ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SH3764	A. BUILDING: _____ B. WING _____	05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA TUCSON, INC	39580 SOUTH LAGO DEL ORO PARKWAY TUCSON, AZ 85739

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X 000	INITIAL COMMENTS The following deficiencies were found during the complaint investigation conducted 04/22/14 through 05/08/14. Complaint #AZ00123153. ADHS Representative Signature _____ date	X 000		
X 242	R9-10-203.C.2.f. Administration R9-10-203. Administration C. An administrator shall ensure that: 2. Policies and procedures for hospital services are established, documented, and implemented that: f. Cover dispensing, administering, and disposing of medication; This RULE is not met as evidenced by: Based on review of hospital policy/procedure, medical record, pharmaceutical references and interview, the Department determined that the administrator failed to ensure that a clinical pharmacist provide clinical pharmacist services related to the drug interaction between Suboxone and Diazepam, as required by hospital policy/procedure for 1 of 1 patient (pt # 1). Findings include: Review of the facility's Policy/Procedure titled Services Provided by Clinical Pharmacist revealed: "...The Clinical Pharmacist provides clinical pharmacist services, including but not limited to the following: Reviewing the following	X 242		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/15/14

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X 242	Continued From page 1 information in the patient's medical record to determine any potential problems related to medication therapy of the patient, including the presence of a diagnosis to support the medications prescribed: Complete orders, including diagnoses and/or problem list...After completing the review, the clinical pharmacist communicates recommendations regarding any drug interactions, medication adverse effects, dosing, monitoring parameters...or any other aspect of the resident's drug therapy to the patient's Provider...." Review of Pt # 1's medical record revealed: On 4/10/14 at 0900, MD # 1 ordered the Opiate Detoxification Protocol Using Suboxone. The protocol included: "...Suboxone 2mg-4mg sublingual every 2 hours PRN withdrawal signs and symptoms x 72 hours based on Clinical Opiate Withdrawal Scale (COWS): 5-12 points = 2 mg Suboxone sublingual; > 12 points = 4 mg Suboxone sublingual...NOT TO EXCEED 24 MG IN 24 HOURS...Librium 25 mg po (by mouth) every 2 hours PRN agitation, insomnia, or withdrawal symptoms x 72 hours. No more than 200 mg in 24 hours...." Pt # 1 was found unresponsive on the morning of 4/13/14. Pt # 1 received 16 mg of Suboxone and 55 mg of Valium, plus 50 mg of Librium between 2015 on 4/11/14 and 2200 on 4/12/14. Pt # 1's medical record did not contain any documentation that consultation occurred between the physician and the clinical pharmacist regarding the interaction between Suboxone and benzodiazepines or that precautionary measures	X 242		

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X 242	Continued From page 2 were implemented when the dose of benzodiazepine was increased. The Director of Pharmacy confirmed, during interview conducted on 5/8/14, that benzodiazepines have a CNS depressant effect when combined with Suboxone. She was unable to provide documentation or information that pharmacy and MD # 1 communicated regarding the drug interaction between Suboxone and benzodiazepines, or specifically Diazepam, prior to, during, or after Pt # 1 received 55 mg of Valium with Suboxone.	X 242		
X 341	R9-10-207.A.1. Medical Staff R9-10-207. Medical Staff A. A governing authority shall ensure that: 1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to a patient in a hospital; This RULE is not met as evidenced by: Based on review of hospital policy/procedure, Pharmacy and Therapeutics Meeting Minutes, medical record, pharmaceutical references and interview, the Department determined that the governing authority failed to ensure direct accountability of the medical staff for the quality of care provided by MD # 1 to Pt # 1 as evidenced by: 1. utilizing the "Opiate Detoxification Protocol Using Suboxone" without documentation of review and approval by the Medical Staff and Governing Authority as required in the hospital Pharmacy and Therapeutics Drug Use Evaluation policy/procedure; and	X 341		

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X 341	Continued From page 3 2. failing to complete and document assessment of Pt # 1's risk of suicide before decreasing his 1:1 observation from 24 hours a day to waking hours only. 1. Review of the facility's policy/procedure titled Pharmacy and Therapeutics Drug Use Evaluation revealed: "...It is the policy of (name of facility) to provide for an ongoing drug use evaluation process to examine the appropriateness, safety and cost effectiveness of medications ordered as they relate to individual patient care...The Pharmacy and Therapeutics Committee continuously monitors and evaluates drug use patterns as they relate to the quality of patient care services...The criteria for appropriateness of drug use are established by the Medical Staff and the Pharmacy and Therapeutics Committee...." Review of Pt # 1's medical record revealed a form titled Opiate Detoxification Protocol Using Suboxone. MD # 1 signed the form on 4/10/14, at 0900, indicating that nursing was to place the patient on the protocol. Nursing administered 12 mg of Suboxone on 4/10/14 between 0930 and 2000; 16 mg of Suboxone on 4/11/14 between 0540 and 2015 and 14 mg of Suboxone on 4/12/14 between 0838 and 2000. The protocol includes administration of 2 mg Suboxone, as needed every 2 hours, for scores between 5-12 points, using the Clinical Opiate Withdrawal Scale and 4 mg of Suboxone every 2 hours, as needed, for scores above 12 points. The bottom of the form contained dates ranging from "4/01" (4/2001) through "5/07" (5/2007), indicating review and or revision of the form. The Director of Patient Services provided	X 341		

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X 341	Continued From page 4 Pharmacy and Therapeutics meeting minutes dated July 22, 2011 which contained a section: "...Suboxone Policy and Procedure...reported the Suboxone procedure is fully implemented. Nursing is still pulling prescriptions from the sign in sheet. Committee discussed tracking of prescriptions...Committee decided a binder will be kept for each doc to keep track of prescriptions..." The minutes did not reference a detoxification protocol. The Director of Patient Services also provided a document titled "Buprenorphine Procedure...Suboxone and Subutex", dated 1/25/2011. The procedure contained information regarding specific provider stock of Buprenorphine products. It did not contain information regarding the detoxification protocol. The Director of Patient Services confirmed, during interview conducted on 5/8/14, that she was unable to provide documentation of approval or review of the Suboxone detoxification protocol by the Medical Staff, Pharmacy and Therapeutics Committee or Governing Authority. 2. Review of Pt # 1's medical record revealed: A Registered Nurse (RN) completed a Suicide Risk Scale for Pt # 1 on 4/9/14, at 1900, rating the patient as a "Very High" risk (score 13). An RN completed a Suicide Risk Scale for Pt # 1 on 4/10/14 at 1635, rating the patient as a "High" risk (score 12). On 4/10/14, at 1630, an RN documented: "...Pt states 'I don't want to be at (facility) I want to die I wish you could kill me. I've done many bad things to my friends and family.' Pt is reporting dark thoughts/dreams about stabbing people,	X 341		

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X 341	Continued From page 5 strangling/or being strangled by police. Call MD on call orders received...F/U (with) psych in AM..." An RN recorded a telephone order from PA-C # 2 on 4/10/14 at 1630: "...PCA (Patient Care Assistant) for safety 24 (hours)...." On 4/10/14, at an undetermined time, an RN completed a Suicide Risk Scale for Pt # 1, rating the patient as a "Medium" risk (score 7). On 4/10/14, at an undetermined time, MD # 1 completed a Suicide Risk Scale for Pt # 1, rating the patient as a "Low" risk (score 5). Pt #1's medical record did not contain any further Suicide Risk Scales completed after 4/10/14. On 4/11/14, at 0230, an RN documented: "...Pt became agitated when he realized that the 1:1 would be with him constantly...Pt insisted that his comments were 'taken out of context' and he would leave AMA (Against Medical Advice) if he was forced to have a 1:1. Provider on call was informed of pt's comments and insisted on continuing the 1:1 until evaluated in the morning...current 1:1 reminded him of someone that had hurt him...A different 1:1 was brought to...The pt expressed gratitude and apologized to staff...fell asleep on couch...2200...went to bed...SRS = 7 (Suicide Risk Scale)...." The medical record did not contain the completed scale. On 4/11/14, at 0700, an RN documented: "...Risk Factors...Self Harm...AMA Risk...Patient continues with 1:1 for safety...." On 4/11/14 at 1210, the patient completed a "Daily Patient Feeling Sheet": "...Sad/Hurt/Pain...Anger...Lonely...Shame...Guilt...Fear..." He rated his depression a "10" with 10	X 341		

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X 341	Continued From page 6 being the worst depression. He marked "Nightmares" for description of his sleep "last night." On 4/11/14, at 0830, an RN recorded a telephone order from MD # 1: "...continue with 1:1 over the weekend. Continue to maintain in...over the weekend. Re-evaluation on Monday...." On 4/12/14, at 0230, an RN documented: "...Pt...disruptive and agitated...1:1 is in constant observance...." On 4/12/14, the Daily Nursing Assessment for the 1st Shift contained documentation that the patient was poorly groomed, his thoughts were tangential, incomplete at times and scattered, his gait was steady, he was agitated at times, angry, and his affect was inappropriate at times, anxious and irritable. Risk Factors included Self-Harm and AMA Risk and Signs and Symptoms of Detox. The Daily Nursing Assessment for the 2nd Shift contained documentation that the patient was well-groomed, his thoughts were tangential, scattered and he had difficulty concentrating; he was agitated, angry, his affect was inappropriate, anxious and irritable. Risk Factors included Signs and Symptoms of Detox, Self-Harm and AMA Risk. On 4/12/14, at 0800, MD # 1 recorded an order: "...PCA during waking hours only. Discontinue when pt goes into room to sleep. Restart in AM at 0700...." On 4/12/14, at 2200, MD # 1 documented: "...Pt was agitated, anxious and irritable. Repeatedly asked for medications...seen arguing with his mother on the phone multiple times...Pt Denies thought of self harm and not SI (Suicidal	X 341		

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X 341	Continued From page 7 Ideation)...." The patient's medical record contained documentation that he had never admitted to suicidal ideation or thoughts of self-harm. He had rated high and/or very high risk for suicide due to other factors. The medical record did not contain documentation by nursing or medicine of the status of his "dark thoughts" or reassessment of his suicide risk other than thoughts of self-harm or suicidal ideation when the 1:1 was discontinued during the night. On 5/8/14, the Director of Patient Services confirmed that a Suicide Risk Assessment was not required when a patient's 1:1 is discontinued. She confirmed that nursing had documented on the Daily Nursing Assessment for the 2nd Shift on 4/12/14, "Risk Factors" which included "Self-Harm" and "AMA" and the MD discontinued the 1:1 during the night.	X 341		
X 343	R9-10-207.A.3. Medical Staff R9-10-207. Medical Staff A. A governing authority shall ensure that: 3. A medical staff member complies with medical staff bylaws and medical staff regulations; This RULE is not met as evidenced by: Based on review of the Bylaws of the Professional Staff Organization (PSO), credential file, medical record and interview, the Department determined that PA-C # 2 failed to comply with the medical staff bylaws as evidenced by giving orders to admit Pt # 1. Findings include:	X 343		

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X 343	Continued From page 8 Review of the Bylaws of the Professional Staff Organization (PSO) of the facility revealed: "...the clinicians practicing at (name of facility) do so in conformity with these bylaws...The Purpose of These Bylaws Shall Be:...To ensure that members of the PSO will exercise only those clinical privileges they are privileged for...Delineation of Core Medical Management privileges...All non MD/DO practitioners who are granted core privileges will be referred to as 'Attending physician's designee' and will be assigned to a specific patient by an order from the attending physician...person with this privilege may: Admit (MD/DO only) diagnose, treat and discharge patients with medical disorders...provide History and Physical evaluations...." Review of PA-C # 2's credential file revealed that his privileges included "Core Medical Management Privileges." Review of Pt # 1's medical record revealed: An RN recorded admission orders via telephone for Pt # 1 from PA-C # 2 on 4/9/14 at 1650. Review of the pre-printed Admission Orders form revealed "...Admit to Attending Provider: (blank)...Diagnosis...Allergies...Date of Birth... (check) to indicate physician has ordered..." The RN placed a check mark in several boxes, indicating the PA-C's admission orders for Pt # 1. Physician # 3, the facility Medical Director, stated during interview conducted on 5/8/14, that he believed that when PA-C # 2 gave admission orders to the RN, that he was not admitting the patient. He stated that the physician "approval" of Pt # 1 for admission documented on a form by the employee who completed the patient's intake	X 343		

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X 343	Continued From page 9 assessment, was admission of the patient. He stated that this approval process was the admission order. He confirmed that this employee was not a nurse. Review of the Rules and Regulations of the Professional Staff of the facility revealed: "Verbal orders/telephone orders May only be accepted by a Nurse LPN or RN...." Physician # 3 confirmed during interveiw conducted on 5/8/14, that if the "approval" for admission was considered to be admission of the patient, only a nurse could record that "approval". He also confirmed that the Medical Staff Bylaws do not allow a non MD/DO to admit a patient. He confirmed that PA-C # 2 gave admission orders for Pt # 1.	X 343		
X 722	R9-10-214.C.14. Nursing Services R9-10-214. Nursing Services C. A nurse executive shall ensure that: 14. A registered nurse assesses, plans, directs, and evaluates nursing services provided to a patient; This RULE is not met as evidenced by: Based on review of medical record, direct observation, and staff interview, the Department determined that the nurse executive failed to ensure that a registered nurse measure, assess and record the patient's vital signs as required by physician orders for 1 of 1 patient who was found unresponsive and required cardiopulmonary resuscitation (Pt # 1).	X 722		

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X 722	Continued From page 10 Findings include: Review of Pt # 1'a medical record revealed: On 4/9/14, at 1650, an RN recorded Admission Orders, received from PA-C # 2 via telephone. A mark was placed in the "Yes" box for: "...FOR PATIENTS WITH DIAGNOSIS OF OPIATE, SEDATIVE HYPNOTIC, AND/OR ALCOHOL DETOX:...." A circle was placed around the following: "...a. Vital signs including CIWA/COWS every 4 hours and PRN while in M.A.S (Medical Assessment and Stabilization)...." During his hospitalization, Pt # 1 was placed on the "Opiate Detoxification Protocol Using Suboxone". An RN recorded Pt # 1's vital signs on 4/12/14, at 1930. Blood Pressure (BP): 142/81, Pulse (P): 98 and Respirations (R): 18. On 4/12/14, at 2200, an RN documented: "...COWS = 14. VS (Vital Signs) BP 142/81; HR (Heart Rate) 98; R 18. (Same findings as recorded at 1930). The Night Shift Supervisor confirmed, during interview conducted on 4/23/14, at 0900, that s/he entered Pt # 1's room at 0130 on 4/13/14, and observed the patient leaning up against the head board with his eyes closed. She stated that she was unable to observe the patient's color, but his breathing appeared "normal." Nursing did not measure and/or record Pt # 1's vital signs at that time. An RN recorded a late entry on 4/14/14, at 1430: "...4/13/14 0400 Late Entry-Patient seen in his room and his bed sleeping. Chest seen rising and falling with each breath. Audible breathing heard...." The RN did not measure and/or record	X 722		

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X 722	Continued From page 11 Pt # 1's vital signs at that time. Direct observation conducted on 5/8/14 revealed that the patient rooms are dark with the drape drawn and the lights off. The distance from the nurses' station to the foot of Pt # 1's bed is approximately 20 feet. The Clinical Technician at the nurses' station on 5/8/14, confirmed that the drape was closed and Pt # 1's room was dark on the morning of 4/13/14. The RN assigned to Pt # 1 on 04/13/2014 at 0700, confirmed during an interview conducted on 04/23/2014, that she first observed Patient #1 in his room from the nurses' station. She entered the patient's room at 0800. The patient was facing the window and replied "No" when asked to "go to the vital sign chair" and take medications. The patient was found at 0845, "clammy, with pale skin, and moist shiny phlegm around his mouth; breathing was like a snore." The PCA 1:1 sitter verified in a phone interview conducted on 04/24/14, that the light had not been turned on in Pt # 1's room until 08:45 a.m. when the patient was found unresponsive. An RN documented on 4/13/14 at 1000: "... Patient received in bed - color natural, respirations easy. Skin appeared natural when first saw -when door opened by 1:1. Patient rechecked at 0845...As refused assessment at approximately 0800. Patient had declined at that time -When checked at 0845 - patient head elevated, color pale, sounded as he was snoring - 1:1 appeared to be sleeping - tried to awaken patient by sternal rub, after saying loudly (pt's name). 1:1 helper roll (sp) patient on side as I	X 722		

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X 722	Continued From page 12 called for help - 911 called by CSS - supervisor RN now present with medical provider (PA). Small amount white phlegm wiped from mouth. VO (verbal order) stat Narcan 0.4 mg. Paramedics on scene - had CSSA make copies of patient MAR (medication administration record) - demographics H&P and psych evaluation, which I handed to paramedics while obtaining Narcan for injection patient transferred to floor - patient given Narcan 0.4 mg IM R deltoid - while patient receiving chest compression and ambu bag from RN and medical provider. Paramedics now present - and took over emergency care. Call placed to patient's mother (name) for update that patient transferred to (name of local hospital) for treatment for unresponsiveness. Treatment team alert notification - to treatment team by supervisor - was done at 0915...." The Director of Nursing confirmed, during an interview conducted on 04/23/14, that nursing did not assess Pt #1 or measure and record Pt #1's vital signs from 1930 or 2200 on 04/12/14, until the patient was found unresponsive at 0845 on 04/13/14. She acknowledged that the staff did not follow physician's orders for measuring/recording vital signs every 4 hours. The Director of Nursing also confirmed that the facility does not have a policy/ procedure for vital signs, specifically to identify which vital signs to measure and record. Pt # 1's medical record did not include measurement of pulse oximetry with any documentation of vital signs prior to those recorded on 4/13/14 at 0845.	X 722		
X 724	R9-10-214.C.16. Nursing Services R9-10-214. Nursing Services	X 724		

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SIERRA TUCSON, INC	39580 SOUTH LAGO DEL ORO PARKWAY TUCSON, AZ 85739

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X 724	Continued From page 13 C. A nurse executive shall ensure that: 16. Nursing personnel document nursing services in a patient's medical record. This RULE is not met as evidenced by: Based on review of hospital policy/procedure, medical record and interview, the Department determined that the nurse executive failed to ensure that an RN implement the Suicide Risk Assessment and Management policy/procedure for 1 of 1 patient who scored as 'Very High" risk on his initial Suicide Risk Assessment (Pt # 1). Findings include: Review of the hospital policy/procedure titled Suicide Risk: Assessment and Management revealed: "...It is the policy of (name of hospital) to assume that all patients/clients admitted are capable of self-harm. As part of the continuing assessment for self-harm, staff will administer an Initial Suicide Risk Scale...as part of the admission evaluation process. Management of suicide risk will be based on the clinical factors determined in the assessment and reassessment process of the patient...throughout the treatment stay. These will include but not be limited to the Initial Suicide Risk Scale, the BDI-II (Beck Depression Inventory-II, and the Beck Hopelessness Scale (BHS)...At admission, the Nurse will complete all sections of the Suicide Risk Scale as part of the nursing assessment process. If the nursing assessment identifies any immediate suicidal risk, a Medical Provider will be notified to obtain safety orders...If the patient's Suicide Risk scale (SRS) is 10 or greater on admission the nurse will administer the BDI-II, and BHS tests, score them and report findings to the Medical Provider...The Nurse will activate High Risk for self-harm on Problem List and Initial	X 724		

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X 724	Continued From page 14 Treatment Plan...If the score is 13 or greater the patient will be placed on a one-to-one (1:1) observation until a face-to-face psychiatric evaluation is completed, unless the Provider orders otherwise...." Review of Pt # 1's medical record revealed: An RN completed the Nursing Admission Assessment on 4/9/14, at 1620. An RN recorded Admission Orders on 4/9/14, at 1650. The RN received the admission orders via telephone. An RN completed an RN Admission Summary and Note on 4/9/14, at 1800. An RN completed a Suicide Risk Scale on 4/9/14, at 1900. The RN recorded Pt # 1's total suicide risk score as 13 and circled: "13-20 Very High." Pt # 1's medical record did not contain documentation that the RN administered the BDI-II or the BHS as required. The patient's treatment plan did not contain documentation of the patient's high risk for self-harm as required and the hospital could not provide documentation that the patient was placed on one-to-one observation until a face-to-face psychiatric evaluation was completed, as required. The medical record did not contain documentation that the RN notified the provider of Pt # 1's score. The medical record did not contain orders which addressed the patient's need for observation on 4/9/14. The Director of Patient Care Services confirmed during an interview conducted on 5/8/14, that Pt # 1's treatment plan did not contain the required documentation of his High Risk for self-harm and that he was not placed on one-to-one observation as required. She stated that a decision had been made to discontinue the BDI-II and BHS. She confirmed that she was unable to provide documentation that the BDI-II and BHS were no	X 724		

ADHS LICENSING SERVICES

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X 724	Continued From page 15 longer necessary if a patient's Suicide Risk Scale was 10 or greater on admission. She confirmed that nursing did not follow the faciltiy's policy/procedure.	X 724		

RECEIVED
OCT 17 2014
ADHS Bureau of Medical Facility Licensing

Acceptable POC 10/17/14 JR

PRINTED: 08/27/2014
FORM APPROVED

ADHS LICENSING SERVICES

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Copies ok.

Current 2567 ok, E IPR revisions.

Attached P&P are in regards to 2567.

X 000 INITIAL COMMENTS

The following deficiencies were fo
complaint investigation conducted
through 05/08/14. Complaint #AZ

ADHS Representative Signature

Linda W Stutsman RN
Date

X 242 R9-10-203.C.2.f. Administration

R9-10-203. Administration
C. An administrator shall ensure th
2. Policies and procedures for hosp
are established, documented, and implemented that:
f. Cover dispensing, administering, and disposing of medication;

This RULE is not met as evidenced by:
Based on review of hospital policy/procedure, medical record, pharmaceutical references and interview, the Department determined that the administrator failed to ensure that a clinical pharmacist provide clinical pharmacist services related to the drug interaction between Suboxone and Diazepam, as required by hospital policy/procedure for 1 of 1 patient (pt # 1).

Findings include:

Review of the facility's Policy/Procedure titled Services Provided by Clinical Pharmacist revealed: "...The Clinical Pharmacist provides clinical pharmacist services, including but not limited to the following: Reviewing the following information in the patient's medical record to

Medical Provider
s related to
r classes of
n the revised
Major Medication Interaction Protocol Special Hospital policy (attached).
The Policy includes a major medication interaction list to ensure that specific, identified interactions will be communicated to the medical provider by the pharmacist on duty during regularly scheduled hours. Recommendations are provided by the pharmacist in consultation with the medical provider. The review and action will be documented in the patient's medical record. Any orders received after pharmacy hours will be reviewed by the nurse against the Major Medication Interaction List. If the new order falls into any of the categories outlined in the list, the nurse will consult with the on-call pharmacist. This communication will be documented in the nursing progress notes.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Executive Director

(X6) DATE
10.15.14

ADHS LICENSING SERVICES

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X 000	INITIAL COMMENTS The following deficiencies were found during the complaint investigation conducted 04/22/14 through 05/08/14. Complaint #AZ00123153. ADHS Representative Signature Linda W Etherington RN 8/27/2014 date	X 000	ADHS Agency Business Office Received OCT 14 2014	
X 242	R9-10-203.C.2.f. Administration R9-10-203. Administration C. An administrator shall ensure that: 2. Policies and procedures for hospital services are established, documented, and implemented that: f. Cover dispensing, administering, and disposing of medication; This RULE is not met as evidenced by: Based on review of hospital policy/procedure, medical record, pharmaceutical references and interview, the Department determined that the administrator failed to ensure that a clinical pharmacist provide clinical pharmacist services related to the drug interaction between Suboxone and Diazepam, as required by hospital policy/procedure for 1 of 1 patient (pt # 1). Findings include: Review of the facility's Policy/Procedure titled Services Provided by Clinical Pharmacist revealed: "...The Clinical Pharmacist provides clinical pharmacist services, including but not limited to the following: Reviewing the following information in the patient's medical record to	X 242	Consultation between the Medical Provider and the clinical pharmacists related to medication combinations or classes of medications is addressed in the revised Major Medication Interaction Protocol Special Hospital policy (attached). The Policy includes a major medication interaction list to ensure that specific, identified interactions will be communicated to the medical provider by the pharmacist on duty during regularly scheduled hours. Recommendations are provided by the pharmacist in consultation with the medical provider. The review and action will be documented in the patient's medical record. Any orders received after pharmacy hours will be reviewed by the nurse against the Major Medication Interaction List. If the new order falls into any of the categories outlined in the list, the nurse will consult with the on-call pharmacist. This communication will be documented in the nursing progress notes.	

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

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X 242	Continued From page 1 determine any potential problems related to medication therapy of the patient, including the presence of a diagnosis to support the medications prescribed: Complete orders, including diagnoses and/or problem list...After completing the review, the clinical pharmacist communicates recommendations regarding any drug interactions, medication adverse effects, dosing, monitoring parameters...or any other aspect of the resident's drug therapy to the patient's Provider...." Review of Pt # 1's medical record revealed: On 4/10/14 at 0900, MD # 1 ordered the Opiate Detoxification Protocol Using Suboxone. The protocol included: "...Suboxone 2mg-4mg sublingual every 2 hours PRN withdrawal signs and symptoms x 72 hours based on Clinical Opiate Withdrawal Scale (COWS): 5-12 points = 2 mg Suboxone sublingual; > 12 points = 4 mg Suboxone sublingual...NOT TO EXCEED 24 MG IN 24 HOURS...Librium 25 mg po (by mouth) every 2 hours PRN agitation, insomnia, or withdrawal symptoms x 72 hours. No more than 200 mg in 24 hours...." Pt # 1 was found unresponsive on the morning of 4/13/14. Pt # 1 received 16 mg of Suboxone and 55 mg of Valium, plus 50 mg of Librium between 2015 on 4/11/14 and 2200 on 4/12/14. Pt # 1's medical record did not contain any documentation that consultation occurred between the physician and the clinical pharmacist regarding the interaction between Suboxone and benzodiazepines or that precautionary measures were implemented when the dose of	X 242	Medical, nursing and pharmacy staff training was provided to the above Policy and was completed in September and October 2014.Trainings were provided by the Director of Patient Care Services and the Director of Pharmacy and her designee. To ensure ongoing compliance, a random selection of five charts will be monitored on a monthly basis beginning October 2014 by the Director of Pharmacy and/or designee. Data will be reported monthly to the Pharmacy and Therapeutics Committee where additional actions to be taken will be identified as needed. Data and findings will be reported to the Quality Committee and included as part of the Governing Body report.	

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X 242	Continued From page 2 benzodiazepine was increased. The Director of Pharmacy confirmed, during interview conducted on 5/8/14, that benzodiazepines have a CNS depressant effect when combined with Suboxone. She was unable to provide documentation or information that pharmacy and MD # 1 communicated regarding the drug interaction between Suboxone and benzodiazepines, or specifically Diazepam, prior to, during, or after Pt # 1 received 55 mg of Valium with Suboxone.	X 242		
X 341	R9-10-207.A.1. Medical Staff R9-10-207. Medical Staff A. A governing authority shall ensure that: 1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to a patient in a hospital; This RULE is not met as evidenced by: Based on review of hospital policy/procedure, Pharmacy and Therapeutics Meeting Minutes, medical record, pharmaceutical references and interview, the Department determined that the governing authority failed to ensure direct accountability of the medical staff for the quality of care provided by MD # 1 to Pt # 1 as evidenced by: 1. utilizing the "Opiate Detoxification Protocol Using Suboxone" without documentation of review and approval by the Medical Staff and Governing Authority as required in the hospital Pharmacy and Therapeutics Drug Use Evaluation policy/procedure; and	X 341	1. The opiate Detoxification protocols previously approved January 23, 2013 by the Policy and Procedure Committee including the acting Medical Director and Pharmacist were sent to the Professional Services Organization Committee (PSO) and approved on September 18, 2014. The Governing Body approved on September 30, 2014.	

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X 341	Continued From page 3 2. failing to complete and document assessment of Pt # 1's risk of suicide before decreasing his 1:1 observation from 24 hours a day to waking hours only. 1. Review of the facility's policy/procedure titled Pharmacy and Therapeutics Drug Use Evaluation revealed: "...It is the policy of (name of facility) to provide for an ongoing drug use evaluation process to examine the appropriateness, safety and cost effectiveness of medications ordered as they relate to individual patient care...The Pharmacy and Therapeutics Committee continuously monitors and evaluates drug use patterns as they relate to the quality of patient care services...The criteria for appropriateness of drug use are established by the Medical Staff and the Pharmacy and Therapeutics Committee...." Review of Pt # 1's medical record revealed a form titled Opiate Detoxification Protocol Using Suboxone. MD # 1 signed the form on 4/10/14, at 0900, indicating that nursing was to place the patient on the protocol. Nursing administered 12 mg of Suboxone on 4/10/14 between 0930 and 2000; 16 mg of Suboxone on 4/11/14 between 0540 and 2015 and 14 mg of Suboxone on 4/12/14 between 0838 and 2000. The protocol includes administration of 2 mg Suboxone, as needed every 2 hours, for scores between 5-12 points, using the Clinical Opiate Withdrawal Scale and 4 mg of Suboxone every 2 hours, as needed, for scores above 12 points. The bottom of the form contained dates ranging from "4/01" (4/2001) through "5/07" (5/2007), indicating review and or revision of the form. The Director of Patient Services provided Pharmacy and Therapeutics meeting minutes	X 341	2. Policy MS 0002 Suicide Risk Assessment and Management was reviewed and revised by the Clinical Committee in May 2014. It was determined the Beck Hopelessness Scale (BHS) and Suicide Risk Assessment (SRA) tools would be utilized to assess a patient's suicide risk. Whenever a patient's status has significantly changed, the medical provider, clinician or nurse will reassess the patient using the Suicide Risk Assessment and document the results in the patient record. All staff was trained on Suicide Prevention via eLearning. All clinical staff was trained on the policy and protocol for Suicide Risk Assessment and Management: Program, Nursing, Medical, Intake (specific to their areas of responsibility as well as the general protocol). All other staff was trained on the basic responsibility for managing the protocol. Trainings were completed May and June 2014 as evidenced by training log listing employee's attendance. Training on these policies are included as part of new employee orientation. Compliance with the Suicide Risk Assessment and Management Policy will be monitored monthly by a random selection of no less than 30 charts beginning. Compliance monitoring is completed by designated medical, nursing and program staff on different aspects of the policy and its compliance. Data is analyzed monthly by the Director of Quality and Risk Management and action(s) to address patterns of non-compliance will be identified and implemented. Findings will be reported quarterly to the Quality Committee.	

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X 341	Continued From page 4 dated July 22, 2011 which contained a section: "...Suboxone Policy and Procedure...reported the Suboxone procedure is fully implemented. Nursing is still pulling prescriptions from the sign in sheet. Committee discussed tracking of prescriptions...Committee decided a binder will be kept for each doc to keep track of prescriptions..." The minutes did not reference a detoxification protocol. The Director of Patient Services also provided a document titled "Buprenorphine Procedure...Suboxone and Subutex", dated 1/25/2011. The procedure contained information regarding specific provider stock of Buprenorphine products. It did not contain information regarding the detoxification protocol. The Director of Patient Services confirmed, during interview conducted on 5/8/14, that she was unable to provide documentation of approval or review of the Suboxone detoxification protocol by the Medical Staff, Pharmacy and Therapeutics Committee or Governing Authority. 2. Review of Pt # 1's medical record revealed: A Registered Nurse (RN) completed a Suicide Risk Scale for Pt # 1 on 4/9/14, at 1900, rating the patient as a "Very High" risk (score 13). An RN completed a Suicide Risk Scale for Pt # 1 on 4/10/14 at 1635, rating the patient as a "High" risk (score 12). On 4/10/14, at 1630, an RN documented: "...Pt states 'I don't want to be at (facility) I want to die I wish you could kill me. I've done many bad things to my friends and family.' Pt is reporting dark thoughts/dreams about stabbing people, strangling/or being strangled by police. Call MD	X 341		

ADHS LICENSING SERVICES

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X 341	Continued From page 5 on call orders received...F/U (with) psych in AM..." An RN recorded a telephone order from PA-C # 2 on 4/10/14 at 1630: "...PCA (Patient Care Assistant) for safety 24 (hours)...." On 4/10/14, at an undetermined time, an RN completed a Suicide Risk Scale for Pt # 1, rating the patient as a "Medium" risk (score 7). On 4/10/14, at an undetermined time, MD # 1 completed a Suicide Risk Scale for Pt # 1, rating the patient as a "Low" risk (score 5). Pt #1's medical record did not contain any further Suicide Risk Scales completed after 4/10/14. On 4/11/14, at 0230, an RN documented: "...Pt became agitated when he realized that the 1:1 would be with him constantly...Pt insisted that his comments were 'taken out of context' and he would leave AMA (Against Medical Advice) if he was forced to have a 1:1. Provider on call was informed of pt's comments and insisted on continuing the 1:1 until evaluated in the morning...current 1:1 reminded him of someone that had hurt him...A different 1:1 was brought to...The pt expressed gratitude and apologized to staff...fell asleep on couch...2200...went to bed...SRS = 7 (Suicide Risk Scale)...." The medical record did not contain the completed scale. On 4/11/14, at 0700, an RN documented: "...Risk Factors...Self Harm...AMA Risk...Patient continues with 1:1 for safety...." On 4/11/14 at 1210, the patient completed a "Daily Patient Feeling Sheet": "...Sad/Hurt/Pain...Anger...Lonely...Shame...Guilt...Fear..." He rated his depression a "10" with 10 being the worst depression. He marked	X 341		

ADHS LICENSING SERVICES

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X 341	Continued From page 6 "Nightmares" for description of his sleep "last night." On 4/11/14, at 0830, an RN recorded a telephone order from MD # 1: "...continue with 1:1 over the weekend. Continue to maintain in...over the weekend. Re-evaluation on Monday...." On 4/12/14, at 0230, an RN documented: "...Pt...disruptive and agitated...1:1 is in constant observance...." On 4/12/14, the Daily Nursing Assessment for the 1st Shift contained documentation that the patient was poorly groomed, his thoughts were tangential, incomplete at times and scattered, his gait was steady, he was agitated at times, angry, and his affect was inappropriate at times, anxious and irritable. Risk Factors included Self-Harm and AMA Risk and Signs and Symptoms of Detox. The Daily Nursing Assessment for the 2nd Shift contained documentation that the patient was well-groomed, his thoughts were tangential, scattered and he had difficulty concentrating; he was agitated, angry, his affect was inappropriate, anxious and irritable. Risk Factors included Signs and Symptoms of Detox, Self-Harm and AMA Risk. On 4/12/14, at 0800, MD # 1 recorded an order: "...PCA during waking hours only. Discontinue when pt goes into room to sleep. Restart in AM at 0700...." On 4/12/14, at 2200, MD # 1 documented: "...Pt was agitated, anxious and irritable. Repeatedly asked for medications...seen arguing with his mother on the phone multiple times...Pt Denies thought of self harm and not SI (Suicidal Ideation)...."	X 341		

ADHS LICENSING SERVICES

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X 341	Continued From page 7 The patient's medical record contained documentation that he had never admitted to suicidal ideation or thoughts of self-harm. He had rated high and/or very high risk for suicide due to other factors. The medical record did not contain documentation by nursing or medicine of the status of his "dark thoughts" or reassessment of his suicide risk other than thoughts of self-harm or suicidal ideation when the 1:1 was discontinued during the night. On 5/8/14, the Director of Patient Services confirmed that a Suicide Risk Assessment was not required when a patient's 1:1 is discontinued. She confirmed that nursing had documented on the Daily Nursing Assessment for the 2nd Shift on 4/12/14, "Risk Factors" which included "Self-Harm" and "AMA" and the MD discontinued the 1:1 during the night.	X 341		
X 343	R9-10-207.A.3. Medical Staff R9-10-207. Medical Staff A. A governing authority shall ensure that: 3. A medical staff member complies with medical staff bylaws and medical staff regulations; This RULE is not met as evidenced by: Based on review of the Bylaws of the Professional Staff Organization (PSO), credential file, medical record and interview, the Department determined that PA-C # 2 failed to comply with the medical staff bylaws as evidenced by giving orders to admit Pt # 1. Findings include: Review of the Bylaws of the Professional Staff	X 343	Medical Staff Bylaws were reviewed and revised allowing a Physician Assistant (PA) and Nurse Practitioner (NP) to provide admission orders consistent with their licensed scope of practice and/or Supervision and Delegation Agreement with a physician member of the Professional Service Organization (PSO), as applicable. The Bylaws were sent to committee and approved. Implementation occurred beginning August 5, 2014.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 343	Continued From page 8 Organization (PSO) of the facility revealed: "...the clinicians practicing at (name of facility) do so in conformity with these bylaws...The Purpose of These Bylaws Shall Be:...To ensure that members of the PSO will exercise only those clinical privileges they are privileged for...Delineation of Core Medical Management privileges...All non MD/DO practitioners who are granted core privileges will be referred to as 'Attending physician's designee' and will be assigned to a specific patient by an order from the attending physician...person with this privilege may: Admit (MD/DO only) diagnose, treat and discharge patients with medical disorders...provide History and Physical evaluations...." Review of PA-C # 2's credential file revealed that his privileges included "Core Medical Management Privileges." Review of Pt # 1's medical record revealed: An RN recorded admission orders via telephone for Pt # 1 from PA-C # 2 on 4/9/14 at 1650. Review of the pre-printed Admission Orders form revealed "...Admit to Attending Provider: (blank)...Diagnosis...Allergies...Date of Birth... (check) to indicate physician has ordered..." The RN placed a check mark in several boxes, indicating the PA-C's admission orders for Pt # 1. Physician # 3, the facility Medical Director, stated during interview conducted on 5/8/14, that he believed that when PA-C # 2 gave admission orders to the RN, that he was not admitting the patient. He stated that the physician "approval" of Pt # 1 for admission documented on a form by the employee who completed the patient's intake assessment, was admission of the patient. He	X 343		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SH3764	A. BUILDING: _____ B. WING _____	05/08/2014

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X 343	Continued From page 9 stated that this approval process was the admission order. He confirmed that this employee was not a nurse. Review of the Rules and Regulations of the Professional Staff of the facility revealed: "Verbal orders/telephone orders May only be accepted by a Nurse LPN or RN...." Physician # 3 confirmed during interveiw conducted on 5/8/14, that if the "approval" for admission was considered to be admission of the patient, only a nurse could record that "approval". He also confirmed that the Medical Staff Bylaws do not allow a non MD/DO to admit a patient. He confirmed that PA-C # 2 gave admission orders for Pt # 1.	X 343		
X 722	R9-10-214.C.14. Nursing Services R9-10-214. Nursing Services C. A nurse executive shall ensure that: 14. A registered nurse assesses, plans, directs, and evaluates nursing services provided to a patient; This RULE is not met as evidenced by: Based on review of medical record, direct observation, and staff interview, the Department determined that the nurse executive failed to ensure that a registered nurse measure, assess and record the patient's vital signs as required by physician orders for 1 of 1 patient who was found unresponsive and required cardiopulmonary resuscitation (Pt # 1). Findings include:	X 722	All nursing staff received additional training May 2014 by the Director of Patient Care Services and the Assistant Director of Nursing on the Detoxification protocols and orders which include frequency and documentation requirements pertaining to vital signs. The Assessment, Stabilization and Discharge from Special Hospital (Desert Flower) Policy was revised to specify the vital sign time intervals for both detoxification and non-detoxification patients on the Special Hospital unit (attached). Nursing staff was trained on October 7, 2014 by the Director of Patient Care Services on these revisions. A separate Vital Signs Policy has been written and implemented (attached). On a nightly basis, compliance with the detoxification vital signs signs policy is	

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X 722	Continued From page 10 Review of Pt # 1'a medical record revealed: On 4/9/14, at 1650, an RN recorded Admission Orders, received from PA-C # 2 via telephone. A mark was placed in the "Yes" box for: "...FOR PATIENTS WITH DIAGNOSIS OF OPIATE, SEDATIVE HYPNOTIC, AND/OR ALCOHOL DETOX:...." A circle was placed around the following: "...a. Vital signs including CIWA/COWS every 4 hours and PRN while in M.A.S (Medical Assessment and Stabilization)...." During his hospitalization, Pt # 1 was placed on the "Opiate Detoxification Protocol Using Suboxone". An RN recorded Pt # 1's vital signs on 4/12/14, at 1930. Blood Pressure (BP): 142/81, Pulse (P): 98 and Respirations (R): 18. On 4/12/14, at 2200, an RN documented: "...COWS = 14. VS (Vital Signs) BP 142/81; HR (Heart Rate) 98; R 18. (Same findings as recorded at 1930). The Night Shift Supervisor confirmed, during interview conducted on 4/23/14, at 0900, that s/he entered Pt # 1's room at 0130 on 4/13/14, and observed the patient leaning up against the head board with his eyes closed. She stated that she was unable to observe the patient's color, but his breathing appeared "normal." Nursing did not measure and/or record Pt # 1's vital signs at that time. An RN recorded a late entry on 4/14/14, at 1430: "...4/13/14 0400 Late Entry-Patient seen in his room and his bed sleeping. Chest seen rising and falling with each breath. Audible breathing heard...." The RN did not measure and/or record Pt # 1's vital signs at that time.	X 722	monitored. Data is analyzed on a weekly basis by the Director of Patient Care Services and/or the Assistant Director of Nursing (DON). Action(s) to address patterns of non-compliance will be identified and implemented. Findings will be reported quarterly to the Quality Committee.	

ADHS LICENSING SERVICES

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X 722	Continued From page 11 Direct observation conducted on 5/8/14 revealed that the patient rooms are dark with the drape drawn and the lights off. The distance from the nurses' station to the foot of Pt # 1's bed is approximately 20 feet. The Clinical Technician at the nurses' station on 5/8/14, confirmed that the drape was closed and Pt # 1's room was dark on the morning of 4/13/14. The RN assigned to Pt # 1 on 04/13/2014 at 0700, confirmed during an interview conducted on 04/23/2014, that she first observed Patient #1 in his room from the nurses' station. She entered the patient's room at 0800. The patient was facing the window and replied "No" when asked to "go to the vital sign chair" and take medications. The patient was found at 0845, "clammy, with pale skin, and moist shiny phlegm around his mouth; breathing was like a snore." The PCA 1:1 sitter verified in a phone interview conducted on 04/24/14, that the light had not been turned on in Pt # 1's room until 08:45 a.m. when the patient was found unresponsive. An RN documented on 4/13/14 at 1000: "... Patient received in bed - color natural, respirations easy. Skin appeared natural when first saw -when door opened by 1:1. Patient rechecked at 0845...As refused assessment at approximately 0800. Patient had declined at that time -When checked at 0845 - patient head elevated, color pale, sounded as he was snoring - 1:1 appeared to be sleeping - tried to awaken patient by sternal rub, after saying loudly (pt's name). 1:1 helper roll (sp) patient on side as I called for help - 911 called by CSS - supervisor RN now present with medical provider (PA).	X 722		

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X 722	Continued From page 12 Small amount white phlegm wiped from mouth. VO (verbal order) stat Narcan 0.4 mg. Paramedics on scene - had CSSA make copies of patient MAR (medication administration record) - demographics H&P and psych evaluation, which I handed to paramedics while obtaining Narcan for injection patient transferred to floor - patient given Narcan 0.4 mg IM R deltoid - while patient receiving chest compression and ambu bag from RN and medical provider. Paramedics now present - and took over emergency care. Call placed to patient's mother (name) for update that patient transferred to (name of local hospital) for treatment for unresponsiveness. Treatment team alert notification - to treatment team by supervisor - was done at 0915...." The Director of Nursing confirmed, during an interview conducted on 04/23/14, that nursing did not assess Pt #1 or measure and record Pt #1's vital signs from 1930 or 2200 on 04/12/14, until the patient was found unresponsive at 0845 on 04/13/14. She acknowledged that the staff did not follow physician's orders for measuring/recording vital signs every 4 hours. The Director of Nursing also confirmed that the facility does not have a policy/ procedure for vital signs, specifically to identify which vital signs to measure and record. Pt # 1's medical record did not include measurement of pulse oximetry with any documentation of vital signs prior to those recorded on 4/13/14 at 0845.	X 722		
X 724	R9-10-214.C.16. Nursing Services R9-10-214. Nursing Services C. A nurse executive shall ensure that: 16. Nursing personnel document nursing services	X 724	Policy MS 0002 "Suicide Risk Assessment and Management" was reviewed and revised by the Clinical Committee. It was determined the Beck Hopelessness Scale and Suicide Risk Assessment tools would be utilized to	

ADHS LICENSING SERVICES

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X 724	Continued From page 13 in a patient's medical record. This RULE is not met as evidenced by: Based on review of hospital policy/procedure, medical record and interview, the Department determined that the nurse executive failed to ensure that an RN implement the Suicide Risk Assessment and Management policy/procedure for 1 of 1 patient who scored as "Very High" risk on his initial Suicide Risk Assessment (Pt # 1). Findings include: Review of the hospital policy/procedure titled Suicide Risk: Assessment and Management revealed: "...It is the policy of (name of hospital) to assume that all patients/clients admitted are capable of self-harm. As part of the continuing assessment for self-harm, staff will administer an Initial Suicide Risk Scale...as part of the admission evaluation process. Management of suicide risk will be based on the clinical factors determined in the assessment and reassessment process of the patient...throughout the treatment stay. These will include but not be limited to the Initial Suicide Risk Scale, the BDI-II (Beck Depression Inventory-II, and the Beck Hopelessness Scale (BHS)...At admission, the Nurse will complete all sections of the Suicide Risk Scale as part of the nursing assessment process. If the nursing assessment identifies any immediate suicidal risk, a Medical Provider will be notified to obtain safety orders...If the patient's Suicide Risk scale (SRS) is 10 or greater on admission the nurse will administer the BDI-II, and BHS tests, score them and report findings to the Medical Provider...The Nurse will activate High Risk for self-harm on Problem List and Initial Treatment Plan...If the score is 13 or greater the patient will be placed on a one-to-one (1:1)	X 724	assess a patient's suicide risk. A significant change in a patient's status requires a reassessment of the patient's acuity and safety risk. The medical provider, clinician or nurse will reassess the patient using the Beck Hopelessness Scale (BHS) and the Suicide Risk Assessment (SRA)and document the results in the patient record. When the clinician completes the BHS and SRA the nursing team is responsible for reviewing the tools and contacting the medical staff member to review the change in a patient's condition. The medical staff member is responsible for determining the frequency of observation required based on the nurses assessment and clinical judgement. Additionally, reassessment of the patient's condition is required each shift; the Nursing Daily Assessment/Progress Note form was revised to include a section for documentation of the reassessment. All clinical staff including nursing staff was trained in May and June 2014. Training on Suicide Risk Assessment and management and the Beck Hopelessness Scale is also part of new employee orientation. Compliance with the policy Suicide Risk Assessment and Management is included as part of the nightly chart audits conducted by the nursing department. Results of the audits are sent to the Assistant DON who is responsible for reviewing, analyzing and determining if any corrective action plan is needed, which may include retraining and/or disciplinary action. The findings are reported quarterly to the Quality Council where further actions or corrective plans may be identified.	

ADHS LICENSING SERVICES

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X 724	Continued From page 14 observation until a face-to-face psychiatric evaluation is completed, unless the Provider orders otherwise...." Review of Pt # 1's medical record revealed: An RN completed the Nursing Admission Assessment on 4/9/14, at 1620. An RN recorded Admission Orders on 4/9/14, at 1650. The RN received the admission orders via telephone. An RN completed an RN Admission Summary and Note on 4/9/14, at 1800. An RN completed a Suicide Risk Scale on 4/9/14, at 1900. The RN recorded Pt # 1's total suicide risk score as 13 and circled: "13-20 Very High." Pt # 1's medical record did not contain documentation that the RN administered the BDI-II or the BHS as required. The patient's treatment plan did not contain documentation of the patient's high risk for self-harm as required and the hospital could not provide documentation that the patient was placed on one-to-one observation until a face-to-face psychiatric evaluation was completed, as required. The medical record did not contain documentation that the RN notified the provider of Pt # 1's score. The medical record did not contain orders which addressed the patient's need for observation on 4/9/14. The Director of Patient Care Services confirmed during an interview conducted on 5/8/14, that Pt # 1's treatment plan did not contain the required documentation of his High Risk for self-harm and that he was not placed on one-to-one observation as required. She stated that a decision had been made to discontinue the BDI-II and BHS. She confirmed that she was unable to provide documentation that the BDI-II and BHS were no longer necessary if a patient's Suicide Risk Scale was 10 or greater on admission. She confirmed	X 724		

ADHS LICENSING SERVICES

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X 724	Continued From page 15 that nursing did not follow the faciltiy's policy/procedure.	X 724		

Sierra Tucson

Policy/Procedure:	Major Medication Interaction Protocol			Page:	1 of 4
Policy Number:	PH1025	Origination:	11/03/92	Revised:	10/9/2014
Reviewed:	03/04/02, 06/14/04, 07/20/04, 10/27/04, 07/22/08, 03/25/11; 09/24/14; 10/7/14				
Department Author:	Pharmacy			Scope:	All Staff
Approved By:	Philip Herschman, Ph.D.				

POLICY

It is the policy of Sierra Tucson to identify a list of medication combinations and/or classes of medications in use that may result in undesirable patient outcomes, and to inform Medical Providers of specific and identifiable interactions.

It is also the policy of Sierra Tucson to review quarterly by the Medical Director and the Pharmacy and Therapeutics Committee the "Major Medications Interaction List" with Pharmacy Services assistance.

THIS POLICY APPLIES TO SPECIAL HOSPITAL.

PROCEDURE

1. After reviewing each new order during regularly scheduled pharmacy hours, if a major medication interaction (as defined by the Major Medication Interactions List) is identified, the pharmacist will notify the patient's Medical Provider. The communication will be documented using the Medical Provider Notification Form, and placed in the patient's chart.

2. Any orders received after pharmacy hours will be reviewed by the nurse against the Major Medication Interaction List. If the new order falls into any of the categories outlined in the Major Medication Interaction List, the nurse will consult with the on-call pharmacist. This communication will be documented in the nursing progress notes.

MAJOR MEDICATION INTERACTION LIST

Based on medications in use at Sierra Tucson, the following list of medication combinations and/or classes of medications are recognized as having the potential to cause major medication interactions that may result in undesirable patient outcomes.

Should a Pharmacist identify the following medication combinations and/or classes of medications when reviewing new orders against the patient's medication profile, he or she will notify the patient's Medical Provider. The communication will be documented by the Pharmacist using the Medical Provider Notification Form.

The Medical Provider documents acknowledgement of the communication on the "Medical Provider Notification" form and returns the form to the Pharmacy. The form is placed in the patient's chart at the time of discharge.

The major medication interaction list includes the following medication combinations and/or classes of medications:

- Buprenorphine and one or more other CNS depressant medications
- Ketorolac and any other NSAID
- Two or more medications that may increase QTc interval
- More than one scheduled opioid medication
- More than two benzodiazepines and/or hypnotic medication
- Two or more antipsychotic medications

Reference: Major Medication Interactions List
Medical Provider Notification Form

MAJOR MEDICATION INTERACTION LIST

Any orders received after pharmacy hours will be reviewed by the nurse against the Major Medication Interaction List.

If the new order falls into any of the categories outlined in the Major Medication Interaction List, the nurse will consult with the on-call pharmacist.

This communication will be documented in the nursing progress notes.

MAJOR MEDICATION INTERACTION LIST
Buprenorphine and one or more other CNS depressant medications
Ketorolac and any other NSAID
Two or more medications that may increase QTc interval
More than one scheduled opioid medication
More than two benzodiazepines and/or hypnotic medication
Two or more antipsychotic medications

The Medical Provider will be responsible for educating the patient on any medications prescribed.

The nurse will identify the labeled medications and provide education to the patient before the initial dose has been administered. The nurse will document this education.

MEDICAL PROVIDER NOTIFICATION FORM

Patient: _____ Med Record #:_____ Lodge: _____

Medical Provider: _____

UPON REVIEW OF THE ABOVE PATIENT'S MEDICATION PROFILE, THE FOLLOWING MEDICATION-RELATED CONCERN(S) HAVE BEEN IDENTIFIED:

☐ Drug-Drug Interaction(s) ☐ Allergy/Disease-related concern

☐ Other: _____

Medication(s) Involved:	

Medication(s) Involved:	
Type of Contact:	☐ Verbal Communication ☐ Telephone Call ☐ Left Voice Mail message - **Please contact pharmacy at x7997** ☐ E-mail

Pharmacist Name: _____Signature:_____Date: _____
Time: ____

I acknowledge having received this medication-related communication: ☐

Medical Provider Name: _____Signature:_____Date: ___
Time: ___

Additional Notes:	

RETURN SIGNED FORM TO PHARMACY

Sierra Tucson

Special-Hospital Policy/Procedure:	**Assessment, Stabilization and Discharge from Special Hospital**			**Page:**	1 of 3
Policy Number:	NR 1046	**Origination:**		**Revised:**	10/9/14
Reviewed:	05/11/99, 02/25/03, 03/18/03, 03/27/03, 10/27/04, 07/22/08, 03/25/11; 9/16/14; 10/1/14; 10/6/14				
Department Author:	Susan Menzie			**Scope:**	All Staff
Approved By:	Philip Herschman, Ph.D.				

POLICY

It is the policy of Sierra Tucson that all new patients who meet criteria for Special Hospital (Desert Flower Hospital) will be admitted to the Medical Assessment Stabilization (MAS) Unit. The following assessments will be conducted while patients are in this area: 1) Nursing Assessment and AIMS {Abnormal Involuntary Movement Scale}; 2) Suicide Risk Assessment; 3) History and Physical; 4) Psychiatric Evaluation

THIS POLICY APPLIES TO SPECIAL HOSPITAL.

PROCEDURE

1. The Nursing Assessment, History & Physical, Psychiatric Evaluation and Patient History will be completed within the first 24 hours of the patient's hospitalization. The patient will be asked to complete a psychosocial assessment form within 48 hours and will give the completed form to their primary therapist.

2. The initial evaluations shall include information necessary to ascertain the patient's medical and psychological status. The relevant information will be summarized in the History and Physical, the psychiatric evaluation and the Special Hospital Initial Treatment Plan.

3. Other assessments completed in the first days of treatment may include a Nutritional Assessment, Therapeutic Recreation Assessment and a more in-depth Psychological Testing & Evaluation.

4. Patients who are in detox will be assessed at a minimum by nurses every four (4) hours. Assessment includes evaluation and documentation of patient's CIWAS/COWS, pulse, respirations, and blood pressure. Temperatures and Pulse Oximetry are evaluated based on nurse's assessment of the patient's condition and documented in the patient clinical record.

5. Non-Detox patients will have vital signs completed and documented, including pulse, respirations, blood pressure and temperature, a minimum of once daily and PRN based on the nurse's clinical judgment in collaboration with the medical provider. Pulse Oximetry is evaluated based on nurse's assessment of the patient's condition.

For additional information, please reference Special Hospital Policy Number NR 1047 VITAL SIGNS.

6. Appropriate DFH staff will monitor patients while in DFH as follows:
   A. Hourly checks of each patient on the unit are conducted and documented in the patient clinical record.
   B. The implementation and frequency of Safety/Support Check-ins, conducted by the nurse are determined by the acuity of the patient and the nurse's clinical assessment, in collaboration with the medical provider and are documented in the patient clinical record.

Guidelines for Discharge to Residential/Level II Program from DFH

The discharge to Residential occurs upon completion of an evaluation by a medical provider to determine the appropriate level of care

The evaluation by the medical provider includes suicide risk and rationale for discharge to the Residential Level of Care.

The Medical Provider will write orders to complete the discharge from DFH.

A Medical Discharge Summary – Special Hospital is completed.

A Primary Therapist, treatment program and attending Medical Provider will be assigned to all patients discharged to Residential.

Guidelines for continued care in DSH

If the patient exhibits the following clinical criteria they will be kept in DFH until they are medically and psychiatrically stable for transfer to the Residential/Level II program: "

   A. Intoxication
   B. Clinically fragile or unstable (cognitively, behaviorally, physiologically, socially, psychiatrically) such that they are not able to participate effectively within Residential/Level II patient community
   C. Suicide Risk requiring 1:1-arms distance level of observation
   D. Active Detoxification and prescribed a detoxification protocol

Additional Guidelines for remaining on continued care in DFH include:

1. Medically unstable
   A. Acute physical illness or disability
   B. Medical condition that requires every four (4) hour or more monitoring.
   C. Medication stabilization
2. Psychiatric instability (i.e., suicidality, homicidality, psychosis, patient fear, etc.)
3. Inability to meet demands of program schedule due to fatigue or low energy level.

Sierra Tucson

Special-Hospital Policy/Procedure:	Vital Signs			Page:	1 of 2
Policy Number:	NR1047	Origination:	10/08/2014	Revised:	
Reviewed:					
Department Author:	Roseann Mollica, Quality/Risk			Scope:	All Staff
Approved By:	Philip Herschman, Ph.D.				

POLICY

It is the policy of Sierra Tucson to provide for best practices in evaluating current physical functioning of patients. Vital sign monitoring can be an indication of health, ill health or clinical deterioration.

Vital signs indicative of physiological instability or ineffective response to treatment orders and/or protocols must be immediately reported to the medical provider.

At no time does the Policy supersede the execution of additional medical regimens and/or the provision of nursing care supportive to or restorative of life and well-being.

When vital signs are refused by the patient, medication(s) as applicable are held and the medical provider is notified. Documentation of all actions and responses are made in the Medical record.

When refusal of vital signs by the patient prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.

For patients undergoing detoxification, vital signs of pulse/heart rate, respiratory rate and effort, and blood pressure are routinely and consistently monitored and documented at a minimum by nurses every four hours.

Temperature, CIWA, COWS, pulse oximetry, pain assessment, and level of consciousness may be additional parameters for evaluation by the nurse based on the patient's condition and/or by medical provider order.

It is expected that more frequent evaluation of vital signs may be necessary to assist the drug- or alcohol- intoxicated or dependent patient through the period of time necessary to eliminate, by metabolic or other means, the presence of the intoxicating substance or dependency factors, while keeping the physiological or psychological risk to the patient at a minimum.

For non-detoxification patients, vital signs are to be completed by the nurse and documented a minimum of once daily and PRN, based on the nurse's clinical judgment and/or in collaboration with the medical provider. Vital signs include temperature, pulse/heart rate, respirations and blood pressure. CIWA, COWS, pulse oximetry, pain assessment, and level of consciousness may be additional parameters for evaluation by the nurse based on the patient's condition and/or by medical provider order.

THIS POLICY APPLIES TO SPECIAL HOSPITAL.

PURPOSE

To implement standardized practices for consistently measuring, recording and assessing vital signs.

PROCEDURE

1. The vital signs policy will be reviewed during orientation with employees hired and assigned to Desert Flower Hospital (DFH).

2. Employees transferring to DFH will have the vital signs policy reviewed with them as part of the orientation program.

3. Vital signs for those patients undergoing detoxification will be documented in the patient's permanent Medical Record every four hours, at a minimum.

4. If clinically indicated, vital signs shall be taken as often as necessary as part of the medical regimen to keep physiological risk to the patient at a minimum. All vital signs are documented in the patient's Medical Record.

5. Vital signs shall be communicated as part of the nursing report to Medical, nursing, and support staff, as clinically appropriate, and in the judgment of the professional nurse.

6. The Medical Director and the Director of Nursing will ensure compliance with the established Policy.

SIERRA TUCSON

October 10, 2014

ADHS
Agency Business Office
Received OCT 14 2014

Arizona Department of Health Services
Bureau of Medical Facilities Licensing
Connie Belden, R.N., Bureau Chief
Linda Ettenborough, R. N., Team Leader
150 North 18th Avenue, Suite 450
Phoenix, Arizona 85007-3242

Re: Sierra Tucson, Inc.
State License Number SH3764

Dear Ms. Belden and Ms. Ettenborough,

This correspondence is in response to the survey conducted at our facility on May 8, 2014. Enclosed is our Plan of Correction along with supporting documentation as requested by your office. For your convenience, changes to our policies are highlighted.

Please do not hesitate to contact me if you have questions. I can be reached at 520-624-4000, extension 2357.

Sincerely,

Philip L. Herschman, Ph.D.
Executive Director
Sierra Tucson

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SH3764	A. BUILDING: _____ B. WING _____	R 10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA TUCSON, INC	39580 SOUTH LAGO DEL ORO PARKWAY TUCSON, AZ 85739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{X 000}	INITIAL COMMENTS Based on an acceptable plan of correction submitted to the Arizona Department of Health Services on 10/17/14, no onsite survey was conducted for the State Complaint Investigation survey, Event # 7Y3K11. _____ ADHS Representative Date	{X 000}		

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