's arrival. Director #5 subsequently reconfirmed with Director #12 the information had been provided to the facility for review prior to Patient #19's admission.

Review of the transferring hospital's documentation, with Director #5, revealed a Behavioral Health Evaluation, Emergency Department (ED) SBAR, and ED Physician Documentation.

i. Review of the transferring hospital's Behavioral Health Evaluation revealed the general medical conditions listed for Patient #19 included uncontrolled diabetes and chronic right foot stump ulcer.

ii. Review of the ED SBAR revealed the patient had a bandaged wound on his left shin and a scabbed ulcer on his right foot.

iii. Review of the Physician Documentation revealed the patient had a past medical history to include right foot amputation from an accident, diabetes. The patient was treated for an elevated blood sugar of 385 on 5/15/19 at 1:26 p.m. and at 9:33 p.m. it was 140.

After review, Director #5 stated Patient #19 fell into the black zone (absolute exclusionary criteria) due the documented uncontrolled diabetes. Director #5 stated this had not been identified in the admission chart audit process, identified by leadership or discussed in any meetings. Director #5 stated she was unsure how this had occurred but a root cause analysis would

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{A 144}	Continued From page 10 need to be conducted. Director #5 then reviewed the Open Call Listing from A&R and stated there was no documentation, which indicated staff had addressed the documented uncontrolled diabetes for Patient #19. The patient was accepted for admission by Physician #8. f. On 5/29/19 at 6:34 p.m., an interview was conducted with Chief Nursing Officer (CNO) #20. CNO #20 stated she had been called prior to Patient #19's admission on 5/16/19 and did not want to accept Patient #19 because she was concerned about his blood sugar. CNO #20 stated she had instructed the nurse to call Physician #21 to notify him CNO #20 was uncomfortable accepting the patient. CNO #20 stated she did not have the final word on denying a patient admission, that was up to the physician. CNO #20 stated she was told, Physician #21 stated he could manage the patient. CNO #20 stated, Patient #19 should have "been caught, it's right here in the black zone and we should not have done it; moving forward I would say no, tell the physician no and be a bit more forceful." CNO #20 stated the facility had no documentation in which any staff had contacted Physician #21 to notify him she did not want to accept the patient or to show Physician #21 reviewed Patient #19's referral packet and stated he could manage the patient.	{A 144}		