Appendix II: Exhibits

Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities

A Senate Committee on Finance Staff Report

June 12, 2024

UHS-FINHELP-00002463 [Redacted]

THE CROSSINGS BEHAVIORAL HEALTH

RESIDENTIAL

TREATMENT CENTER PROGRAM HANDBOOK

The Crossings

at Alliance Health Center

INFORMATION FOR PARENTS/GUARDIANS AND

CROSSINGS RESIDENTIAL TREATMENT CENTER

OVERVIEW

Welcome to the Residential Treatment Center (RTC) at the Crossings. The purpose of the handbook is to introduce you to our staff here and to our program rules and expectations and also to give you the information needed to succeed here. You probably are angry about being placed here and may not feel that you need treatment. Talk to us about these feelings and do your best in the program and you will benefit and possibly enjoy your stay at The Crossings.

Our program is designed to prepare teens who have a history of severe emotional, behavior and/or family problems to succeed in a group home or family type placement such as foster care or placement back with biological family. The program operates around a schedule of activities and events that helps you gain the skills you need to succeed.

The staff at The Crossings, believe in some important values that we feel you should know about. We hope that you will come to believe in them as well.

TEAMWORK-We encourage everyone involved in your treatment to work together so that you can get the most from our program.
HOPE- We sincerely believe in you. We believe that you can achieve good or positive things in your life. We want to encourage you to never give up hoping for improved relationships with family (whether that is biological family or a foster family), friends, teachers, and other authority figures.
PERMANENCE- There is a permanent positive, placement out there for you and we are dedicated to helping you get there.
SELF-ESTEEM- We feel good about the job we do and enjoy working with our residents. We like helping kids realize their potential and go on to do well in other placements, including school and college
RESPONSIBILITY- We will perform our jobs to the best of our ablilities, even if you choose not to do your best.
RESPECT- We will try to keep safe your rights and confidentiality, praise your progress, confront your problems and focus on you and your needs. We won't yell at you, disrespect you or otherwise mistreat you. (see detailed rights posted on unit.)
BOUNDARIES- We will act like adults and give you the chance to develop your talents, set your goals and grow in positive ways. We don't expect you to be perfect. We want you to enjoy being a kid.
EMPATHY- We care about the problems you and/or your family have faced. We hopethat you are able to tell that we are concerned for you and understand that you need to work on some problem areas.
SAFETY- Your safety is our number one concern. We will maintain a safe enviroment in which you can hopefully face and work through difficult problems.

PERSONAL BELONGINGS- WHAT TO BRING

Items you must have:

- •Toothbrush
- •Toothpaste
- •Shampoo
- •Deoderant (No aerosol)
- •Name Written in all clothing
- •Dryer sheets
- •Swimsuit
- •Gym clothes
- •Casual clothes (appropriate to the season-5 to 7 changes)
- •Stamps & Stationary

We will provide essential personal hygiene items to those residents who do not have them. We will encourage your DHS social worker to provide you with these items or send money adequate for clothing/shoes and personal hygiene.

Optional Items: • Hair care supplies
(1 each:mousse, gel, oil and conditioner)
•Non-aerosol, non-alcoholic hair spray
•Blow dryer
•Floss
•3 to 4 toys (labeled).

•Items permitted on Level III

•Minimal make-up (girls only)
•Minimal Jewelry

Items Not Allowed: •Wire coat hangers •Glass items •Razors of any kind •Cell phones •Food •Plastic bags •Lighters •Toxic substances i.e nail polish Or nail polish remover •Mirrors

Note: You are responsible for personal items, including jewelry, in your possession. We are responsible for items kept in restricted area. We encourage you not to have expensive items here. Send them home. There is no need to have cash or to keep money in your room. Turn it in, and it will be kept for you. Video games, MP3, radios or other toys cannot be in your room except on weekends during free time, or during designated times such as holidays when school is out.

WHAT TO TAKE AWAY FROM HERE

Besides the values mentioned above, we hope to teach you several "life skills." These are the tools you need for success in your next placement. These include managing your feelings (identification, ownership, processing), good decision-making, learning positive behavior, anger management, conflict resolution, appropriate communication skills (assertiveness) and refusal skills or "learning to say no"(for drugs, alcohol, violence). You will be given an opportunity to learn about these skills, and we will help you be able to use them.

LENGTH OF STAY

You must be asking, "What do I have to do to get out of here?" To complete our program, you must achieve Program Level III and then hold it four (4) consecutive weeks, **PLUS** complete your treatment plan goals. You can complete the program in three-four months if you work hard. Normal stay is six to seven months. It may be in your best interest to stay longer, if you are waiting on your placement to be arranged or need to finish a school term here.

RTC STAFF AND THEIR ROLES

PSYCHIATRIST- A doctor who leads your care and treatment team. The doctor will prescribe medications if needed to help you. **Your doctor while at The Crossings is Dr. [redacted] Dr. [redacted] will also see you on the week Dr. [redacted] does not. She can also discuss with you any concerns related to medications or medical concerns**

PSYCH TECH- the staff that works directly with you throughout the day and night, monitoring your progress and behavior. They typically will be the staff who redirect you and document point loss when you do not follow the rules. There will be a psych tech supervisor also working each shift that you can go to if you do not agree with the consequences given to you by a staff member or if you feel you have been unfairly treated by a psych tech. The psych tech supervisorts for each shift are:

[redacted] 7A - 3P & 11P - 7A shift
[redacted] 7A - 3P - M-F
[redacted] w/e - various shifts - every other w/e
[redacted] 3P - 11P

[redacted] relief supervisor
[redacted] relief supervisor
At times there may be other staff who supervise when needed

THERAPIST- Meets with you to help you identify and work through personal and family problems in a positive way. With your assistance your therapist should set treatment goals and evaluate every month if you made the goals set in your treatment plan. Your therapist serves as the point person for establishing and maintaining contact with your family, the court, DHS, etc. If you would like a copy of your treatment plan please ask your therapist for a copy.

RN or LPN- Nurse who carries out the doctor's orders for any medical problems, gives you your medications, educates you about health issues, and supervises psych tech staff. [redacted] is the director of nursing. She will take care of scheduling your outside doctor appointments, complete your admission paperwork and listen to day to day concerns you might have.

PROGRAM DIRECTOR- Supervises all staff and makes sure that the program fulfills its goal to help you get on the right track. **The program director at The Crossings is** [redacted]

TEACHER- We are set up as a special, non-public school. You will be in classes with a certified teacher and 10-12 other residents. [redacted] **is our school principal and Mrs.** [redacted] **is our Special Education Coordinator. School is year round with time-off for holidays. Typical school hours are 8:30 AM - 3:30 PM**

Other therapist/staff are involved in your care as well: Occupational Therapy, Ropes Course instructors, Speech Therapy if needed, Substance Abuse Recovery, Recreation and others. If you need special help of some sort let us know, we will work to get it for you.

WHAT IS EXPECTED OF YOU? RESPECT!

We have one basic rule: respect (honor) yourself, peers, staff, family and property. This means you must do your best in all parts of the program, learn to accept praise and criticism and focus on your own issues. Later in this handbook, we will list examples of major and minor violation of this rule, and the consequences for major and minor violations. We expect that you develop the positive attitudes and behaviors (life skills) that ensure success here and in your next (hopefully permanent) placement.

POINTS AND LEVELS

We run a level system. Progressing through the level system is based on earning hourly points from 6a.m. to 10p.m. You may earn up to "four" (4) points per hour. When you go on passes or outings the point system continues. You earn up to 4 additional points an hour when you are in group or individual therapy. The points will be added and divided by the appropriate number of time segments in order to obtain a daily average. Daily averages will be totaled to obtain a weekly average. This will determine what level you are on each week and the privileges that you will receive for that week (see skelton level sheet for explanation of privileges). Entry level has specific assignments which must be completed prior to change in Entry Level status. These assignments include an autobiography, passing a rules test, and attending 90% of all groups during the first week of your stay. Your assignments should be turned in to your therapist to be discussed at treatment team. The following is the score range for each level:

0.0-0.7	Low Score AP Status
0.8-1.7	Level 1
1.8-2.6	Level 2
2.7-3.4	Level 3
3.5-4.0	Level 4

There can be an Optional Daily Group Level if staff feels that a pod is not working together and are not focused on treatment. An average of each community member's daily level will determine the Community Level. The privileges for all the members of that pod will be based on the Community Level

rather than each individual's level. This can assist in higher-level peers pulling together and assisting lower level peers to gain a higher level.
Example: A resident may be on level 3 and have access to Level 3 privileges but the Community Level is Level 2. That Level 3 resident can only access level 2 privileges. Residents will be given a warning prior to being placed on Optional Community Level status in order to give the community a chance to change its attitude and focus before receiving alternative programming.

ALTERNATIVE PROGRAMMING

You will hear the staff use the term "AP". AP stands for Alternative Program. If you cannot manage your behavior and you break certain rules then you will be placed on AP. The following reasons for automatic AP status:

Destruction of Property	Elopment Behavior (running away)
Provoking Peers	Physical Harm to self (cutting)
Cursing	Inappropriate Sexual Behavior

Situations which may call for you being placed on AP could include repeat behaviors such as name calling, using profanity toward peer, intimidating peer, lying, provoking others, sexual rule breaking, stealing, threatening others, or being verbally abusive or cursing peers or adults. These "lesser" behaviors will first result in points loss but if these behaviors continue after being redirected several times then it will result in being placed on AP. AP can be for 2-4 hours initially but may be for as long as 6 hours if offense or behaviors warrants this.

AP PROCESS AND ASSIGNMENTS:

Once you are told that you are being placed on AP the nurse will have you sign a Notice of Intervention, Structure and Exit Criteria Form. Before signing the form the nurse will explain to you why you are being placed on AP, how long you are being placed on AP, what you are restricted from, and what you have to do in order to complete your AP. After this has been explained to you then assignments will be given to you at the beginning of every hour until you have completed your AP. School work assignments will also be provided during your AP time period to assist you in not missing assignments which might affect your class grades. Assignments should be specific to your offense. For example, if you are on AP for racial slurs then you may have to write a 150-word essay on how racism negatively effects people. After the assignment is complete it will be reviewed, by two staff members to decide if your assignment will be accepted. If the assignment is not acceptable then staff will give feedback pointing out how to improve your efforts. In order to go from AP back to regular programming you must complete the time limit set for your AP, complete each assignment given to you each hour, and must earn a minimum of a 2.5 average during the hours of your AP. AP should assist you in gaining knowledge and understanding of your behavior and how it affects others. The purpose of AP is not to "punish" but to reinforce positive ways of dealing with the same behavior which led to your beings placed on AP.

AP hours begin at 8a.m. and end at 8p.m. Therefore, if you are placed on AP in the evening hours it may result in you going to bed at 8p.m. and then completing your AP hours beginning at 8a.m. the next day.

24 HOUR PROGRAM:

In order to keep everyone here safe we must have more tougher consequences for those behaviors which could lead to harm to staff or peers or situations which could cause extreme conflict on your pod. These situations would include:

Threatening to a cause a Disruption on your Pod
Threatening Physical Harm to Staff or Peers
Physical Aggression Directed at Peers
Sexual Contact with a Peer

For these type behaviors a 24 Hour Program will be given to the resident. Once placed on the 24 Hour Program the resident must complete his hourly assignments. The resident is not allowed to talk except to ask staff a question. The resident should raise his hand before speaking and receive permission from his assigned staff member prior to asking his question. Meals will be served in the AP room or pod. Assignments will be given starting at 8:00 AM and ending at 8PM.

3-DAY PROGRAM

This plan is to be used for those residents who have repeated behavioral problems which includes aggressive, demanding and disrespectful behavior or "gang-like" behavior such as planning to "jump" a peer. The following interventions will be used in order to change behavior to allow the resident to learn from his behavior and show that he/she can display appropriate behavior and good decision making skills.

Rules to be Followed:

1. All personal items will be removed from their bedroom except for clothing.
2. Schoolwork is to be brought to the resident to be completed in AP. Work is to be completed in crayon.
3. There will be no participation in activity groups or outside activities.
4. They will receive one monitored five minute phone call with their therapist per week until the conclusion of the intensive intervention.
5. Group participation is allowed based on each individual's behavior. If their behavior is aggressive in nature and/or disruptive to the group then they will not be allowed to participate which will be reflected in their tretment plan.
6. The minimum length of time for intensive intervention once initated will be 3 days.
7. Residents earn "3's" or "0's" during the entire time they are on the 3-Day Program. Their behavior is either compliant or non-compliant.
8. Residents must earn a 2.5 average or higher in order to advance to the next day of the program.

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Course of Action:

Day 1:

- The resident will only be allowed to attend process group (if their behavior warrants) and will go to bed at 8:00 PM. If they are in the isolation room they will be allowed to go to their room at 7:30 PM to take care of their personal hygiene needs prior to bedtime.

Day 2:

- If the resident is compliant with all rules and completes their schoolwork between the hours of 8:00 AM and 3:00 PM then they can go to the cafeteria and pick out their **food for the evening meal but return to eat their meal on the pod. Breakfast and lunch will be brought to the resident by staff and eaten on the pod.** If they are not compliant with the rules and/or do not complete their schoolwork then they continue with Day 1 interventions.

Day 3:

- Resident must have completed Day 2 requirements.
- If the resident continues to be compliant with all rules throughout the school day and completes all schoolwork for the day then they earn the following:
  - ***allowed to go to the cafeteria to pick out meals but return to pod to eat meals**
  - *may attend one activity group during school hours.
  - *may go to dayroom x30 minutes in the evening
  - *At the conclusion of Day 3 if the resident has earned an average of 2.5 or greater than they will have completed their 3-Day Program and will be able to reurn to their normal schedule the following morning.

5-DAY PROGRAM:

This plan is to be used for those residents who have severe repeated behavioral problems which includes aggression directed toward staff, aggressive behavior which is planned i.e. two or more peers working together to harm someone, ongoing aggressive behavior after being placed on a 3 Day Program. The interventions used are the same as for the 3 Day Program.

Rules to be Followed:

9. All personal items will be removed from their bedroom except for clothing.
10. There will be no participation in activity groups or outside activities.
11. They will receive one monitored five minute phone call with their therapist per week until the conclusion of the intensive intervention.
12. Group participation is allowed based on each individual's behavior. If their behavior is aggressive in nature and/or disruptive to the group then they will not be allowed to participate which will be reflected in their treatment plan.
13. The minimum length of time for intensive intervention once initiated will be 5 days.
14. Residents earn "3's" or "0's" during the entire rime they are on the 5-Day Program. Their behavior is either compliant or non-compliant..
15. Residents must earn a 2.5 average or higher in order to advance to the next day of the program.

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Course of Action:

Day 1:

- The resident will only be allowed to attend process group (if their behavior warrants) and will go to bed at 8:00 PM. If they are in the isolation room they will be allowed to go to their room at 7:30 PM to take care of their personal hygiene needs prior to bedtime.

Day 2:

- If the resident is compliant with all rules and completes their schoolwork between the hours of 8:00 AM and 3:00 Pm then they can go to the cafeteria and pick out their food for the evening meal but return to eat their meal on the pod. Breakfast and lunch will be brought to the resident by staff and eaten on the pod. If they are not compliant with the rules and/or do not complete their schoolwork then they continue with Day 1 interventions.

Day 3:

- Resident must have completed Day 2 requirements.
- If the resident continues to be compliant with all rules throughout the school day and completes all schoolwork for the day then they earn the following:
  - *allowed to go to the cafeteria to pick out meals but return to pod to eat meals.
  - *may attend one activity group during school hours.
  - *may go to dayroom x30 minutes in the evening

Day 4:

- Resident must have completed Day 2 and Day 3 requirements.
- If the resident continues to be compliant with all rules throughout the school day and completes all schoolwork for the day then they earn the following:
  - • Meals in the cafeteria with their pod
  - • May attend activity groups
  - • May go to the dayroom x60 minutes in the evening.

Day 5:

- Resident must have completed Day 2, Day 3, and Day 4 requirements.
- The resident may attend school in the AP room
- If the resident continues to be compliant with all rules throughout the school day and completes all schoolwork for the day then they may be re-integrated at 2:30 PM of the 5th day with their peer group.
- All personal items will be returned to the resident at this time.

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SKELETON LEVEL SYSTEM

Alternative Program (AP)	Entry Level	Level One	Level Two	Level Three	
•based on behavioral expectations, requires 15 minute checks. •0.0-0.7 avg. or placed on AP for behavioral consequences	•15 minutes checks •complete assignments •learn rules, autobiography	•15 minute checks •0.8-1.7	•15 minute checks •1.8-2.6	•15 minute checks •2.7-3.4	
Expectation:	Expectation:	Expectation:	Expectation:	Expectation:	
•No phone calls •Meals on Unit •No radio or TV •Cannot vote on unit issues •No magazines •Attends schools •8:00 PM bedtime •No outings with exception of Challenge course group work.	•Attends School •Wears own clothes •Attends all groups •All calls made with therapist present •Meals in cafeteria •No personal music •Can vote on unit issues •No magazines •9:00 PM bedtime	•Attends School •Wears own clothing •May receive one incoming or outgoing call per week •Meals in cafeteria •May have free time •Family visitation: 2 hours on campus •No video games •Voting permitted •No magazine •Library book allowed •9:00 PM bedtime	•Attends School •Wears own clothing •Attends all groups •Game room •May have two incoming or out going calls per week •Meals in cafeteria •Visitation: 3 hours on campus. Can visit on hospital grounds. •No video games •Voting permitted •No Magazines •Library book allowed •CD player w/ headphones in room only •9:30 PM bedtime •May shave w/ staff supervision	•Attends school •Wears own clothing •Attends all groups •Game room •May have three incoming or out going calls per week. •Meals in cafeteria •Visitation:4 hours on campus or 4 hours off campus •Voting permitted •Snack Machine •CD player w/ headphones in room only •Make-up privileges (females only) •10:00PM bedroom	

Increased hours on holidays, all levels are available with therapist and guardian OK. Allowances can also be made for distance and travel difficulties. Watches are OK on all levels, so long as they are worn and used appropriately.
Visitation hours are from 2:00 p.m. to 4:30 p.m.

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LEVELS AND PRIVILEGES

It is worth your effort to earn level promotion. Please note, however, that phone contacts, visits and passes with your family don't have to be earned.

Visits	Saturday & Sunday, 2:00 p.m. to 4:30 p.m. (same for holidays) No Food, No children under 12, No cell phones
Passes	No passes on entry level. All passes must be connected to your treatment plan.

PRIZES

Pod Competitions	Field trip and/or special meal away Level I may attend. No attendance for those owing consequences Or on precaution and awareness. (monthly) Monthly there are low seclusion block parties, low AP block parties, Pod with the cleanest room competitions, etc.

Your treatment plan may have special rewards that apply to you to reward you for progress in treatment. This is usually at the program directors or therapists discretion.

THERAPIES AND ACTIVITIES

Community Meetings- with your pod once a day to get focused on progress and deal with community problems, grievances and special interventions.

Group Therapy- Based on your treatment plan, you will be assignedto one or more of our topic groups:

- •Anger Management
- •Abuse Recovery
- •Feeling Expression
- •Social Skills Training
- •Substance Abuse Recovery/Prevention
- •Criminal Thinking

You will also participate in ROPES course work, Occupational therapy, music and various recreation activities.

Family Therapy- You and your parents/guardian meet with the therapist twice a month. The more involved your family can be in your treatment the more you will get out of our program and the easier the transition back home once you are discharged.

Journal- Your therapist on an individual basis may give you an outline or specific assignments to follow for daily journaling. This is not a diary. Your therapist is expected to check it and discuss it with you. If you lack a jornal outline or assignment, write at least a $^{1}/_{2}$ page about your day.

Life Skills- Group and one-to-one instruction on hygiene, housekeeping,laundry and the like, plus training on the "life skills" for permanent placement (see page 2).

Current Events- Use TV news to learn about our community, nation and world.

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OUTINGS:

Reward Outings Girls- Friday or Saturday Boys- Friday or Saturday	You must not owe restitution
Regular Outings Narcotics Anonymous Weekends-Sports Events, Church	You must not owe restitution

Religious Services- Community church leaders come to our program every Sunday and offer pastoral counseling, gospel singing and study of the Bible. If you want to attend let your psych tech know. If you do not want to attend you will not receive consequences for lack of participation.

Each pod has its own daily schedule. If you have ideas for other activities, let us know. Your input is appreciated.

ASSESSMENTS

To help us understand you, various staff gather information about you and your family

- •Nursing Assessment
- •Physical Exam
- •Academic Placement Exams
- •Occupational Therapy Assessment
- •Urine Drug Screen
- •Psychiatric History and Evaluation
- •Social History
- •Vison and Hearing Screens
- •Admission Lab Work
- •Substance Abuse Evaluation

In addition your doctor may order:

Psychological Testing Psychosexual Evaluation

We reassess your needs and status as appropriate. You help yourself by participating honestly and openly.

MASTER TREATMENT PLAN, DISCHARGE PLANNING AND TREATMENT TEAM REVIEW

Your therapist works directly with you to develop your treatment plan. This official document outlines the steps you must take to advance through the program towad completion of the program, Also, it guides staff efforts to help you. A copy is provided to you, your family and your DHS worker and/or Probation Officer, It is updated monthly, based on a Treatment Team Review. This is a formal, brief meeting you attend, with your psychiatrist, therapist, nurse and other staff. Your family and DHS worker are invited. Your initial "Master Treatment Plan" and subsequent updates will list where we recommend you go to live upon completion of treatment. We begin planning for discharge when you enter the program. If you are involved with Mississippi DHS your treatment plan will be closely coordinated with your ISP (Individualized Service Plan).

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RULES AND CONSEQUENCES

As stated earlier, we expect you to show respect for yourself, peers, staff and property. Our rules apply both when you are here and away. It would be impossible to list all the ways to violate this expectation of respect, but here are some common violations, divided between major and minor. Generally speaking, minor violations are acts of immaturity and irresponsibility, while major violations are acts of defiance and meanness.

DISRESPECT FOR SELF

Major:

- Physical self harm actions (includes piercing)
- Dishonesty (deliberate, intentional), cheating
- Secrecy in matters of major rule
- Giving or exchanging of phone numbers and/or addresses with a peer, visitor or hospital patient, without therapist okay
- Drug/alcohol use
- Inducing vomiting, or otherwise making yourself sick
- Misuse of medication (cheeking, storing, attempting to exchange)

Minor:

- Failure to wear glasses or other prescribe learning aid
- "Off Task" during school, group or any part of program schedule
- "Put Downs" to oneself, self ridicule
- Poor effort during activity, laziness
- Allowing others to misuse or take advantage of you without speaking out
- Tardiness and/or coming to an activity unprepared (i.e. assignments not done, materials not in hand)
- Profanity (verbal or written)

DISRESPECT FOR PEERS

- Violence assaults, sexual/romantic contact
- Threats of harm
- Breaking confidentiality
- Gang talk/involvement/Gang material
- Inciting/challenging peer to break a rule
- Lending/borrowing
- Derogatory, direct name calling/insults
- Dress code violation/hygiene violation
- Sexual talk, romantic/sexual notes
- Horseplay, shadow boxing
- Teasing, bickering
- Interrupting, constant arguing, lack of cooperation with your group or team

DISRESPECT FOR STAFF/FAMILY/ADULTS

Major:

- Threats of harm
- Assaults/Violence
- Interfering in staff's actions with a peer
- Entering Staff work station without permission
- Failure to comply with (obey) a lawful directive (order)by staff in an urgent situation. (you will be warned when you are in such a situation and the directive repeated)
- Theft
- Derogatory, direct name calling

Minor:

- Failure to acknowledge when spoken to
- At RN's station without permission
- Unintentionally exercising a privilege not lawfully earned (intentional would be dishonesty)
- Interrupting, arguing on and on, whining
- Attempting to split or divide adults (i.e. manipulate, play one off the other)

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STOP THINK AND TALK

Prevention of Sexual Activity in Our Facility

STOP –
Sexual Behavior
Respect yourself and others!
Sexual Behavior is not allowed while you are a patient at our Facility.

How can I identify Sexual abuse?
Abuse is being forced to do or accept any unwanted acts of a sexual nature including **touch, threats, or anyone limiting your freedom or ability to ask for help.**

THINK –
Be aware of risks
Patients who engage in sexual interactions.
Are at risk for contracting HIV, sexually transmitted diseases, Hepatitis C or pregnancy.

THINK–
Confirmed threats or acts may be prosecuted with possible civil and criminal proceedings; involvement of local/State police, state agencies, etc.

THINK –
Be aware of peers with poor boundaries
Patients who are **confused or aggressive** may not be able to "stop" when asked -- ask staff for help.

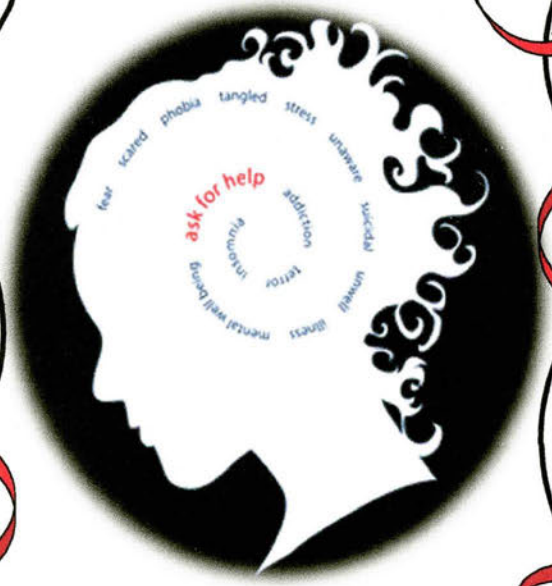
TALK –
Your Responsibility
Report to staff:
- Any verbal physical sexual behavior
- If anyone asks/threatens you to do something you don't want to do.

Roommates
If you are concerned about a peer or your roommate- SPEAK UP!

Focus on Yourself
- Participate in all groups and activities to get the most benefit during your stay.
  - Talk to staff
  - Keep focus on your treatment
- Staff and Patients interactions are treatment focused only

TALK-
How To Get Help?
- Follow unit rules
- Talk to staff if:
- You do not feel safe
- You see/hear something that is unsafe, abusive, or dangerous

How to report threats or intimidating behaviors?
If you feel that you have been abused physically, sexually, or emotionally:
Please notify the unit staff immediately or contact Unit Staff or Patient Advocate



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DISCIPLINE STEPS/CONSEQUENCES

You earn points, levels and graduation by complying with rules and progressing in reaching your treatmet goals. You you're your progress when you fail to do so. The following is the guideline for earning points.

GENERAL CRITIERIA FOR AWARDING SCORES:

SCORE CRITERIA

0 Resident activity resistant to expectations OR demonstrates problematic or disruptive behavior.

EXAMPLE:
- aggression
- destructive to property
- inappropriate interaction with others
- consistent lack of consideration or others
- threats of aggression
- irresponsible behavior

REFUSAL TO: accept feedback, attend scheduled activities, and follow milieu expectations

1. Resident NOT demonstrating problematic or disruptive behavior OR is passively complaint to expectations requiring more than 1 prompt. Resident requires frequent reminders to follow UNIT SCHEDULE or UNIT GUIDELINES.

   EXAMPLE:
   - Cursing
   - Rude Behavior
   - Provoking others
   - Accepts minimal feedback yelling
   - Disruptive behavior minimized responsible behavior
   - Inconsistent in following program expectations
   - Refusal to participate in schedule activities
   - Sarcasm
   - Poor boundaries

2. Resident attempting to comply with expectations, yet having difficulty with consistency (50-60% successful) AND no problematic or disruptive behavior requiring no prompt. Residents requires no reminders to follow UNIT SCHEDULE or UNIT GUIDELINES.

   EXAMPLE:
   - express some empathy
   - generally responsible
   - actively participates in scheduled activities
   - needs prompts to follow expectations
   - needs redirection
   - express feelings well

3. Resident is compliant with expectations while achieving greater consistency (60-91% successful) And no problematic or disruptive behavior requiring no prompts, Residents requires no reminders to follow UNIT SCHEDULE or UNIT GUIDELINES.

   EXAMPLE:
   - sets example for peers
   - establishes realistic goals
   - supportive of others
   - holds others accountable
   - offers feedback to others
   - express empathy
   - demonstrates responsible behavior
   - accepts and uses feedback
   - follows milieu expections without need for prompt

4. Resident is compliant with expectations while achieving greater consistency (99-100% successful) AND no problematic or disruptive behavior requiring no prompts. Resident requires no reminder to follow UNIT SCHEDULE or UNIT GUIDELINES.

   EXAMPLE:
   - sets example for peers
   - offers positive feedback
   - leader in groups and activities
   - consistently accepts and uses feedback
   - supportive of others
   - demonstrates responsible behavior
   - expresses empathy

Restriction to unit means you only go to school and "on unit" activities. Meals will be brought to you:

- •breakfast-cereal, milk and juice
- •Lunch-your choice of meat and two vegetables, bread
- •Supper-your choice of meat, two vegetables, bread
- •snack-same as peers (no snack machine)

If your actions are especially dangerous to yourself or others, you can be removed from the unit to a separate, "time out" are. You return to the unit only when self-control is regained and safety.

It is also the policy of RTC to file legal charges when the violation merits such. We consult with your guardian before taking such action. We also use the brief "time-outs" on the unit, to help you regain self-control. In severe situations, in which a whole team is in

PRECAUTIONS AND AWARENESS STATUS

Precautions and awareness are MD orders which limit your movement. They are for the following situations:

•Assault
•Elopement
•Suicide
•Self Mutilation
•Sexual Acting Out
•Safety
•Seizure

When on precautions, you are limited to the unit, school and family therapy area. Meals will be brought to you. You get a regular tray. Visits must be in the building. On awareness, you may attend activities within the locked areas of the facility.

The doctor must order a change in precaution or awareness status for you, based on your history and situation as you begin the program.
The purpose of precautions and awareness is to focus your attention, and that of staff, on any issues that threatens the safety of you, a peer, or staff. Staff has special duties to complete for those on precaution. Don't joke about issues pertaining to precautions.

RULES FOR SPECIAL SITUATIONS

CAFETERIA

• Wash handsbefore all meals and snacks
• No outside food, in Cafe or on unit, except for birthday cake on your birthday or as part of staff led activity. No special food from family. You must earn a pass and go out to eat with your family.
• No seconds and no dessert at lunch or dinner until you have eaten 100% of one meat, one grain and one vegetable (green salad counts as a vegetable).
• Stay with your group or family in cafe.
• Utensils and food must be used as intended
• No food or drink is to leave cafe, except as prepared by staff for residents not in the cafe's
• Clean up spills, keep volume of talk low: ask for permission to get seconds or put tray up.
• Limit sodas and juice to one glass and one refill, Drink water instead.
• No conversation with other units or groups, without permission of the staff directly supervising you.
• No seconds on desserts.
• Don't waste food. Don't take food you don't intend to eat.

DRESS CODE

• Change clothes in your bathroom, behind closed doors.
• Clothing must be modest and not provocative, with no written or symbolic reverences to gangs, drugs, sex, alcohol, crime, profanity, gore, Satanism or tobacco.
• Shorts and skirts must be 2" inches above the knee or longer
• Shoes must be worn when off the unit, slippers are OK on your hallway, only. You must wear shoes and socks or slippers whenever you are out of your room.
• Tank tops / Sleeveless shirts are not allowed to be worn unless they are worn under a shirt with sleeves.

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- Clothes must be clean and neat, not shredded or written on by hand.
- Jewelry is only allowed for residents on Level III. Curling Irons, Jewelry must not present a danger to self or others.
- No ear, nose, belly, tongue, or similiar rings or piercing of flesh.
- Rings for finger are permitted as long as they are not sharp. (Must be on Level 3)
- No eyebrow shaving without supervision from staff.

** DON and/or RN on duty are to make the final call on dress code disputes.

HYGIENE

- Shower daily, Wash hands frequently. Always wash hands after toileting
- Use deodorant
- Wear clean clothing
- Wash clothes on your assigned day, at assigned location. A pod Tues & Fri; B pod Wed & Sat; C pod- Thurs. & Sun. Mon-Free day
- Keep shoelaces tied, hair groomed, don't mix clean and dirty clothing.
- Wear shorts or swim trunks in the pool with T-shirt
- Tend to bodily functions privately and appropriately.
- Keep nails trimmed short, neat and clean.
- Wigs, hairpieces and weird hair colors are not permitted, unless medically indicated Don't expect the program to pay for upkeep of expensive hairstyles.

RULES FOR SPECIAL SITUATIONS

Lights in the day room are on when room is in use:

- Keep your room neat and clean
- Make bed neatly
- Fold clothes
- Store dirty clothes in bottom of wardrobe
- Leave things neat
- Pictures/posters must be Okayed by therapist and meet guidelines of dress code.
- Sharps/ restricted items must be turned in per daily schedule.
- Music must be kept at a low level
- Handle unit clean up chores (regular and special assignments).
- Never enter a Peer's room, without staff permission
- Linen change- A pod Monday, B pod Wednesday, C pod Thursday

CONTRABAND

These items should never be in your possession while in our program: tobacco, drugs, weapons, drug/gang paraphernalia, sharps, products with alcohol, medication or food from home, aersol, pens, items inconsistent with dress code guidelines, money, pencils without metal tips and crayons are the only writing utensil not restricted. Restricted items needed for hygiene must be turned in per unit schedule.

OTHER CONCERNS

Search Policy

Searches of possessions and person are conducted at admission and upon return from a pass. Search is by a same sex staff member. Searches of room or other hospital property may be initiated whenever indicated to ensure the safety of residents or staff. Drug screens will be conducted after all passes.

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Visitation

Visitation will be on Saturday or Sunday 2 to 4:30 PM. Other hours can be arranged to meet family needs, but such requests must go through your therapist. Visitors under age 12 must be approved by your therapist. Smoking is prohibited throughout the building for all persons, including visitors. Former residents may not visit, unless such is Okayed by the Program Director, as part of a special assembly or program. Visitors must know you id# and be listed by your guardian on your visitor list.

You have the right to refuse to see visitors, if you have a visit while on restriction, your assignments are held until the close of the visit, but nevertheless must be completed. If your behavior is dangerous or out of control at the time a visitor comes, the RN on duty has the responsibility to delay the visit until you have self-control and the visitor must wait in the lobby.

Lending and Borrowing

Don't lend. Don't borrow. If you need something, tell adults. If you wish to donate items to RTC, with approval of parent/guardian, your therapist alone may accept them, and recycle them to other teens as appropriate. Lending/borrowing is a major violation.

PASSES (TEMPORARY LEAVE OF ABSENCE OR TLOA)

We expect you to take passes primarily with the adults you intend to live with at discharge. These adults need to participate in therapy here in order to learn our rules and point system, because when you go on passes you remain under that system. You may not leave on a pass if you are on precautions or awareness status. You may leave if on restriction or owing consequences if your family/guardian and your therapist feel it would benefit you in your treatment to be allowed to go on the pass. If this occurs you will be expected to serve that consequence at home. The adult monitors your rule compliance and performance and returns your point card to the RTC with you. They are expected to give you the same consequences for rule violations just as if such occurred here. If appropriate to the situation, you will serve the consequence upon your return. The aim of passes is to build a strong family bond. During passes, you must be supervised at all times by adults, unless you are on Level 3. Then, your family and therapist may help you plan non-adult supervised activities. Note that pass rules usually do not apply to pre-placement visits.

Phone Calls

Staff keeps track of your calls per week. Family may call in at any time to get a report from the RN, but you may only call out (staff dial the number) to speak to them in the evening after school hours. If the phone rules present a special problem for you or your family, refer them to your therapist.

Medications, Treatment Refusal and AMA Discharge

You have the right to refuse medications, unless Dr. [redacted] directs the RN that you receive medicine, even against your will, in situations of harm to self or others. You may refuse to participate in a treatment activity, but such non-participation will result in a consequence. Your parent/guardian may sign you out of the program against your physician's advice, unless it is believed you present an immediate danger to yourself or others. In such a case, we seek guidance from the court and/or warn those you present a danger to. If your refusal of medications harms your mental status, the doctor may order precautions/awareness for your situation.

Problem Solving

It will be unusual if you complete the program without having a significant conflict or complaint with a peer or staff member. It is expected that you first attempt to resolve the issue directly with the person(s) involved. If that fails, or would create greater harm, take it to your therapist. If that fails to resolve the issue, you are expected to submit a written complaint to the Program Director. Possible abuse or mistreatment of you by a peer, staff, visitor or family must be reported immediately. It is a rule violation to not speak up if you are mistreated. If it's not possible to begin with your therapist, discuss your concern with the RN, psych tech or any staff available. **DO NOT TOLERATE MISTREATMENT.** If you feel you can't discuss this situation with the staff, or the situation is so serious that you must reach an authority outside the hospital, special phone numbers are posted at the "Bill of Rights" on the unit. Any staff will assist you in making a call to one or more of those patient advocate agencies at your request. Remember that honesty is a program expectation. If you have received consequences for a rule violation, and believe this handbook was not properly applied, you must submit a report. You are expected to serve the consequences if program leadership determines that adults truly were in error and you were, according to this handbook, given a consequence unfairly, the program will make it up to you.

CROSSROADS SCHOOL

Success in school is a key part of growing up to be productive and happy. We are proud of our school program as we offer most regular credits, a GED preparation program and evalutation and service under Mississippi Special Education regulations. Our points and levels system applies at school, though the teachers also set additional rules and expectations that apply in their classrooms. The usual consequence for minor school time violations will be additional schoolwork on the unit, and meals on the unit. You may attend school while on precautions or awareness, unless the nurse on duty assesses that such attendance puts you at risk of harm to self or otheres. We will maintain an in-school suspension program in order to continue to provide education even when your behavior is not appropriate for your regular classroom.

CROSSROADS SCHOOL IN-SCHOOL SUSPENSION RULES

• You must maintain a 2.5 average between the hours of 8:30 a.m. and 3:30 PM in order to get out of ISS. If you do not maintain this average then you will be in the ISS the following day.

• You will not participate in activity groups while you are in ISS. You will have work detail such as picking up trash on the grounds or sweeping. This will be supervised by a psych tech.

• You cannot talk during ISS. If you do you will begin to lose points for that hour.

• You cannot make noises during ISS. To help you with this, we will insist that all four legs on the desk stay on the floor and you stay facing forward in your desk.

• You will be given a written assignment. If you do not complete your assignment then you will have to continue to be in ISS the following day.

• If you refuse to work on your assignment for that hour then you receive a "0" for that hour.

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Bed Rest

If you miss school or other activities due to illness, you must be on "bed rest" with no participation in activities. You will receive a liquid diet until physical symptoms have resolved i.e. fever, nausea, vomiting. The point and level system is suspended during bed rest.

If you are not on bed rest, and just refuse to get up and attend the scheduled activities (school, group, etc.), you receive a zero for the hour that you stay in bed. If you are missing school then you will be required to make up your missed school work after school hours (After School Suspension).

Property Destruction Consequences

When you break or destroy things, we expect restitution. A restitution log weill be kept tracking the repayment for damages, the usual steps are:

- Points and level loss
- Resident cleans up/repairs the property
- Earned outings and/or allowances are missed (cost of outing applied to your restitution account.

As appropriate, restitution, is made to a peer, family member or agencies to recover the cost of the itmes destroyed. This applies even when you destroy your own property. We will not take money sent to you by your family or guardian. You must work the restitution off.

Seclusion/Restraint and Hands-On

In situations in which you present an immediate physical danger to yourself or others, and other efforts to help you have failed, the doctor may order seclusion (locked in a small, safe room alone but with close supervision by staff). This is done only as a last resort, and for the briefest amount of time possible for you to regain self-control.
It is staff's desire to not touch you physically, other than handshakes and friendly pats on the shoulder. (We will refrain from even that if such makes you uncomfortable. Let staff know). However, staff have the obligation to hold, physically control and transport residents as needed to keep the unit safe. Again, we use such physical control. (hands on) only as a last resort, to provide for the safety of residnets and staff.

Movies

We sometimes watch videos or go out to movies. G, PG, and PG 13 videos only are allowed.
Movies edited for TV are okay. At times an R-rated movie may be shown in a group setting if there is significant therapeutic value to be gained.

Fire Drills

Expect fire and other safety drills while here. It's a part of group living. Follow staff instructions exactly when alarms sound. It might not be a drill.

Responding to Violence

We take a strong stand against violence, so we want you to know what to do if a peer atempts to assault you:

1) call for staff and let staff handle things
2) walk away from the situation, fast!
3) If 1 and 3 Fails, you may hold your peer and
4) If you shove, punch, slap, choke or otherwise get violent, you will be consequented for assault.

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Off Grounds Contacts and Outings

Contacts with fellow residents or former residents, while off grounds (and not a part of your youth group), must be okayed by the therapist(s) involved. Remember, on outings and passes all regular program rules apply.

Mail

You may receive mail. It must have your client ID# and a return address and it must be opened in staff's presence. You may buy stamps and stationary. Do not sign up for a music club or like while here.

Dating

We want you to get home or to a community placement in which dating is an expectation. Here, dating is against the rules. This includes giving and receiving "love" notes and the likes. If you receive such a note and wish to avoid a major violation, turn it in to staff immediately or destroy it completely. CO-ED socials are scheduled, but must be earned. All program rules apply during these events.

Discharge Planning

Your treatment plan identifies a target placement. The plain is modified monthly as you progress through the program. You will work closely with your therapist and family ro develop a relapse prevention plan. If you are headed to a group or foster home, pre-placement visits will be arranged if possible. We will help you and your family locate the help you need to avoid a setback (relapse) and we will make every effort to have recommendations in place for your follow-up care that will assist you in succeeding in your next placement.

We will celebrate your completion of the program and then stay in touch with you to get reports on how you are doing at home.

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UHS-FINHELP-00008660 [Redacted]

Final Accreditation Report

Premier Behavioral Health Solutions of FL

[redacted]

Bradenton, FL [redacted]

Organization Identification Number: [redacted]

60-day Evidence of Standards Compliance Submitted: 9/26/2022

ESC Programs Reviewed

Behavioral Health Care and Human Services

Final Report: Posted 9/27/2022

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The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	9/26/2022	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health Care and Human Services

Standard	Level of Compliance
CTS.02.01.11	Compliant
CTS.02.02.01	Compliant
CTS.03.01.03	Compliant
CTS.04.03.33	Compliant
IC.01.03.01	Compliant
NPSG.15.01.01	Compliant
WT.03.01.01	Compliant
WT.04.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP & Addendum Text
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.02.02.01	5	The organization collects assessment data on each individual served.	When indicated, the following evaluations are conducted: - Mental status - Psychological - Psychiatric - Intellectual and cognitive functioning
CTS.03.01.03	3	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The objectives of the plan for care, treatment, or services meet the following criteria: - They are based on identified goals - They include identified steps to achieve the goal(s) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress
CTS.04.03.33	3	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
IC.01.03.01	1	The organization identifies risks for acquiring and spreading infections.	The organization identifies infection risks based on the following: - Its setting and population served - The care, treatment, or services it provides - For 24-hour care settings: Its monitoring of infection prevention and control activities and/or tracking and analyzing the occurrence of infections Note 1: The infections that should be tracked are those that are most relevant to the organization's setting, services, and population(s). The organization may contact its local health department for statistics and other information on some infections, and track other infections internally.

Standard	EP	Standard Text	EP & Addendum Text
			For example, an organization may decide to track conjunctivitis itself but rely on health department statistics related to tuberculosis. Note 2: The risk of infection will vary across behavioral health care or human services settings. For example, infection risks in group homes, day treatment programs, foster care homes, and couples counseling will vary by hours of contact, number of individuals served, and location and type of service.
NPSG.15.01.01	1	Reduce the risk for suicide.	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care and human services settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).
NPSG.15.01.01	4	Reduce the risk for suicide.	Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.
WT.03.01.01	1	Staff performing waived tests are competent.	The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff who perform waived testing.
WT.04.01.01	1	The organization performs quality control checks for waived testing on each procedure. Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.	The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables. (See also LD.04.01.01, EP 1)

Final Accreditation Report

Premier Behavioral Health Solutions of FL

[redacted]

Bradenton, FL [redacted]

Organization Identification Number: [redacted]
Unannounced Extension Event New Service: 8/4/2022 - 8/4/2022

Program Surveyed
Behavioral Health Care and Human Services

Final Report: Posted 8/4/2022

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The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	08/04/2022 - 08/04/2022	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.01.11	1	Low / Limited	✓
CTS.02.02.01	5	Moderate / Limited	✓
CTS.03.01.03	3	Moderate / Limited	✓
CTS.04.03.33	3	Low / Limited	✓
IC.01.03.01	1	Moderate / Widespread	✓
NPSG.15.01.01	1	High / Widespread	✓
	2	High / Widespread	✓
	4	High / Pattern	✓
WT.03.01.01	1	Low / Limited	✓
WT.04.01.01	1	Low / Widespread	✓

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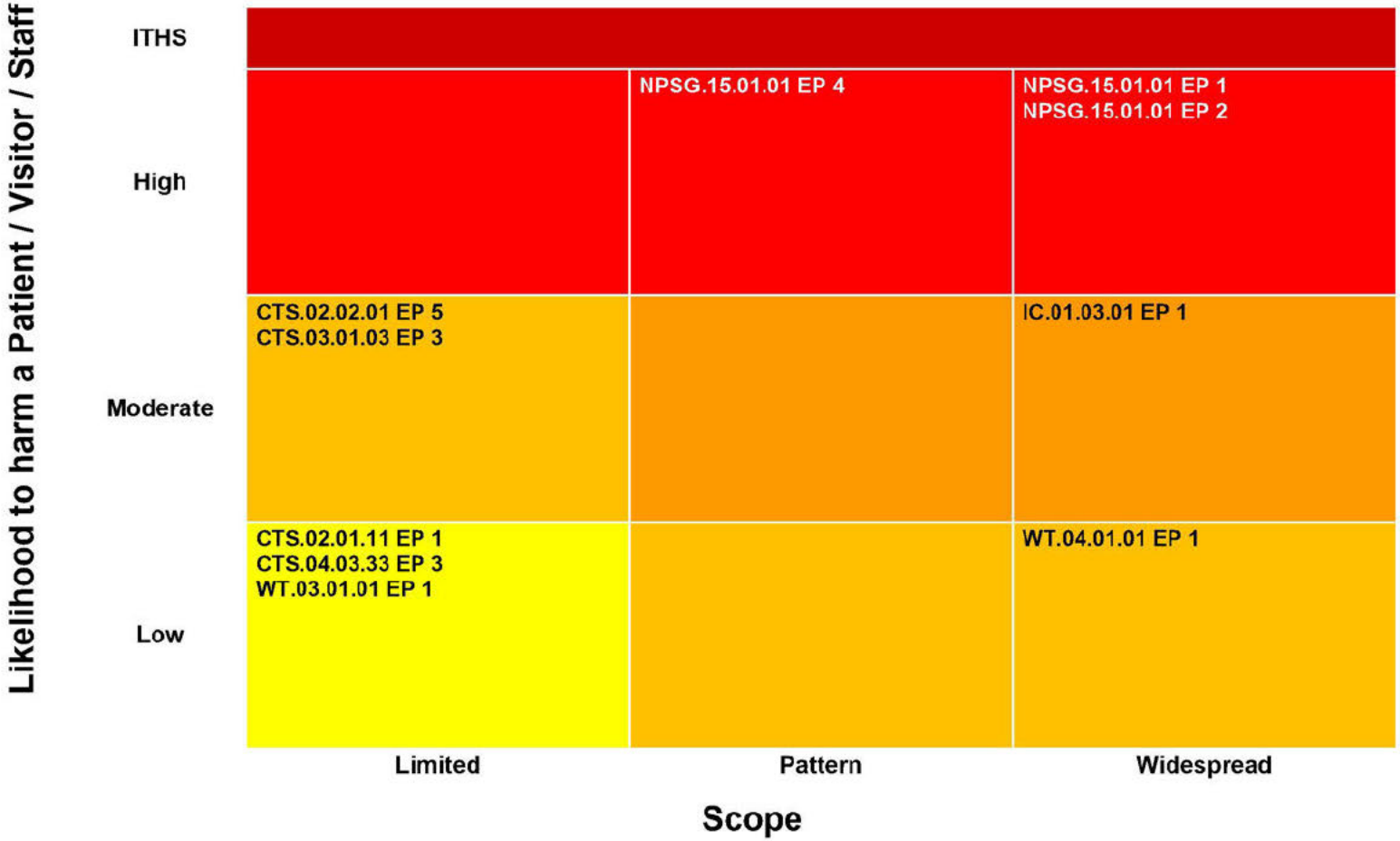
SAFER™ Matrix

Program: Behavioral Health Care and Human Services



The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.11	1	Low Limited	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting	1) Observed in Individual Tracer at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of a completed nutritional screening was not presented. Evidenced by the patient (Turtles') record reviewed with an admission year of 2022, nutritional screener did not demonstrate the completed question of "5% above body mass index (BMI) or 95% below BMI." The Program Director acknowledged the incomplete question and indicated the question was correlative to the required "weight gain or loss of 10 pounds" within the last 30 days.
CTS.02.02.01	5	Moderate Limited	When indicated, the following evaluations are conducted: - Mental status - Psychological - Psychiatric - Intellectual and cognitive functioning	1) Observed in Individual Tracer at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of a completed psychiatric evaluation was not presented. Evidenced by the psychiatric evaluation reviewed demonstrated inconsistent assessment information and indicated level of care. Specifically, the indicated level of care demonstrated outpatient treatment counseling, followed by an incomplete attestation section of the psychiatric evaluation, confirming the completion of the psychiatric assessment and the appropriate level of psychiatric care. The Chief Executive Officer and Program Director acknowledged the incorrect level of care and identified the document as incorrect. The Program Director further indicated: an updated document was developed that the provider did not use to assess psychiatric needs for the appropriate level of care.
CTS.03.01.03	3	Moderate Limited	The objectives of the plan for care, treatment, or services meet the following criteria: - They are based on identified goals - They include identified steps to achieve the goal(s) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress	1) Observed in Individual Tracer at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of identified goals in association with the assessed needs was not presented. Evidenced by a patient (Turtles') record reviewed with an admission year of 2022, Child Post Traumatic Stress Disorder (PTSD) Symptom Scale (CPSS) screener and psychosocial assessment demonstrated trauma. The Treatment plan goals did not reflect a trauma specific goal during care, treatment and or services.
CTS.04.03.33	3	Low Limited	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.	1) Observed in Building Tour at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidenced of appropriate storage of food was not demonstrated. Evidenced by the refrigerator that housed the patients (Turtles) snacks (milk, ensure, etc.) did not have a thermometer.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
IC.01.03.01	1	Moderate Widespread	The organization identifies infection risks based on the following: - Its setting and population served - The care, treatment, or services it provides - For 24-hour care settings: Its monitoring of infection prevention and control activities and/or tracking and analyzing the occurrence of infections Note 1: The infections that should be tracked are those that are most relevant to the organization's setting, services, and population(s). The organization may contact its local health department for statistics and other information on some infections, and track other infections internally. For example, an organization may decide to track conjunctivitis itself but rely on health department statistics related to tuberculosis. Note 2: The risk of infection will vary across behavioral health care or human services settings. For example, infection risks in group homes, day treatment programs, foster care homes, and couples counseling will vary by hours of contact, number of individuals served, and location and type of service.	1) Observed in Infection Control Tracer at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of identified communicable disease risk(s) and or infection (s) prevention method(s) were not presented. Evidenced by the admission bathroom located on the Turtle Cove impatient unit did not present visible hand hygiene methods. The reviewed Infection Control Plan also did not identify communicable diseases and or preventive methods.
NPSG.15.01.01	1	High Widespread	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk (s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care and human services settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).	1) Observed in Environment of Care Session at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of an environmental suicide risk assessment, identifying features in the physical environment to attempt suicide was not presented.

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Standard	EP	SAFER™ Placement	EP Text	Observation
NPSG.15.01.01	2	High Widespread	Screen all individuals served for suicidal ideation using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.	1) Observed in Individual Tracer at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of an evidenced based screening tool for suicidal, homicidal, and or self-harming behaviors was not demonstrated. Evidenced by the Health Care Organization (HCO) Representative indicated the Assessing and Managing Suicide Risk (AMSR), used as the present screening tool, was an approved suicide screening tool by The Joint Commission. The HCO Representative presented documentation from the year of 2021, by a previous Field Director addressing the tool with surveyors and not an approval of the tool.
NPSG.15.01.01	4	High Pattern	Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.	1) Observed in Individual Tracer at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of an appropriate level of risk and a mitigation plan was not demonstrated. Evidenced by two patients' (Turtles') records reviewed demonstrated a presenting problem for admission as Suicidal Ideations, present, thoughts of ideations, a plan, and self-harming behaviors within the last 30 days. The Assessing and Managing Suicide Risk (AMSR) demonstrated a "similar" suicide risk level. Followed by a documented procedure of " five-minute checks for the first 24-hours and 15 minutes checks following," within the summative narrative of the screener. The records did not demonstrate a safety plan for the patient and or further re-assessment during care, treatment, and or services.
WT.03.01.01	1	Low Limited	The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff who perform waived testing.	1) Observed in Environment of Care Session at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of the Certified Laboratory Improvement Amendment (CLIA) certificate director was not demonstrated on the employee competency training for the point-of-care (POC) test(s)
WT.04.01.01	1	Low Widespread	The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables. (See also LD.04.01.01, EP 1)	1) Observed in Data Session at Premier Behavioral Health Solutions of FL [redacted] Bradenton, FL) site . Evidence of a written policy to demonstrate documented performance of quality control checks and or rationale for checks in association with the Certified Laboratory Improvement Amendment (CLIA) point-of-care (POC) test(s) was not presented.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP & Addendum Text
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.02.02.01	5	The organization collects assessment data on each individual served.	When indicated, the following evaluations are conducted: - Mental status - Psychological - Psychiatric - Intellectual and cognitive functioning
CTS.03.01.03	3	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The objectives of the plan for care, treatment, or services meet the following criteria: - They are based on identified goals - They include identified steps to achieve the goal(s) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress
CTS.04.03.33	3	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
IC.01.03.01	1	The organization identifies risks for acquiring and spreading infections.	The organization identifies infection risks based on the following: - Its setting and population served - The care, treatment, or services it provides - For 24-hour care settings: Its monitoring of infection prevention and control activities and/or tracking and analyzing the occurrence of infections Note 1: The infections that should be tracked are those that are most relevant to the organization's setting, services, and population(s). The organization may contact its local health department for statistics and other information on some infections, and track other infections internally.

Standard	EP	Standard Text	EP & Addendum Text
			For example, an organization may decide to track conjunctivitis itself but rely on health department statistics related to tuberculosis. Note 2: The risk of infection will vary across behavioral health care or human services settings. For example, infection risks in group homes, day treatment programs, foster care homes, and couples counseling will vary by hours of contact, number of individuals served, and location and type of service.
NPSG.15.01.01	1	Reduce the risk for suicide.	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care and human services settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).
NPSG.15.01.01	2	Reduce the risk for suicide.	Screen all individuals served for suicidal ideation using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.
NPSG.15.01.01	4	Reduce the risk for suicide.	Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.
WT.03.01.01	1	Staff performing waived tests are competent.	The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff who perform waived testing.
WT.04.01.01	1	The organization performs quality control checks for waived testing on each procedure. Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.	The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables. (See also LD.04.01.01, EP 1)

The Joint Commission

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Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

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Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

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Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

UHS-FINHELP-00008684 [Redacted]

The Joint Commission

Final Accreditation Report

Keystone Memphis L.L.C.

[redacted]

Memphis, TN [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 4/9/2018 - 4/13/2018

Program Surveyed
Behavioral Health

Final Report: Posted 4/16/2018

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health	04/09/2018 - 04/13/2018	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

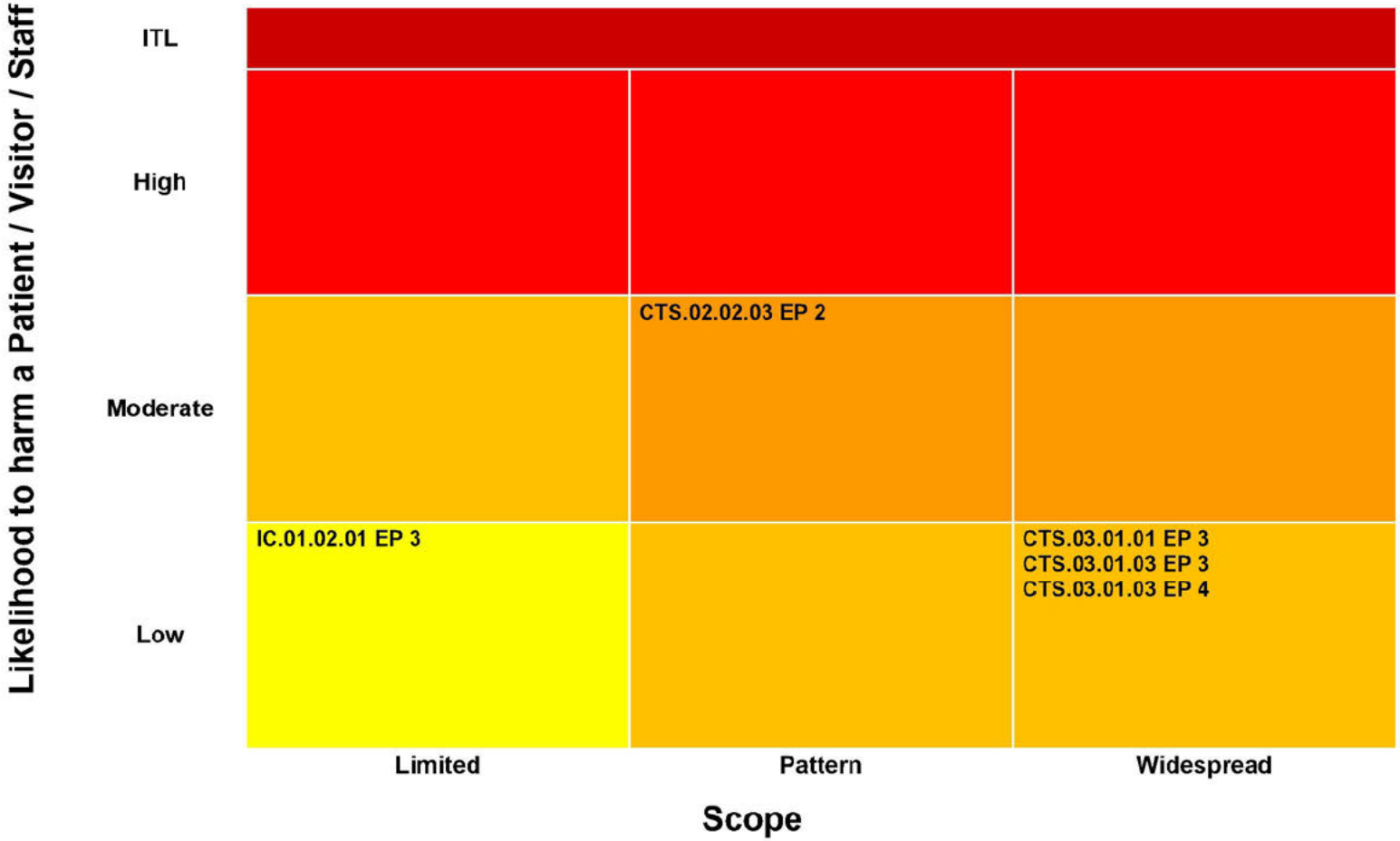
The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.02.03	2	Moderate / Pattern	✓
CTS.03.01.01	3	Low / Widespread	✓
CTS.03.01.03	3	Low / Widespread	✓
	4	Low / Widespread	✓
IC.01.02.01	3	Low / Limited	✓

The Joint Commission
SAFER™ Matrix

Program: Behavioral Health



The Joint Commission
Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.02.03	2	Moderate Pattern	The needs of the individual served are identified based on information from the assessment.	1). Observed in Record Review at Keystone Memphis LLC [redacted] Dyersburg, TN) site . In 2 of 2 patient records reviewed, it was noted that the diagnoses both included cannabis use disorders, however the master treatment plans did not include this as a goal .
CTS.03.01.01	3	Low Widespread	Planning for care, treatment, or services includes identifying objectives for the identified goals. (See also CTS.03.01.03, EP 3)	1). Observed in Record Review at Keystone Memphis LLC [redacted] Memphis, TN) site . In 6 of 6 patient records reviewed, it was noted that the treatment plan contained goals and interventions for each patient , however there were not measurable objectives to indicate goal attainment.
CTS.03.01.03	3	Low Widespread	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress	1). Observed in Record Review at Keystone Memphis LLC [redacted] site . In 6 of 6 patient records reviewed, it was noted that the objectives for treatment in the treatment plan were not written in terms that provided indications of progress. The treatment plan updates did include narratives that spoke to the patients' general progress in treatment.
				2). Observed in Record Review at Keystone Memphis LLC [redacted] site . In 2 of 2 patient records reviewed, it was noted that the objectives in the treatment plans were not written in terms that provided indices of progress. The treatment plans did identify specific interventions related to each goal but lacked objectives for each goal.
CTS.03.01.03	4	Low Widespread	The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual's needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.	1). Observed in Record Review at Keystone Memphis LLC [redacted] Memphis, TN) site . In 6 of 6 patient records reviewed, it was noted that the goals in the master treatment plans were not readily identified as obtained when the treatment plans were reviewed and updated. There was evidence of new added goals in treatment plan updates.
IC.01.02.01	3	Low Limited	The organization provides staff and individuals served with supplies to support infection prevention and control activities. Note: Examples of such supplies may include liquid hand sanitizers, gloves, tissue, and cleaning supplies. The organization's infection control activities apply only to those locations where care, treatment, or services are provided; the organization is not	1). Observed in Building Tour at Keystone Memphis LLC [redacted] Memphis, TN) site . During a walk through of the facility it was observed that a hand sanitizer station in the administrative area contained expired sanitizer gel.

Standard	EP	SAFER™ Placement	EP Text	Observation
			required to provide supplies for use outside of these locations.	

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Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.02.03	2	A complete and accurate assessment drives the identification and delivery of the care, treatment, or services needed by the individual served.	The needs of the individual served are identified based on information from the assessment.
CTS.03.01.01	3	The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served. Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.	Planning for care, treatment, or services includes identifying objectives for the identified goals. (See also CTS.03.01.03, EP 3)
CTS.03.01.03	3	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress
CTS.03.01.03	4	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual's needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.
IC.01.02.01	3	Organization leaders allocate needed resources for infection prevention and control activities.	The organization provides staff and individuals served with supplies to support infection prevention and control activities. Note: Examples of such supplies may include liquid hand sanitizers,

Standard	EP	Standard Text	EP Text
			gloves, tissue, and cleaning supplies. The organization's infection control activities apply only to those locations where care, treatment, or services are provided; the organization is not required to provide supplies for use outside of these locations.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

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Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Final Accreditation Report

Keystone Memphis L.L.C.
[redacted]
Memphis, TN [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 6/1/2018

ESC Programs Reviewed
Behavioral Health

Final Report: Posted 6/19/2018

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Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health	6/1/2018	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.02.03	Compliant
CTS.03.01.01	Compliant
CTS.03.01.03	Compliant
IC.01.02.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.02.03	2	A complete and accurate assessment drives the identification and delivery of the care, treatment, or services needed by the individual served.	The needs of the individual served are identified based on information from the assessment.
CTS.03.01.01	3	The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served. Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.	Planning for care, treatment, or services includes identifying objectives for the identified goals. (See also CTS.03.01.03, EP 3)
CTS.03.01.03	3	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress
CTS.03.01.03	4	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual's needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.
IC.01.02.01	3	Organization leaders allocate needed resources for infection prevention and control activities.	The organization provides staff and individuals served with supplies to support infection prevention and control activities. Note: Examples of such supplies may include liquid hand sanitizers,

Standard	EP	Standard Text	EP Text
			gloves, tissue, and cleaning supplies. The organization's infection control activities apply only to those locations where care, treatment, or services are provided; the organization is not required to provide supplies for use outside of these locations.

UHS-FINHELP-00008702 [Redacted]

Joint Commission Health Care Organization

Organization ID: [redacted] Keystone Memphis L.L.C.
[redacted] Memphis, TN [redacted]

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 1/6/2022

Behavioral Health Care and Human Services CTS.02.01.11 EP 1
Likelihood: Low Scope: WideSpread

Standard Text: The organization screens all individuals served for their nutritional status.

EP Text: The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following:- Food allergies- Weight loss or gain of 10 pounds or more in the last 3 months- Decrease in food intake and/or appetite- Dental problems- Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting

Finding(s): 1) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site .
In 2 out of 2 residential records reviewed, the nutritional screening did not include questions about weight loss or gain of 10 pounds or more in the last 3 months, a decrease in food intake and/or appetite or dental problems. Eating disorder behaviors and food allergies were included in the screening. This was confirmed by the CEO and Director of Risk Management.

Assigning Accountability

The Director of Nursing Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

On 11/12/2021, the Director of Nursing Services revised the Nursing Admission Assessment to include a nutritional screening that includes questions about the following: food allergies, weight loss or gain of 10 pounds or more in the last 3 months, decrease in food intake and/or appetite, dental problems, and eating habits or behaviors that may be indicators of an eating disorder, including bingeing or inducing vomiting. The revised Nursing Assessment was approved by the Director of Nursing, the Medical Director, Chief Executive Officer and Director of Risk Management on 11/12/2021.

On 11/12/2021, 11/16/2021 and 11/20/2021, the Director of Nursing Services provided training on the revised nutritional screening to all nurses.

Q. All corrective actions described above were completed by

Nov 20, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The Director of Nursing Services will audit nutritional screenings to ensure all revised questions are being answered and addressed.

The Director of Nursing will ensure that orientation and annual training sessions for nursing staff include training content on the nutritional screening and assessment process.

Q. What is the frequency of the monitoring activities?

The Director of Nursing will audit nutritional screenings on a weekly basis until four consecutive months of 100% compliance is achieved, then audit monthly thereafter.

The Director of Nursing will review nurse training records annually to ensure presence of nutritional screen training.

Q. What data will be collected from these activities?

Data collected will include completion of each question asked on the nutritional screening and actions taken to ensure nutritional assessments are obtained when indicated.

Data collected will include compliance rates of all nursing staff receiving training on the nutritional screening and assessment process.

Q. To who, and how often, will this data be reported?

The Director of Nursing Services will report findings to the Performance Improvement Committee on a monthly basis and the Medical Executive Committee on a quarterly basis.

The Director of Nursing Services will report training compliance results to the Performance Improvement Committee and the Medical Executive Committee on an annual basis.

Behavioral Health Care and Human Services CTS.03.01.03 EP 1
Likelihood: Moderate Scope: WideSpread

Standard Text: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

EP Text: The organization develops a plan for care, treatment, or services that reflects the assessed

needs, strengths, preferences, and goals of the individual served.

Finding(s): 1) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site .
In 2 out of 2 client records reviewed, the treatment plans were not individualized and had the same goals with little exception. For example, the goal of "Will maintain positive behavior compliance by decreasing externalized behaviors to monthly by discharge" was on both treatment plans with the same short term goals/objectives. In addition, all of the identified needs and goals from the assessment were not included on the treatment plan, deferred or referred out to another provider. For example, in one client record reviewed substance abuse was not included on the treatment plan, however was identified in the assessment as a problem. There was no process in place to defer an identified problem or need or to refer out to another provider. This was confirmed by the CEO and Director of Risk Management.

2) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Dyersburg, TN) site .
In one client residential record reviewed at the McDowell location, the treatment plan did not include all of the identified needs and goals from the assessment. For example, the treatment plan did not address harm to self, ADHD or psychosis, which were identified as treatment needs in the initial assessment. This was confirmed by the Clinical Director and Director of Nursing.

Assigning Accountability

The Director of Clinical Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Chief Executive Officer
Chief Quality Officer
Director of Clinical Services

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

1. A PI Team consisting of the Group Chief Executive Officer, the Clinical Services Directors (Compass Intervention Center and McDowell Center for Children) and the Chief Quality Officer will audit the Master Treatment Plan, including the Master Problem List and all Treatment Plan Updates to ensure the following criteria is met:

A. Treatment Plans are individualized.

B. That all the identified needs and goals from assessments are included on the treatment plan, deferred or referred out to another provider.

C. That documentation exists regarding the rationale for referring or deferring an identified problem.

2. Action plans to ensure a compliance score of 100% will be developed, implemented and evaluated for effectiveness in the event that any deficiencies are found.

3. Training surrounding policy CS 20 Treatment Planning will be conducted by the Clinical Program Directors and/or the Group Chief Executive Officer for any current therapist when indicated and for all newly hired therapist on an on-going basis.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

The Clinical Services Directors, Group Chief Executive Officer and the Chief Quality Officer met to discuss why treatment plans were not consistently individualized and frequently contained the same goals and why all the needs and goals from patient assessments were not addressed, referred or deferred out with supporting documentation. The following issues summarize the findings that contributed to this issue:

Policy CS 20 did not discuss that all identified problems must be addressed in the treatment plan, referred out or deferred and that in the event a problem is referred out or deferred, there must be documentation explaining the rationale for not addressing the problem in the treatment plan.

Policy CS 20 did not clearly state that goals are to be quoted in the patient's own words.

The Master Problem List did not contain a prompt or area to document why an identified problem was referred out or deferred.

The Treatment Plan Update did not prompt the therapist to document goals, using quotes in the patient's own words.

Revisions to policy CS 20 and to the Master Treatment Plan template and Treatment Plan Update template were made. The revisions simplify the process of individualized treatment plan development, documenting and targeting the patient's goals for treatment and clearly documenting when problems are referred out or deferred. The Clinical staff were retrained and understand the process. There is a strong plan to audit compliance and provide re-education to current staff when needed. This training will additionally be added to new hire training for all new therapists. These actions will help ensure compliance with this standard on an ongoing basis.

Q. All corrective actions identified below must be completed prior to submission

1. On 11/18/2021, 11/29/2021 and 11/30/2021, the Clinical Services Directors and the Group Chief Executive Officer met to review and discuss the following:

A. Policy CS 20 Treatment Planning

B. Templates for the Master Treatment Plan Problem List and the Treatment Plan Update

C. To review and discuss the findings related to CTS.03.01.03 EP 1.

2. On 11/30/2021, Policy CS 20 Treatment Planning was revised to reflect that Identified problems are either included in the care plan, deferred or referred to another provider. Policy states that when

problems are deferred or referred to another provider, the rationale is documented on the Master Problem List. The revised policy also clarifies that short-term goals and objectives are to be written in the patient's own words. The policy revision was approved by the Clinical Services Directors, the Group Chief Executive Officer and the Chief Quality Officer.

3. On 11/30/2021, the Master Treatment Plan Problem List template was revised to allow for clarification on targeted, deferred, and referred treatment needs. The revisions were approved by the Directors of Clinical Services for each facility, the Group Chief Executive Officer and the Chief Quality Officer.

4. On 11/30/2021, the Treatment Plan Update template was revised to provide individualized, specific objectives in the patient's own words that allow for clear measurability and target dates. The revisions were approved by the Directors of Clinical Services, the Group Chief Executive Officer and the Chief Quality Officer.

5. Training around the revised policy CS 20, changes to the Master Treatment Plan and Treatment Plan Update templates and the development of the plan for care, treatment and services that reflects the assessed needs, strengths, preferences, and goals of the individuals served was completed with all Therapists on 12/06/2021 and 12/09/2021. The trainings were provided by each Director of Clinical Services and the Group Chief Executive Officer.

6. The new templates for the Master Treatment Plan Problem List and the Treatment Plan Update was initiated on December 9, 2021 for all new admissions. The new template for the Treatment Plan Update was initiated on patients admitted prior to December 9, 2021 on January 1, 2022.

Q. All corrective actions described above were completed by

Jan 01, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

1. A PI Team consisting of the Group Chief Executive Officer, the Clinical Services Directors and the Chief Quality Officer will audit The Master Treatment Plan, including the Master Problem List and all Treatment Plan Updates to ensure the following criteria is met:

A. Treatment Plans are individualized.

B. That all of the identified needs and goals from assessments are included on the treatment plan, deferred or referred out to another provider.

C. That documentation exist regarding the rationale for referring or deferring an identified problem.

2. Action plans to ensure a compliance score of 100% will be developed, implemented and evaluated for effectiveness in the event that any deficiencies are found.

Q. What is the frequency of the monitoring activities?

Audits will occur on a weekly basis by the Group Chief Executive Officer, the Clinical Services Director and the Chief Quality Officer. Weekly audits will continue until 95% compliance is achieved for four consecutive months, followed by monthly audits thereafter.

Q. What data will be collected from these activities?

1. The Master Problem List contains all identified problems of the individual served. This audit will include at minimum a review of all initial assessments, including the Intake Assessment (Psychosocial Part I), Initial Clinical Assessment (Psychosocial Part II), Nursing Admission Assessment, Psychiatric Evaluation, and the History and Physical to ensure all problems are captured.

2. The Master Problem List will be audited against the Treatment Plan Updates to determine if all identified problems are being addressed in the Treatment Plan.

3. The Master Problem List will be audited to determine if there is documentation indicating the rationale for referring or deferring identified problems that are not addressed in the Treatment Plan.

Q. To who, and how often, will this data be reported?

Findings of these audits will be reported to the Performance Improvement Committee monthly and the Medical-Executive Committee quarterly.

Behavioral Health Care and Human Services CTS.03.01.03 EP 2
Likelihood: Low Scope: Pattern

Standard Text: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

EP Text: The plan for care, treatment, or services includes the following: - Goals that are expressed in a manner that captures the individual's words or ideas- Goals that build on the individual's strengths- Factors that support the transition to community integration when identified as a need during assessment- The criteria and process for the individual's expected successful transfer and/or discharge/termination of services, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01)Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.

Finding(s): 1) Observed in Individual Tracer at Keystone Memphis LLC [redacted]
Memphis, TN) site .
In 2 out of 2 residential records reviewed, the treatment goals were not in the client's own words or in words that represent the client, but in clinical jargon. For example, one goal was "Patient will show an increase in daily coping skills and decrease mood instability to once per month". This was confirmed by the CEO and Director of Risk Management.

Assigning Accountability

The Clinical Services Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

The Clinical Services Director and the Group Chief Executive Officer met to review the templates for the Master Treatment Plan Problem List and the Treatment Plan Update and to review and discuss the findings related to CTS.03.01.03 EP 2 on 11/18/2021, 11/29/2021 and 11/30/2021.

Policy CS 20 was revised to indicate that short-term goals and objectives are to be written in the patient's own words in quotes. The policy revision occurred on 11/30/2021 and was approved by the Clinical Services Director, the Group Chief Executive Officer and the Chief Quality Officer.

The Treatment Plan Update format was revised to provide individualized, specific objectives in the patient's own words that allow for clear measurability and target dates on 11/30/2021. The revisions were approved by the Clinical Services Director, the Chief Executive Officer and the Chief Quality Officer.

Training around the revised policy CS 20, and changes to the Master Treatment Plan and Treatment Plan Update templates was completed with all Therapists on 12/06/2021 and 12/09/2021. The Director of Clinical Service and the Chief Executive Officer provided the trainings.

The new template for the Treatment Plan Update was initiated on December 9, 2021 for all new admissions. The new template for the Treatment Plan Update was initiated on patients admitted prior to December 9, 2021 on January 1, 2022.

Q. All corrective actions described above were completed by

Jan 01, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

A PI Team consisting of the Group Chief Executive Officer, the Clinical Services Director and the Chief Quality Officer will audit Treatment Plan Updates to ensure the following criteria is met:

Treatment Plans are individualized and contain goals written as quoted in the patient's own words.

Q. What is the frequency of the monitoring activities?

Audits will occur on a weekly basis by the Group Chief Executive Officer, the Chief Quality Officer and the Clinical Services Director until 95% compliance is achieved for four consecutive months, then monthly thereafter.

Q. What data will be collected from these activities?

Goals on the Treatment Plan Update will be audited to ensure they are quotes in the patient's own words.

Q. To who, and how often, will this data be reported?

Findings of these audits will be reported to the Performance Improvement Committee on a monthly basis and the Medical-Executive Committee on a quarterly basis.

Behavioral Health Care and Human Services CTS.03.01.03 EP 3
Likelihood: Moderate Scope: Pattern

Standard Text: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

EP Text: The objectives of the plan for care, treatment, or services meet the following criteria:- They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)- They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress

Finding(s): 1) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site .
In 2 out of 2 client records reviewed, the short term goals or objectives were not specific or stepped out in an effort to determine progress and/or completion of goals. For example, one short term goal was "Patient will process triggers and develop skill-building to reduce occurrences of externalized behaviors impacting referral behaviors". This was confirmed by the CEO and Director of Risk Management.

Assigning Accountability

The Clinical Services Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Chief Executive Officer
Chief Quality Officer
Director of Clinical Services

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

A Performance Improvement Team (PIT) consisting of the Group Chief Executive Officer, the Director of Clinical Services and the Chief Quality Officer will audit Treatment Plan Updates to ensure each identified step to achieve objectives is clearly documented, that the identified steps are specific to assess the progress of the individual served and that each identified step is expressed in terms that provide indices of progress.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

The Clinical Services Directors, Group Chief Executive Officer and the Chief Quality Officer met to discuss why objectives for the plan for care, treatment, or services did not meet criteria that demonstrated identified steps to achieve goals, that the steps are sufficiently specific to assess the progress of the patient and that the steps are expressed in terms that provide indices of progress. It was determined that the template used did not support documentation this specific regarding the objectives for the plan for care, treatment or services. The form did not prompt the therapist to document specific steps to achieve goals. Additionally, all therapists did not understand the process of identifying and documenting steps to achieve objectives in a manner that is patient specific to assess the progress of the patient and are expressed in terms that provide indices of progress.

Q. All corrective actions identified below must be completed prior to submission

The Treatment Plan Update was revised on 11/30/2021 to facilitate documentation of patient specific steps to meet objectives that assess the prgress of the patient in meeting objectives and are expressed in terms that provide indices of prgress.

The Group Chief Executive Officer and the Clinical Services Director provided education and training on 12/06/2021 and 12/09/2021. Training included use of the new Treatment Plan Update template and education targeted individualize steps, that are measurable to the patient's progress and are written in a manner that demonstrate indices of progress.

The newly revised Treatment Plan Update template was put into use on all new admissions on 12/09/2021 and put into place for all patients admitted prior to 12/09/2021 on 01/01/2022.

Q. All corrective actions described above were completed by

Jan 01, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

A PI Team consisting of the Group Chief Executive Officer, the Director of Clinical Services and the Chief Quality Officer will audit Treatment Plan Updates to ensure each identified step to achieve objectives is clearly documented, that the identified steps are specific to assess the progress of the individual served in meeting goals and that each identified step is expressed in terms that provide indices of progress.

Q. What is the frequency of the monitoring activities?

Audits of Treatment Plan Updates will occur on a weekly basis until four consecutive months of 95% compliance is achieved, then monthly thereafter.

Q. What data will be collected from these activities?

Data collected will include an assessment that objectives meet the following criteria: include identified steps to achieve goals, are specific to assess the patient's progress and are expressed in terms that provide indices of progress.

Q. To who, and how often, will this data be reported?

Audit findings will be reported to the Performance Improvement Committee on a monthly basis and to the Medical Executive Committee on a quarterly basis.

Behavioral Health Care and Human Services LD.04.01.01 EP 1
Likelihood: Moderate Scope: Limited

Standard Text: The organization complies with law and regulation.

EP Text: The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)

Finding(s): 1) Observed in Document Review at Keystone Memphis LLC [redacted] Dyersburg, TN) site .

The McDowell residential location performs waived testing, including urine drug screens and blood glucose monitoring, however did not have a CLIA certificate at the time of the survey. The organization was able to show verification of the completed application and payment for a CLIA certificate onsite during the survey.

Assigning Accountability

The Director of Nursing Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

A clarification was completed on this finding by the facility. On the day of survey, November 10, 2021, the CLIA Waiver was paid for and a receipt of this was shown to the Joint Commission surveyor during the survey. The organization received written correspondence that the CLIA Waiver was mailed out on November 16, 2021. On November 29, 2021, McDowell Center for Children received their CLIA certificate in the mail; the effective date is 09/23/2021.

Q. All corrective actions described above were completed by

Nov 29, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The current CLIA Certificate expires 09/26/2023. The Director of Nursing/Infection Control Nurse will include in monthly Infection Control meeting minutes the effective and expiration date of the current CLIA Certificate which will enable her to track when renewal is due. In August 2023, the Director of Nursing/Infection Control Nurse will submit required documentation and payment to ensure the CLIA Waiver Certificate does not expire.

Q. What is the frequency of the monitoring activities?

Monthly meeting minutes will contain the CLIA expiration date. Minutes for the meeting held in August 2023 will reflect activities taken to renew the certificate.

Q. What data will be collected from these activities?

Data collection will include the CLIA expiration date and actions taken to renew the certificate in a timely manner to prevent expiration.

Q. To who, and how often, will this data be reported?

Infection Control Committee will report to the Performance Improvement Committee on a monthly basis.

Behavioral Health Care and Human Services MM.01.01.03 EP 1
Likelihood: Low Scope: WideSpread

Standard Text: The organization safely manages high-alert and hazardous medications.Note: This standard is applicable to organizations that engage in any of the medication management processes.

EP Text: The organization identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications.Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. (See also EC.02.02.01, EP 2)

Finding(s): 1) Observed in Medication Management Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site .
The organization had not developed or implemented a list of hazardous medications that are stored, prescribed and/or administered. This was confirmed by the RN. This was corrected onsite during the survey.

Assigning Accountability

The Director of Nursing Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

On 11/10/2021, the Director of Nursing posted the facility specific list of hazardous medications in each of the medication rooms.

Q. All corrective actions described above were completed by

Nov 10, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The Director of Nursing Services will conduct monthly audits to ensure a list of facility specific hazardous medications is posted in each Medication Room. The Pharmacist Consultant has added to his monthly audit form to check each Medication Room for postings of the facility specific list of hazardous medications and to include findings in the monthly Pharmacy Consultant Report/Medication Room Inspection Report.

Q. What is the frequency of the monitoring activities?

Monthly audits will occur by the Pharmacy Consultant and the Director of Nursing.

Q. What data will be collected from these activities?

To ensure compliance with the hazardous medications listing, the Pharmacy Consultant and the Director of Nursing will collect data to confirm that the list of facility specific hazardous medications is posted in each of the Medication Rooms.

Q. To who, and how often, will this data be reported?

The Pharmacy Consultant and the Director of Nursing Services will report findings on a quarterly basis to the Pharmacy and Therapeutics Committee.

Behavioral Health Care and Human Services MM.03.01.01 EP 7
Likelihood: Moderate Scope: Limited

Standard Text: The organization safely stores medications.Note: This standard is applicable only to organizations that store medications at their sites.

EP Text: For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy.Note: This element of performance is also applicable to sample medications.

Finding(s): 1) Observed in Medication Management Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site .
The medication room refrigerator had an opened vial of tuberculin that was not dated with the expiration date of 28 days after opening according to the manufacturer and the organization's policy. This was confirmed by the RN. This was corrected onsite during the survey.

Assigning Accountability

The Director of Nursing Services is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

On 11/10/2021, Policy NS 67 Medication Storage and Safety was revised to state that all multi dose vials are to be labeled with open dates and expiration dates of 28 days after the open date.

On 11/10/2021, the Director of Nursing Services posted a 28-day calendar to the walls of each Medication Room.

On 11/16/2021 and 11/20/2021, the Director of Nursing provided education to all nurses that participate in medication management processes regarding multi dose vials open and expiration dates and labeling.

The Pharmacy Consultant added to his monthly Medication Room audit form to include an audit of all multi dose vials opened and expiration dates.

Q. All corrective actions described above were completed by

Nov 20, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The Pharmacy Consultant and the Director of Nursing will audit all multi dose vials to ensure they have been labeled with the open date and the expiration date.

Q. What is the frequency of the monitoring activities?

The audits will occur on a monthly basis by the Pharmacist Consultant and the Director of Nursing.

Q. What data will be collected from these activities?

Data that will be collected from these activities will be the number of multi dose vials present, the number of multi dose vials that are labeled with opened dates and the number labeled with expiration dates.

Q. To who, and how often, will this data be reported?

The Pharmacist Consultant and the Director of Nursing will report findings to the Pharmacy and Therapeutics Committee on a quarterly basis.

Behavioral Health Care and Human Services NPSG.15.01.01 EP 5
Likelihood: Low Scope: Limited

Standard Text: Reduce the risk for suicide.

EP Text: Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following:- Training and competence assessment of staff who care for individuals served at risk for suicide- Guidelines for reassessment- Monitoring individuals served who are at high risk for suicide

Finding(s): 1) Observed in Document Review at Keystone Memphis LLC [redacted] Memphis, TN) site .
The organization's suicide risk policy did not include the competence assessment for staff who care for individuals served who are at risk for suicide. The organization had a process to assess suicide risk competency, however did not include this in the written suicide risk policy. This was confirmed by the CEO and Divisional Clinical Director.

Assigning Accountability

The Director of Risk Management is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

Policy NS 34 Suicide Risk Assessment was revised to include that a training and a competence assessment must be completed by all staff (therapist, RNs, Intake Clinicians) who assess a patient's suicide risk.

Q. All corrective actions described above were completed by

Nov 15, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

Compliance will be monitored through ensuring continued training and competence as well as annual policy reviews and updates.

Q. What is the frequency of the monitoring activities?

The Director of Human resources will audit the files of all new applicable employees to ensure suicide assessment training and competency documentation is present on monthly basis.

Q. What data will be collected from these activities?

Data collected will include an attestation that training was received and a copy of the completed competency in the employees' training file.

Q. To who, and how often, will this data be reported?

The Human Resources Director will report findings to the Performance Improvement Committee on a monthly basis until four consecutive months of 100% compliance is achieved and report annually thereafter.

The Joint Commission

Final Accreditation Report

Keystone Memphis L.L.C.
[redacted]
Memphis, TN [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 11/10/2021 - 11/10/2021

Program Surveyed
Behavioral Health Care and Human Services

Final Report: Posted 12/6/2021

The Joint Commission
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The Joint Commission
Executive Summary

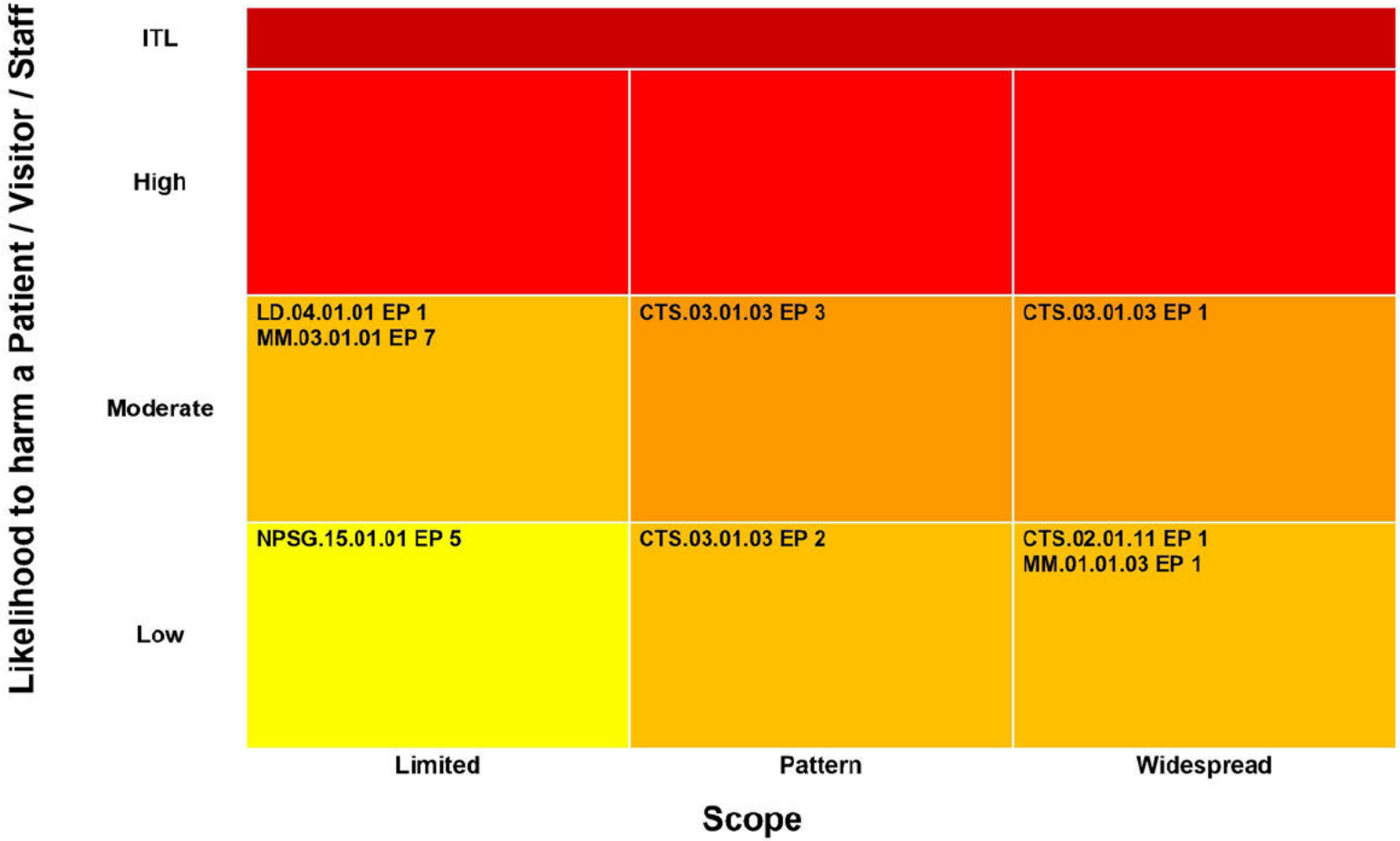
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	11/10/2021 - 11/10/2021	Requirements for Improvement	Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.01.11	1	Low / Widespread	✓
CTS.03.01.03	1	Moderate / Widespread	✓
	2	Low / Pattern	✓
	3	Moderate / Pattern	✓
LD.04.01.01	1	Moderate / Limited	✓
MM.01.01.03	1	Low / Widespread	✓
MM.03.01.01	7	Moderate / Limited	✓
NPSG.15.01.01	5	Low / Limited	✓

The Joint Commission
SAFER™ Matrix
Program: Behavioral Health Care and Human Services



The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.11	1	Low Widespread	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting	1) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site . In 2 out of 2 residential records reviewed, the nutritional screening did not include questions about weight loss or gain of 10 pounds or more in the last 3 months, a decrease in food intake and/or appetite or dental problems. Eating disorder behaviors and food allergies were included in the screening. This was confirmed by the CEO and Director of Risk Management.
CTS.03.01.03	1	Moderate Widespread	The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	1) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site . In 2 out of 2 client records reviewed, the treatment plans were not individualized and had the same goals with little exception. For example, the goal of "Will maintain positive behavior compliance by decreasing externalized behaviors to monthly by discharge" was on both treatment plans with the same short term goals/objectives. In addition, all of the identified needs and goals from the assessment were not included on the treatment plan, deferred or referred out to another provider. For example, in one client record reviewed substance abuse was not included on the treatment plan, however was identified in the assessment as a problem. There was no process in place to defer an identified problem or need or to refer out to another provider. This was confirmed by the CEO and Director of Risk Management.
				2) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Dyersburg, TN) site . In one client residential record reviewed at the McDowell location, the treatment plan did not include all of the identified needs and goals from the assessment. For example, the treatment plan did not address harm to self, ADHD or psychosis, which were identified as treatment needs in the initial assessment. This was confirmed by the Clinical Director and Director of Nursing.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.03.01.03	2	Low Pattern	The plan for care, treatment, or services includes the following: - Goals that are expressed in a manner that captures the individual's words or ideas - Goals that build on the individual's strengths - Factors that support the transition to community integration when identified as a need during assessment - The criteria and process for the individual's expected successful transfer and/or discharge/termination of services, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01) Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors. Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.	1) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site . In 2 out of 2 residential records reviewed, the treatment goals were not in the client's own words or in words that represent the client, but in clinical jargon. For example, one goal was "Patient will show an increase in daily coping skills and decrease mood instability to once per month". This was confirmed by the CEO and Director of Risk Management.
CTS.03.01.03	3	Moderate Pattern	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress	1) Observed in Individual Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site . In 2 out of 2 client records reviewed, the short term goals or objectives were not specific or stepped out in an effort to determine progress and/or completion of goals. For example, one short term goal was "Patient will process triggers and develop skill-building to reduce occurrences of externalized behaviors impacting referral behaviors". This was confirmed by the CEO and Director of Risk Management.
LD.04.01.01	1	Moderate Limited	The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)	1) Observed in Document Review at Keystone Memphis LLC [redacted] Dyersburg, TN) site . The McDowell residential location performs waived testing, including urine drug screens and blood glucose monitoring, however did not have a CLIA certificate at the time of the survey. The organization was able to show verification of the completed application and payment for a CLIA certificate onsite during the survey.
MM.01.01.03	1	Low Widespread	The organization identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. (See also EC.02.02.01, EP 2)	1) Observed in Medication Management Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site . The organization had not developed or implemented a list of hazardous medications that are stored, prescribed and/or administered. This was confirmed by the RN. This was corrected onsite during the survey.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
MM.03.01.01	7	Moderate Limited	For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. Note: This element of performance is also applicable to sample medications.	1) Observed in Medication Management Tracer at Keystone Memphis LLC [redacted] Memphis, TN) site . The medication room refrigerator had an opened vial of tuberculin that was not dated with the expiration date of 28 days after opening according to the manufacturer and the organization's policy. This was confirmed by the RN. This was corrected onsite during the survey.
NPSG.15.01.01	5	Low Limited	Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for individuals served at risk for suicide - Guidelines for reassessment - Monitoring individuals served who are at high risk for suicide	1) Observed in Document Review at Keystone Memphis LLC [redacted] Memphis, TN) site . The organization's suicide risk policy did not include the competence assessment for staff who care for individuals served who are at risk for suicide. The organization had a process to assess suicide risk competency, however did not include this in the written suicide risk policy. This was confirmed by the CEO and Divisional Clinical Director.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.03.01.03	1	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.
CTS.03.01.03	2	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The plan for care, treatment, or services includes the following: - Goals that are expressed in a manner that captures the individual's words or ideas - Goals that build on the individual's strengths - Factors that support the transition to community integration when identified as a need during assessment - The criteria and process for the individual's expected successful transfer and/or discharge/termination of services, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01) Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors. Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.
CTS.03.01.03	3	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served

The Joint Commission

Standard	EP	Standard Text	EP Text
			- They are expressed in terms that provide indices of progress
LD.04.01.01	1	The organization complies with law and regulation.	The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)
MM.01.01.03	1	The organization safely manages high-alert and hazardous medications. Note: This standard is applicable to organizations that engage in any of the medication management processes.	The organization identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. (See also EC.02.02.01, EP 2)
MM.03.01.01	7	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. Note: This element of performance is also applicable to sample medications.
NPSG.15.01.01	5	Reduce the risk for suicide.	Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for individuals served at risk for suicide - Guidelines for reassessment - Monitoring individuals served who are at high risk for suicide

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

UHS-FINHELP-00008742 [Redacted]

Final Accreditation Report

First Hospital Panamericano
[redacted]
Cidra, PR [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 10/26/2021 - 10/29/2021

Programs Surveyed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 10/31/2021

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	10/26/2021 - 10/29/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date
Behavioral Health Care and Human Services	10/26/2021 - 10/28/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

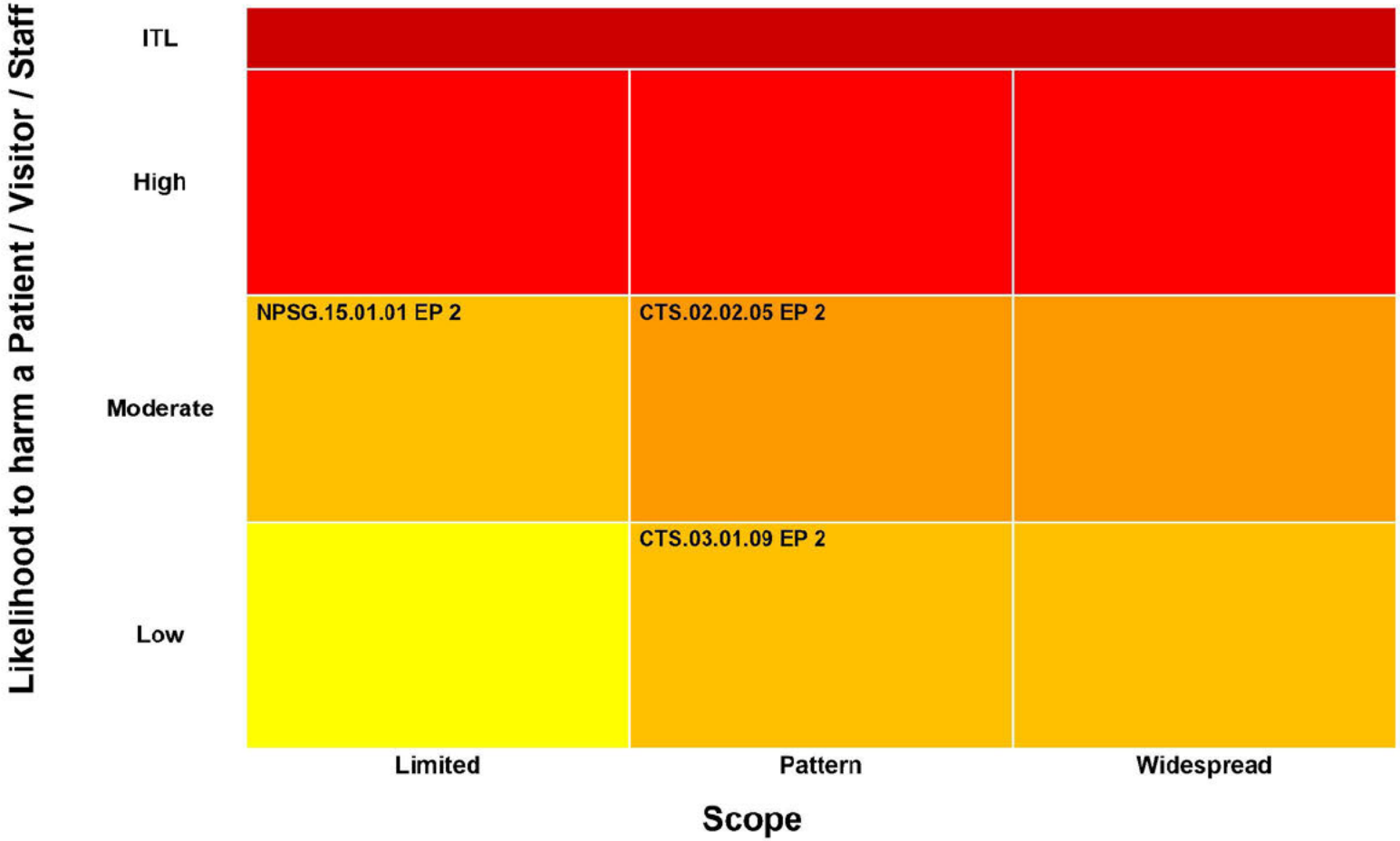
The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.02.05	2	Moderate / Pattern	✓
CTS.03.01.09	2	Low / Pattern	✓
NPSG.15.01.01	2	Moderate / Limited	✓

The Joint Commission
SAFER™ Matrix

Program: Behavioral Health Care and Human Services



The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.02.05	2	Moderate Pattern	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis. Note: For child welfare: The agency also identifies family members, including from the family of origin and/or resource family, who may have experienced trauma, abuse, neglect, or exploitation. The agency defines which family members to include in this process.	1) Observed in Individual Tracer at First Hospital Panamericano [redacted] Cidra, PR) site . This patient in the RTC was not screened for trauma, neglect, or exploitation. Upon reviewing another patient in the partial hospitalization program, it was also observed that the integrated evaluation collected whether the patient experienced emotional, physical and sexual abuse; however, did not collect trauma, neglect or exploitation at the time of the survey. According to the Director of Quality and Compliance and the Director of Outpatient programs, a new tool was implemented in October 2021 that includes those areas; however, that was not yet in use when these patient were admitted.
CTS.03.01.09	2	Low Pattern	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.	1) Observed in Individual Tracer at Centro Acceso y Tratamiento Panamericano de Ponce [redacted] Ponce, PR) site . The residential program used an outcome tool that was placed in a binder separate from the patient's medical record and sent to corporate to be aggregated; however, this tool was not incorporated in any way into the patient's treatment plan and was not included in their medical record. In addition, a patient's treatment plan at the Ponce PHP did not include the PHQ9 outcome tool information.
NPSG.15.01.01	2	Moderate Limited	Screen all individuals served for suicidal ideation using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.	1) Observed in Individual Tracer at First Hospital Panamericano [redacted] Cidra, PR) site . An updated suicide risk screen was not conducted when a patient moved from the organization's inpatient unit to the residential unit. The inpatient screen identified this patient was at heightened suicide risk; however, an updated risk screen was not conducted when she changed level of care to ensure an accurate and updated risk screen was present. According to the Director of Quality and Compliance, an updated process was implemented in October 2021 to ensure this occurred; however, this admission occurred prior to the change in process.

Standard	EP	Standard Text	EP Text
		Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.	physician promptly notified of his or her admission to the hospital. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed in advance of changes to his or her plan of care.

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.02.05	2	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation.	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis. Note: For child welfare: The agency also identifies family members, including from the family of origin and/or resource family, who may have experienced trauma, abuse, neglect, or exploitation. The agency defines which family members to include in this process.
CTS.03.01.09	2	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
NPSG.15.01.01	2	Reduce the risk for suicide.	Screen all individuals served for suicidal ideation using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.

The Joint Commission

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Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

The Joint Commission

Final Accreditation Report

First Hospital Panamericano
[redacted]
Cidra, PR [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 1/21/2022

ESC Programs Reviewed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 1/27/2022

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Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	1/21/2022	No Requirements for Improvement	None	None
Behavioral Health Care and Human Services	1/21/2022	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health Care and Human Services

Standard	Level of Compliance
CTS.02.02.05	Compliant
CTS.03.01.09	Compliant
NPSG.15.01.01	Compliant

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Standard	EP	Standard Text	EP Text
		Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.	physician promptly notified of his or her admission to the hospital. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed in advance of changes to his or her plan of care.

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.02.05	2	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation.	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis. Note: For child welfare: The agency also identifies family members, including from the family of origin and/or resource family, who may have experienced trauma, abuse, neglect, or exploitation. The agency defines which family members to include in this process.
CTS.03.01.09	2	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
NPSG.15.01.01	2	Reduce the risk for suicide.	Screen all individuals served for suicidal ideation using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

UHS-FINHELP-00008758 [Redacted]

The Joint Commission

Final Accreditation Report

First Hospital Panamericano
[redacted]
Cidra, PR [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 11/6/2018

ESC Programs Reviewed
Hospital
Behavioral Health

Final Report: Posted 12/17/2018

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- Requirements for Improvement (RFI) Summary 6

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Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	11/6/2018	No Requirements for Improvement	None	None
Behavioral Health	11/6/2018	No Requirements for Improvement	None	None

Appendix 61.

CONFIDENTIAL

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.03.01.03	Compliant
CTS.03.01.09	Compliant
NPSG.15.01.01	Compliant
RC.01.01.01	Compliant

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Appendix

Standard and EP Text

Program: Hospital

Standard	EP	Standard Text	EP Text
EC.02.05.09	12	The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.	The hospital implements a policy on all cylinders within the hospital that includes the following: - Labeling, handling, and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2 - Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder - Adaptors or conversion fittings are prohibited - Oxygen cylinders, containers, and associated equipment are protected from contamination, damage, and contact with oil and grease - Cylinders are kept away from heat and flammable materials and do not exceed a temperature of 130°F - Nitrous oxide and carbon dioxide cylinders do not reach temperatures lower than manufacturer recommendations or -20°F - Valve protection caps (if supplied) are secured in place when cylinder is not in use - Labeling empty cylinders - Prohibiting transfilling in any compartment with patient care (For full text, refer to NFPA 99-2012: 11.6.1; 11.6.2; 11.6.5; 11.7.3)
EC.02.06.01	1	The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
IC.01.06.01	4	The hospital prepares to respond to an influx of potentially infectious patients.	The hospital describes, in writing, how it will respond to an influx of potentially infectious patients. (See also EM.01.01.01, EP 2) Note: One acceptable response is to decide not to accept patients.
IC.02.02.01	4	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.
LS.02.01.30	3	The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.	All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistive rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square

The Joint Commission

Standard	EP	Standard Text	EP Text
CTS.03.01.03	4	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual's needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.
CTS.03.01.09	2	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
NPSG.15.01.01	1	Identify individuals at risk for suicide.	Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.
RC.01.01.01	6	The organization maintains complete and accurate clinical/case records.	The organization uses standardized formats to document the care, treatment, or services it provides to individuals served.

The Joint Commission

Final Accreditation Report

First Hospital Panamericano
[redacted]
Cidra, PR [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 8/21/2018 - 8/24/2018

Programs Surveyed
Hospital
Behavioral Health

Final Report: Posted 9/7/2018

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Executive Summary

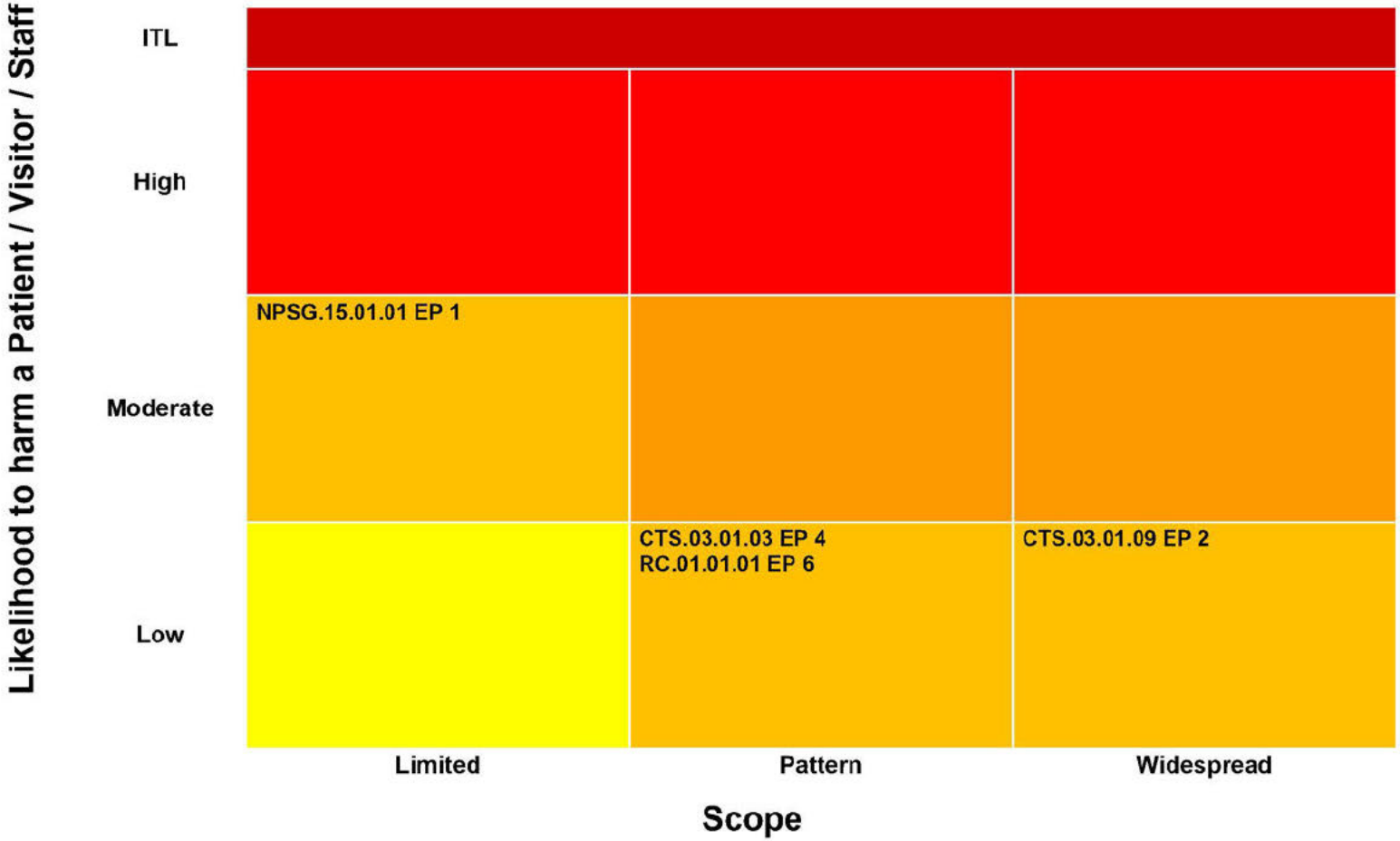
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	08/21/2018 - 08/24/2018	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date
Behavioral Health	08/21/2018 - 08/23/2018	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.03.01.03	4	Low / Pattern	✓
CTS.03.01.09	2	Low / Widespread	✓
NPSG.15.01.01	1	Moderate / Limited	✓
RC.01.01.01	6	Low / Pattern	✓

The Joint Commission
SAFER™ Matrix
Program: Behavioral Health



The Joint Commission
Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.03.01.03	4	Low Pattern	The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual's needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.	1). Observed in Tracer Activities at First Hospital Panamericano [redacted] Cidra, PR) site . In 2 of 3 tracers conducted, the Goals and Objectives within individual Treatment Plans remained unchanged despite noted behavioral changes in clients. In one instance, the client's privileges were withdrawn (Rojo Grava) following self-harming behavior. Despite the self-harm, which amounted to poor coping on the part of the client, Treatment Plan Goals and Objectives weren't updated/modified to reflect the need to learn more effective coping. This finding was discussed with the Chief Executive Officer.
CTS.03.01.09	2	Low Widespread	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.	1). Observed in Individual Tracer at First Hospital Panamericano [redacted] Cidra, PR) site . The organization used the PHQ-9 at admission and discharge, and aggregated the results as part of a Performance Improvement/Outcomes Measurement initiative. However, the instrument was not used at regular intervals throughout care and there was no evidence that results were used to guide individual treatment planning. This finding was discussed with the Chief Executive Officer.
NPSG.15.01.01	1	Moderate Limited	Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.	1). Observed in Tracer Activities at First Hospital Panamericano [redacted] Cidra, PR) site . The intake General Practice physician is tasked with completing the Columbia suicide screening tool at admission. Noted during tracer activity on the NOVO (Detox) unit, the "protective factors" section imbedded within the Columbia screening tool was left undone (blank). Protective factors help mitigate overall suicide risk and can serve as the foundation of the individualized treatment plan. This finding was discussed with the Chief Executive Officer.
RC.01.01.01	6	Low Pattern	The organization uses standardized formats to document the care, treatment, or services it provides to individuals served.	1). Observed in Tracer Activities at First Hospital Panamericano [redacted] Cidra, PR) site . In 2 of 2 tracers conducted, Novo unit; the substance abuse history imbedded within the Intake Assessment was incomplete. Specifically, the "Age of First Use", the "Duration of Use" and the "Use in the last 24-48 hours" were unanswered for a patient with poly-substance use. The General Practice Physician who completed the Intake Assessment used a narrative style to document substance history, missing some important features required of the assessment form. This finding was discussed with the Chief Executive Officer.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation

The Joint Commission

Standard	EP	Standard Text	EP Text
CTS.03.01.03	4	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual's needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.
CTS.03.01.09	2	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
NPSG.15.01.01	1	Identify individuals at risk for suicide.	Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.
RC.01.01.01	6	The organization maintains complete and accurate clinical/case records.	The organization uses standardized formats to document the care, treatment, or services it provides to individuals served.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

UHS-FINHELP-00008775 [Redacted]

SCL-300
(09/12)

STATE OF WYOMING
Department of Family Services

FACILITY VISIT

Facility: WBI - Pathways & Pathfinder

Facility: _____ Date: 1-17-2018 Time: 245 pm

Facility Type: ☐ Crisis Center ☐ Group Home ☑ RTC
☐ CPA ☐ TFC ☐ Detention Center

Address: [redacted] City: Casper

Reason: ☑ Unannounced Visit ☐ Complaint Investigation ☐ Change Request
☐ Compliance Monitoring ☐ Technical Assistance

Rule Violations: _____

* discussion regarding CIRS

* WBI investigation w/ 305 done

27 Total
12 female A
2 child
8 male
Civil
5 boys A

Redacted - PII - Pathfinder - in order for fire, sprinkler done • Fencing still working to do optimista W/Medicai

Observations/Comments:

Redacted - PII - feed off each other escalating in lots of incidents bt New years.

Redacted - PII - moved to BOCES on the 8th

Redacted - PII - discharged from Acute to ER yesterday. and Denver Childrens

Compliance Due Date: NA

Provider Comments (optional)

[redacted] 1-17-2018
Facility Licensing Officer Date

[redacted] 1/17/2018
Facility Representative Date

[redacted] DFS
Detective [redacted]

STATE OF WYOMING
Department of Family Services

SCL-301
(6/13)

Allegation of Non-Compliance

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has received a complaint alleging violations of Wyoming Substitute Care Licensing Rules or Certification Law. The department is legally mandated to investigate all Substitute Care complaints. This complaint was received on: 2/1/2018

The Department of Family Services requests your cooperation. In the absence of such cooperation, the Department of Family Services may take whatever steps are necessary to assure the safety of children.

The Department of Family Services' information may be shared with authorized individuals or agencies, which include, but are not limited to: the Attorney General, County Attorney, and Law Enforcement.

Allegation:	It was reported that youth with known sexual behaviors towards others was placed in a shared room with another youth.	Allegation Type:	Reported
Rules Violated:	**Chapter 3** **Section 13. Child Health and Safety** (a) The organization shall develop, adopt, follow and maintain on file written policies and procedures to keep children safe and healthy while in their facilities. (b) Health and Safety Documentation. Within twenty-four (24) hours of admission to the program, the program intake staff shall document or obtain the health and safety status of the child including: (xvii) Sexual history or behavior patterns that may place the child or other children at risk; (c) Child's Health and Safety Plan. If indicated in the health and safety documentation, an individual written plan to address the child's health and safety issues shall be developed and implemented as soon as practical but not more than seven (7) calendar days from the date of the screening.		

Allegation:	No CIR was received by licensing for a child-on-child incident reported to the local office by WBI on 1-30-2018.	Allegation Type:	Reported
Rules Violated:	**Chapter 3** **Section 4. Critical Incident Reporting** (a) The organization shall develop, adopt, follow and maintain on file written policies, procedures and reporting forms governing all aspects of reporting critical incidents. The following types of incidents shall be reported as critical incidents: (v) Child-on-child sexual contact;		

If you have questions regarding this matter, please contact the facility Licensing Officer listed below.

Licensing Officer:	[redacted]		
Address:			
City:	Rock Springs	State:	WY
Telephone:	[redacted]	Zip Code:	[redacted]

[redacted] 2-2-18

(Licenser) (Date)

cc: Substitute Care Facility
Licenser

SCL-300
(09/12)

STATE OF WYOMING
Department of Family Services

FACILITY VISIT

Facility: CRI

Facility: Pathways PathFinders Date: 2-5-18 Time: 11:30 AM

Facility Type: ☐ Crisis Center ☐ Group Home ☑ RTC
☐ CPA ☐ TFC ☐ Detention Center

Address: _____ City: Casper

Reason: ☑ Unannounced Visit ☑ Complaint Investigation ☐ Change Request
☐ Compliance Monitoring ☐ Technical Assistance

Rule Violations: _____

Exit door on girls side has cold air coming from bottom.

Observations/Comments: 24 total 11a girls 13 boys combo of both pathways & pathFinders. Investigation was not for pathways & pathFinders. Moving PathFinders back sol for March 1st

Compliance Due Date: 30 days.

Provider Comments (optional)

[redacted]
Facility Licensing Officer

2-5-18
Date

[redacted]
Facility Representative

2/5/18
Date

STATE OF WYOMING
Department of Family Services

SCL-305
(7/16)

NOTICE OF NON-COMPLIANCE

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute Pathfinders	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has completed the investigation/inspection regarding alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children received on: 3-28-2018

The following finding(s) are being made on the alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children:

Allegation:	It was reported that youth was sexually assaulted by another child several times.	Reported
Date of Allegation:	3-28-18	
Finding:	Allegations not supported	
Rules Violated:	Chapter 3 Section 2 Responsibilities of the Organization (e) The organization shall oversee quality assurance of the program. In this regard, the organization shall make provisions for examining and evaluating its programs at predetermined intervals to: (i) Ensure that the care and services provided are in accordance with the purpose of the organization; (ii) Evaluate the effectiveness and efficiency of services provided;	
Explanation for findings:	Interviews with youth and staff found that staff followed required supervision at time of incidents reported. Staff took appropriate action once they were made aware of allegations by youth against another youth.	

Allegation:	It was reported that youth was sexually assaulted by another child several times.	Reported
Date of Allegation:	3-28-18	
Finding:	Allegations not supported	
Rules Violated:	Chapter 3 Section 11. Staff Training. (a) Orientation Training. All staff (including foster parents) must complete a prescribed number of hours of orientation training, as set forth in each program-specific chapter of these rules. (L) The overall importance of the direct supervision and safety of children;	
Explanation for findings:	Through review of files and interviews it found that staff was current on training provided by facility.	

Per the Administrative Rules for Certification of Providers of Substitute Care Services for Children, the corrective action plan (CAP) to address the issues of non-compliance, must be submitted for approval within thirty (30) days of the below date.

If you disagree with the Department's finding of non-compliance of the Administrative Rules for Certification of Providers of Substitute Care Services for Children, you may request an administrative hearing within ten (10) days of your receipt of this letter (W.S. 14-4-108). Administrative Hearing procedures are included in the Department's Contested Case Hearing Rules. If you need a copy of the Rules or assistance in requesting an administrative hearing, you may contact your Licenser or Supervisor listed below.

Licenser: [redacted]
Address: [redacted]
City: Rock Springs, WY
Telephone: [redacted]

[redacted] 6-21-18
(Licenser) (Date)

[redacted] 6-8-2018
(Manager) (Date)

cc: Substitute Care Facility
Licenser

STATE OF WYOMING
Department of Family Services

SCL-305
(7/16)

NOTICE OF NON-COMPLIANCE

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute Pathfinders	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has completed the investigation/inspection regarding alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children received on: 4-2-2018

The following finding(s) are being made on the alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children:

Allegation:	It was reported that a child that was placed on a safety plan by DFS that required them in staff view at all times was in the room of a child of the opposite gender and out of staffs view.	Reported
Date of Allegation:	4-2-18	
Finding:	Support allegation.	
Rules Violated:	Chapter 3 Section 2 Responsibilities of the Organization (e) The organization shall oversee quality assurance of the program. In this regard, the organization shall make provisions for examining and evaluating its programs at predetermined intervals to: (i) Ensure that the care and services provided are in accordance with the purpose of the organization; (ii) Evaluate the effectiveness and efficiency of services provided;	
Explanation for findings:	Video of incident shows youth on a safety plan, that was to be in staffs view at all times, was in the room of another child of opposite gender and out of staff's supervision.	
Recommendations for Compliance:	The organization's corrective action plan should include the development, adoption, follow-up and monitoring of written policies and procedures governing all elements regarding appropriate supervision of youth. The policy should include what direct care supervision is. In addition, the policy should include procedures for training and monitoring of all staff. The organization should ensure that day to day operations are consistent with policy and procedure. The organization should train and re-train all organization members on procedure for providing direct care to youth residents.	
Corrective Action Plan (CAP) Due Date:	30 - Days	

Allegation:	It was reported that a child that was placed on a safety plan by DFS that required them in staff view at all times was in the room of a child of the opposite gender and out of staffs view.	Reported
Date of Allegation:	4-2-18	
Finding:	Support allegation.	
Rules Violated:	Chapter 3 Section 13. Child Health and Safety. (a) The organization shall develop, adopt, follow and maintain on file written policies and procedures to keep children safe and healthy while in their facilities.	
Explanation for findings:	Through interviews and video it was found that staff did not completely follow a safety plan left by DFS.	
Recommendations for Compliance:	The organization's corrective action plan should include the development, adoption, follow-up and monitoring of written policies and procedures governing all elements of safety of the residents. The plan should include the steps to notify all staff of safety plans and special needs of youth in care. The organization should ensure that day to day operations are consistent with policy and procedure. The organization should train and re-train all organization members on procedure for following safety plans by facility as well as DFS.	
Corrective Action Plan (CAP) Due Date:	30- Days.	

Per the Administrative Rules for Certification of Providers of Substitute Care Services for Children, the corrective action plan (CAP) to address the issues of non-compliance, must be submitted for approval within thirty (30) days of the below date.

If you disagree with the Department's finding of non-compliance of the Administrative Rules for Certification of Providers of Substitute Care Services for Children, you may request an administrative hearing within ten (10) days of your receipt of this letter (W.S. 14-4-108). Administrative Hearing procedures are included in the Department's Contested Case Hearing Rules. If you need a copy of the Rules or assistance in requesting an administrative hearing, you may contact your Licenser or Supervisor listed below.

Licenser: [redacted]
Address: [redacted]
City: Rock Springs, WY
Telephone: [redacted]

[redacted] 6-21-18
(Licenser) (Date)

[redacted] 6-8-2018
(Manager) (Date)

cc: Substitute Care Facility
Licenser

WYOMING BEHAVIORAL INSTITUTE

DFS - Plan of Correction April Complaint Site Survey 2018

Findings	Action/Follow up	Responsible Person	Date
It was reported that a child that was placed on a safety plan by DFS, that required the child in staff view at all times, was in the room of a child of the opposite gender and out of staffs view.	Pathfinders' staff have been trained on safety plans to the understanding that they are responsible to follow the safety plan at all times.	[redacted] LPC	7/27/2018
	New procedure will be instituted that any safety plan must be signed off on by a director level position to be implemented.	[redacted] LPC	7/27/2018
	WBI is in the process of changing observation policy to reflect only three observation statuses: 1:1, Q5 checks, and Q15 checks. All residential staff will be trained on the new policy and procedure. High precautions and Moderate precautions will be discontinued as a practice at WBI.	[redacted] LPC, [redacted] DON	7/27/2018

[redacted]
Casper, WY [redacted]
[redacted]
fax
fax [redacted] **medical records**

Wyoming Behavioral Institute

Memo

From: [redacted] Executive Director of Residential Services

Date: 7/17/2018

Re: Safety Plans

Attn: All Staff

When a patient has been placed on a safety plan all staff are to be made aware of that at each shift report. Safety plans are required to be followed with attention to detail. It is not the job of the staff to determine the validity of a safety plan, but to maintain the expectations of that safety plan. Safety plans are to be followed in exact accordance with how they are written. Failure to do so could impact the integrity of the program and the safety of the unit. Any concerns with not following the safety plan as written will be administratively reviewed and may be subject to corrective action.

Safety plans initiated by an external agency must be agreed to by a Director level position or higher. This will be to ensure that the expectations of the safety plan are effectively communicated, implemented, and followed.

All your efforts to keep the unit safe and structured are appreciated and recognized. Continued attention to safety will help us to grow and strengthen ourselves as a program.

If you have any questions please feel free to contact me.

STATE OF WYOMING
Department of Family Services

SCL-305
(10/2014)

NOTICE OF NON-COMPLIANCE

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has completed the investigation/inspection regarding alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children received on: 2-13-19

The following finding(s) have been found on the alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children:

Allegation:	It was reported that youth contacted her mother after a possible suicidal ideation or attempt. When mom called back to speak to a staff member because her daughter was so upset the staff was unaware of what was going on.	Reported
Date of Allegation:	2-13-19	
Finding:	Evidence was found to support a rule violation	
Rules Violated:	Chapter 3 Section 4. Critical Incident Reporting (a)The organization shall develop, adopt, follow and maintain on file written policies, procedures and reporting forms governing all aspects of reporting critical incidents. The following types of incidents shall be reported as critical incidents: (iii)Suicidal, homicidal or unable to meet basic needs; (b)A verbal report must be made immediately to the child's legal guardian upon occurrence of a critical incident except as provided in (iv) above.	
Explanation for findings:	Through interviews with parent and staff it was found that staff did not follow policy on calling parents and submitting a CIR.	
Recommendations for Compliance:	The organization shall retrain staff on policy and procedures in handling any suicide ideation or attempt.	
Corrective Action Plan due date	Organization has clearly defined what needs to be reported on CIR as it pertains to suicide attempts or ideation. They have also trained staff on current policy on how to handle calls to parents and reporting. No further correction is required at this time.	

Allegation:	It was reported that youth had a possible suicidal attempt or ideation and not CIR was sent to DFS.	Reported
Date of Allegation:	2-13-19	
Finding:	Evidence was found to support a rule violation	
Rules Violated:	Chapter 3 Section 4. Critical Incident Reporting (a)The organization shall develop, adopt, follow and maintain on file written policies, procedures and reporting forms governing all aspects of reporting critical incidents. The following types of incidents shall be reported as critical incidents: (iii)Suicidal, homicidal or unable to meet basic needs; (c)The verbal report must be followed by completion and submission of the DFS Critical Incident Report Form to the certifying authority within two (2) working days after the occurrence.	
Explanation for findings:	Through interviews with parent and staff it was found that staff did not follow policy on calling parents and submitting a CIR.	
Recommendations for Compliance:	The organization shall submit a CIR for any suicide ideation or attempt that was serious enough that steps were taken to assure safety of a child.	
Corrective Action Plan due date:	Organization has clearly defined what needs to be reported on CIR as it pertains to suicide attempts or ideation. They have also trained staff on current policy on how to handle calls to parents and reporting. No further correction is required at this time.	

Per the Administrative Rules for Certification of Providers of Substitute Care Services for Children, the corrective action plan (CAP) to address the issues of non-compliance, must be submitted for approval within thirty (30) days of the below date.

If you disagree with the Department's finding of non-compliance of the Administrative Rules for Certification of Providers of Substitute Care Services for Children, you may request an administrative hearing within ten (10) days of your receipt of this letter (W.S. 14-4-108). Administrative Hearing procedures are included in the "Wyoming Substitute Care Rules, Chapter 4 and based upon the above statute. If you need a copy of the Rules or assistance in requesting an administrative hearing, you may contact your Licenser or Supervisor listed below.

Licenser: [redacted]
Address: [redacted]
City: Rock Springs, WY [redacted]
Telephone: [redacted]

[redacted] 4-4-19
(Licenser) (Date)

[redacted] 04-15-2019
(Manager) (Date)

cc: Substitute Care Facility
Licenser

SCL - 300
(07/2018)
Services

STATE OF WYOMING
Department of Family

Substitute Care
Facility Site Visit Form

Facility Name	(DBT Pathways
Facility Address	
Director	[redacted]
Date & Time of Visit	3-12-19 11 am
Staff met with during the visit	Redacted - PII

Facility Type:	**Reason for Visit:**
■ Residential Treatment ■ Detention Center ■ Group Home ■ Crisis Center ■ Other_____	☐ Unannounced Visit ☑ Investigation ☐ Change Request ☐ Compliance Monitoring ☐ Other_____

Current Resident Census: 25 26a

Describe Visit and Areas Inspected:

Met with staff on investigation. Walk
on, not found rooms are clean. Spoke
about CIR's and what needs reported

Rule Violation(s) and Action Needed:

A representative of the Department of Family Services has observed an alleged violation of Wyoming Substitute Care Licensing Rules or Certification Law. **This form serves as notice of observation of alleged non-compliance for the below-listed rules.** The Department requests your cooperation. In the absence of such cooperation, the Department may take whatever steps are necessary to assure the safety of children. The Department's information may be shared with authorized individuals or agencies, which include but are not limited to, the Attorney General, County Attorney, and law enforcement. A Notice of Non-Compliance (SCL-305) will follow to notify you of Licensing's findings. A corrective action plan and/ or additional verifications may need to be submitted.

Description of Observation:	Chapter and Section:	Action Needed:

Corrective Action Plan Due Date: [redacted]

Facility Staff Signature Redacted - PII

Licensor Signature [redacted]

STATE OF WYOMING
Department of Family Services

SCL-305
(10/2014)

NOTICE OF NON-COMPLIANCE

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has completed the investigation/inspection regarding alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children received on: 5-3-19

The following finding(s) have been found on the alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children:

Allegation:	It was reported that youth was pulled from his bed by staff for not leaving his room. During the incident the youth is reporting injuries.	Reported
Date of Allegation:	5-3-19	
Finding:	Evidence was found to not support a rule violation	
Rules Violated:	Chapter 3 Section 23.Child Rights. All organizations shall develop and maintain a child's rights policy that supports and protects the fundamental human, civil, constitutional, and statutory rights of all children. These rights shall include, but are not limited to, the following: (a)Every child and family shall have the right to be free from abuse, financial or other exploitation, retaliation, humiliation and neglect;	
Explanation for findings:	Through interviews with staff involved and youth that witnessed the event it was found that a restraint was done correctly and the youth was feared to be a danger to himself due to past behavior.	

Per the Administrative Rules for Certification of Providers of Substitute Care Services for Children, the corrective action plan (CAP) to address the issues of non-compliance, must be submitted for approval within thirty (30) days of the below date.

If you disagree with the Department's finding of non-compliance of the Administrative Rules for Certification of Providers of Substitute Care Services for Children, you may request an administrative hearing within ten (10) days of your receipt of this letter (W.S. 14-4-108). Administrative Hearing procedures are included in the "Wyoming Substitute Care Rules, Chapter 4 and based upon the above statute. If you need a copy of the Rules or assistance in requesting an administrative hearing, you may contact your Licenser or Supervisor listed below.

Licenser: [redacted]
Address:
City: Rock Springs, WY [redacted]
Telephone: [redacted]

[redacted] 5-10-19
(Licenser) (Date)

[redacted] 6-10-19
(Manager) (Date)

cc: Substitute Care Facility
Licenser

STATE OF WYOMING
Department of Family Services

SCL-301
(6/13)

Allegation of Non-Compliance

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has received a complaint alleging violations of Wyoming Substitute Care Licensing Rules or Certification Law. The department is legally mandated to investigate all Substitute Care complaints. This complaint was received on: 5-3-2019

The Department of Family Services requests your cooperation. In the absence of such cooperation, the Department of Family Services may take whatever steps are necessary to assure the safety of children.

The Department of Family Services' information may be shared with authorized individuals or agencies, which include, but are not limited to: the Attorney General, County Attorney, and Law Enforcement.

Allegation:	It was reported that youth was pulled from his bed by staff for not leaving his room. During the incident the youth is reporting injuries.	Allegation Type:	Reported
Rules Violated:	Chapter 3 Section 23.Child Rights. All organizations shall develop and maintain a child's rights policy that supports and protects the fundamental human, civil, constitutional, and statutory rights of all children. These rights shall include, but are not limited to, the following: (a)Every child and family shall have the right to be free from abuse, financial or other exploitation, retaliation, humiliation and neglect;		

If you have questions regarding this matter, please contact the facility Licensing Officer listed below.

Licensing Officer:	[redacted]		
Address:	[redacted]		
City:	Rock Springs	State:	WY
Telephone:	[redacted]	Zip Code:	[redacted]

[redacted] 5-9-19

(Licenser) (Date)

cc: Substitute Care Facility
Licenser

STATE OF WYOMING
Department of Family Services

SCL-305
(10/2014)

NOTICE OF NON-COMPLIANCE

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has completed the investigation/inspection regarding alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children received on: 5-3-19

The following finding(s) have been found on the alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children:

Allegation:	It was reported that youth was pulled from his bed by staff for not leaving his room. During the incident the youth is reporting injuries.	Reported
Date of Allegation:	5-3-19	
Finding:	Evidence was found to not support a rule violation	
Rules Violated:	Chapter 3 Section 23.Child Rights. All organizations shall develop and maintain a child's rights policy that supports and protects the fundamental human, civil, constitutional, and statutory rights of all children. These rights shall include, but are not limited to, the following: (a)Every child and family shall have the right to be free from abuse, financial or other exploitation, retaliation, humiliation and neglect;	
Explanation for findings:	Through interviews with staff involved and youth that witnessed the event it was found that a restraint was done correctly and the youth was feared to be a danger to himself due to past behavior.	

Per the Administrative Rules for Certification of Providers of Substitute Care Services for Children, the corrective action plan (CAP) to address the issues of non-compliance, must be submitted for approval within thirty (30) days of the below date.

If you disagree with the Department's finding of non-compliance of the Administrative Rules for Certification of Providers of Substitute Care Services for Children, you may request an administrative hearing within ten (10) days of your receipt of this letter (W.S. 14-4-108). Administrative Hearing procedures are included in the "Wyoming Substitute Care Rules, Chapter 4 and based upon the above statute. If you need a copy of the Rules or assistance in requesting an administrative hearing, you may contact your Licenser or Supervisor listed below.

Licenser: [redacted]
Address:
City: Rock Springs, WY Suite [redacted]
Telephone:

[redacted] 5-10-19
(Licenser) (Date)

[redacted] 6-10-19
(Manager) (Date)

cc: Substitute Care Facility
Licenser

STATE OF WYOMING
Department of Family Services

SCL-301
(6/13)

Allegation of Non-Compliance

Notice To Director:	[redacted]	Notice To Board of Directors:	[redacted]
Facility Name:	Wyoming Behavioral Institute Pathfinders	Facility Name:	WBI
Mailing Address:	[redacted]	Mailing Address:	[redacted]
City:	Casper, WY [redacted]	City: Casper, WY [redacted]	Casper, WY [redacted]

The Department of Family Services has received a complaint alleging violations of Wyoming Substitute Care Licensing Rules or Certification Law. The department is legally mandated to investigate all Substitute Care complaints. This complaint was received on: 6-18-2019

The Department of Family Services requests your cooperation. In the absence of such cooperation, the Department of Family Services may take whatever steps are necessary to assure the safety of children.

The Department of Family Services' information may be shared with authorized individuals or agencies, which include, but are not limited to: the Attorney General, County Attorney, and Law Enforcement.

Allegation:	A child is reporting unwanted touch and treatment form another youth causing her to feel unsafe.	Allegation Type:	Reported
Rules Violated:	**Chapter 3** **Section 13 Child Health and Safety.** (a) The organization shall develop, adopt, follow and maintain on file written policies and procedures to keep children safe and healthy while in their facilities.		

Allegation:	Reports to DFS about youth possibly exposing themselves to another youth was not included on the CIR sent to licensing.	Allegation Type:	Reported
Rules Violated:	**Chapter 3** **Section 4. Critical Incident Reporting.** (a)The organization shall develop, adopt, follow and maintain on file written policies, procedures and reporting forms governing all aspects of reporting critical incidents. The following types of incidents shall be reported as critical incidents: (v)Child-on-child sexual contact;		

If you have questions regarding this matter, please contact the facility Licensing Officer listed below.

Licensing Officer:	[redacted]		
Address:			
City:	Rock Springs	State:	WY
Telephone:	[redacted]	Zip Code:	[redacted]

[redacted]
(Licenser)

6-24-19
(Date)

cc: Substitute Care Facility
Licenser

SCL-300
(05/09)

STATE OF WYOMING
Department of Family Services

FACILITY VISIT

Facility: WBI

Facility: _____ Date: 10-15-19 Time: 3:30pm

Facility Type: ☐ Crisis Center ☐ Group Home ☒ RTC
☐ CPA ☐ TFC ☐ Detention Center

Address: _____ City: Casper

Reason: ☒ Unannounced Visit ☐ Complaint Investigation ☐ Change Request
☐ Compliance Monitoring ☐ Technical Assistance

Rule Violations:

Observations/Comments:

Visit with Redacted - PII and Redacted - PII
24 youth @ WBI today. One youth is 9 yrs old.

Compliance due date: _____

Provider Comments (optional):

[redacted] 10-15-19
Facility Licensing Officer Date

[redacted] 10/15/19
Facility Representative Date

Optum®

WYhealth

On-Site Compliance Review
Wyoming Behavioral Institute

Dates of review: March 29 & 30, 2022

Prepared for: Wyoming Department of Health

Submitted by: Optum

Date of Submission: April 19, 2022

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UHS-FINHELP-00008795

1 Overview

The purpose of an on-site compliance review (OSCR) is to verify that the Psychiatric Residential Treatment Facility (PRTF) follows all applicable state and federal requirements for mental health treatment, and to monitor the quality of treatment provided to Wyoming Medicaid beneficiaries.

The goals of the OSCR are as follows:

- Assess the program and services offered by the PRTF through direct observation, document review, and staff/resident interviews by experienced clinicians.
- Provide clear, specific feedback about review findings to PRTF staff for services to be improved.

The implementation of the OSCR helps to make sure of the quality of services given to Medicaid beneficiary families and guardians and provides the opportunity to improve the quality of services through the feedback process.

1.1 Compliance Areas Validated

1.1.1 Administrative

This area includes the organizational structure and management of the facility. The facility's administrative functions are evaluated by reviewing the following:

- Policy and Procedure Manual
- Staff credentials
- Transfer arrangements and agreements with hospitals
- Incident report process
- Quality management and improvement program
- Additional documents as required

1.1.2 Program

This area includes the philosophy and structure of the facility's approach to treatment (treatment strategy, program design and plan to implement). The facility's program is evaluated through review of documents (such as, program description, policies and

procedures, unit rules/regulations, unit level systems, schedule of unit activities, staff training, seclusion/restraint logs, etc.), and facility tour and staff interviews.

1.1.3 Services

This area includes the way the PRTF program translates the program philosophy and strategy into treatment for residents. The review team looks at whether services are delivered in a manner that provides maximum benefit to each child through implementation of an individualized treatment plan. The facility's services are evaluated through review of clinical records and resident interviews.

1.2 Method of Review Process

1.2.1 Review Team

Table 1: Name, Role and Affiliation of Review Team

Name/Role	Affiliation
[redacted] LPC, Reviewer	Optum
[redacted] MD, Psychiatric Reviewer	Seattle Children's Hospital

1.2.2 Review Process

1.2.2.1 Administrative Introduction and Entrance Interview

An entrance interview was conducted on March 29, 2022, with the Wyoming Behavioral Institute (WBI) leadership team. The team was given the opportunity to inform the reviewer of any changes, improvements, etc. recently implemented by the PRTF.

1.2.2.2 Facility Tour

A tour of WBI was conducted to review the condition of the living and treatment spaces in which WY Medicaid youth spend their time.

1.2.2.3 Review of Administrative and Program Records

A review of the WBI administrative and program records was conducted. Information reviewed included policies and procedures, program descriptions, transfer agreements with hospitals, staff credentials, seclusion/restraint logs, and quality improvement documents.

1.2.2.4 Review of Clinical Records

The clinical record review for five WY Medicaid youth at WBI was completed by an independently licensed Mental Health Professional and a Board-Certified Psychiatrist.

1.2.2.5 Staff Interviews

Five staff members were randomly selected for interviews from a variety of disciplines. The purpose of the staff interviews is to determine whether there is guiding treatment principles at WBI that staff uses in their everyday work with WY Medicaid youth, how well program guidelines are carried out in practice, and to assess the collaborative processes among the treatment team.

1.2.2.6 Resident Interviews

Five WY Medicaid youth were selected for interviews. One of the five youth was experiencing mood instability to the point of aggression and lacked the ability to participate safely in an interview. Four youth were interviewed. Interviews were conducted to get their perception of care provided by the PRTF.

1.2.2.7 Exit Interview

An exit interview was conducted on March 30, 2022, with the WBI executive team to present an overview of the OSCR visit findings. At this time, the executive team was able to ask questions and request examples of problems cited.

1.2.2.8 Written Report

This document serves as the written report to Wyoming Department of Health (WDH) and upon approval by the Department, presented to the PRTF for quality improvement.

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2 OSCR Findings

2.1 Administrative

2.1.1 Overview

The overall impression of WBI was positive. The structure and management of WBI is organized in a way that appears to adequately meet the behavioral health needs of WY Medicaid enrolled youth.

2.1.2 Administrative Documentation Review Findings — Appendix A

The PRTF provided documentation indicating that its accreditation and licensing were current. Professional licensing/certification documentation was reviewed and indicated that all staff licensing/credentialing is current and without Medicaid/Medicare exclusions.

All documents requested were available to the reviewer by the various request deadlines. Electronic delivery of the clinical records was completed by the due date and the PRTF communicated with the reviewer to ensure any questions did not delay delivery.

WBI provided documentation that incidents had been reported to WDH. This documentation was consistent with incident reporting records kept by WDH.

2.1.3 Facility Tour Findings – Appendix B

A tour of the WBI facility shows wear and tear typical of a building utilized for PRTF level services.

The majority of the facility was well maintained and clean. The exceptions were a door damaged by a youth during an explosive episode appeared to pose a potential injury risk, cracked and damaged pavement in the parking lot posed a tripping hazard, and the drain in one sidewalk had a hole in the concrete with rebar showing. The sidewalk had been closed and was clearly marked as such. When asked about the sidewalk and pavement, the leadership team reported that they had been searching for a paving or concrete company to do the work but had not been successful in finding a company to come and provide a bid for the work.

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2.2 Program

2.2.1 Overview

WBI is licensed for 44 beds on three units. The leadership team explained that Wyoming determines facility capacity based on space availability, not actual bed count. WBI only has 34 beds available for PRTF youth. The census on the day of the entrance interview was 28 youth.

WBI provides care to youth assigned female at birth ages 10-17 years old. Common diagnoses treated are Post Traumatic Stress Disorder, Major Depressive Disorder, and Bipolar Disorder as well as services for youth engaging in sexually maladaptive behaviors; youth identifying as lesbian, gay, bi-sexual, transgender, and queer and youth diagnosed with a Substance Use Disorder (SUD).

WBI's primary therapeutic focus is on providing trauma informed care (TIC). This is done in a variety of ways including the use of Trauma Focused Cognitive Behavior Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), and various therapeutic and community groups.

The youth participate in a psychiatrist led Doctor Group a minimum of two days per week. Each group is followed up with the psychiatrist meeting individually with each youth. Youth are given a therapeutic assignment to complete the day before Doctor Group, so they come prepared to participate.

Youth participate in weekly Trauma Group which includes completion of a trauma packet with various exercises the work on with their therapist, in family therapy, and alone to process their trauma history and to develop positive coping skills.

Additional services provided include skills groups, daily goals groups, family therapy, art therapy, music therapy, and Occupational Therapy.

Family day passes have resumed in response to Center for Disease Control COVID-19 guidelines; however, overnight passes are still not allowed to minimize the risk of exposure.

The average length of stay was reported by the leadership team to be approximately 90 days. The WY Medicaid enrolled youth interviewed and whose clinical records were

reviewed, had an average length of stay of 56 days. Admit/ Discharge data is detailed in Table 2.

WBI is not equipped to treat youth with medical conditions that require 24-hour nursing, diminished cognitive abilities that would prevent the youth from benefiting from treatment, a history of Conduct Disorder, or youth with a history of extreme sexual aggression. The facility layout does not allow for sufficient separation of genders, so WBI has made the decision to not accept male youth.

Table 2: Admit/Discharge Data

Client Code	Admit	Discharge	Length of Stay
Redacted - PII	2-14-2022	n/a	51+
	2-25-2022	n/a	62+
	2-18-2022	n/a	55+
	2-10-2022	n/a	47+
	2-28-2022	n/a	65+

2.2.2 Program Documentation Review Findings – Appendix C

2.2.2.1 Behavioral Program

The behavior program at WBI is based on the Nurtured Heart approach. The focus is to acknowledge and reward desired behaviors and to extinguish undesired behaviors.

There are four phases of treatment with each phase having an expectation of increased level of responsibility, self-awareness, and accompanying privileges. Movement through the phases is based on the youth completing various worksheets that are then reviewed and signed by staff agreeing that the youth has met that task's expectations.

Once a youth has moved from one phase to another, regression in use of coping skills or unsafe behavior can lead to them being placed on the status of "off trust" indicating that the youth is struggling and requires additional structure to manage their behavior. The leadership team reported that in rare cases a youth might be moved back to a previous phase if they had eloped or engaged in self-harm after moving to the higher two of the four levels.

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2.2.2.2 Training

The staff education plan indicates that all WBI staff are adequately trained to work with youth in a PRTF environment. Topics of education include, suicide awareness, infection prevention, milieu strategies, overview of psychiatric diagnoses, and proper documentation procedures.

The leadership team reported that a major part of ongoing staff training is the impact trauma has on youth behavior and how to work in ways that maintain safety without further traumatizing the youth. This includes a loosening of standards on issues related to how clean the youth keep their rooms and what they choose to wear. It also included ongoing discussions in shift change meetings about various interventions staff have found are successful with specific youth.

2.2.2.3 Restraint/Seclusion

All clinical staff members involved in the direct care of youth at WBI are trained in use of the Handle with Care model of restraint. Training is completed at the time of orientation with refresher training being completed yearly after that.

Seclusion rooms are well-lighted and ventilated. Youth can be always monitored through both direct observation and by camera. Some of the seclusion rooms have murals painted on the walls and WBI staff report there are plans to paint murals on the walls of all seclusion rooms.

WBI also provides some spaces that are not utilized as seclusion rooms for youth to go if they feel overstimulated and need to take a time out.

2.2.2.4 Outcomes

WBI uses various methods to measure outcomes. These include tracking seclusion and restraint data, staff availability and turnover, youth and family satisfaction survey results, and the comparison data of Child and Adolescent Behavior Assessment- by Youth (CABA-Y) and Child and Adolescent Behavior Assessment- by Informant (CABA-I) taken at intake and discharge.

Quantitative data provided by the leadership team for 2021 shows that out of 98 youth discharged, the CABA-Y score improved for 69 youth, the CABA-I score improved for

81 youth, and the patient satisfaction score improved for 81 youth. Data for other outcome measures were not requested or provided.

2.2.3 Staff Interview Findings – Appendix D

Five staff members were randomly selected for interviews. All five staff members agreed to participate in the interview process.

All staff members interviewed could provide multiple examples of ways that WBI provides TIC. These included education of staff on the ways that a history of trauma can impact the behavior of the youth, focus on the use of verbal de-escalation to manage situations in which youth may become unsafe for themselves or others, and groups that focus on a range of factors addressing trauma.

All staff members interviewed report that the supervision they received was helpful and improved the quality of their work with the youth. They all named multiple people they could go to if their direct supervisor was not available. One staff member reported that WBI was the best place they had ever worked in terms of the willingness of staff to work as a team in the best interest of the youth.

When asked about training at WBI, all five staff members reported that they felt well trained to work with youth experiencing a variety of mental health and behavioral challenges. Trainings identified as being helpful in elevating their confidence to do their work competently included Nurtured Heart and Handle with Care. The Handle with Care training was called out as an excellent source of increasing options for verbal de-escalation.

Every staff member interviewed could explain the appropriate use of restraint and seclusion, identify which staff members could authorize use, and describe the documentation process. They all could name at least five different methods of de-escalation used, with two staff members reporting the de-escalation method used varied based on the youth in questions trauma history.

Staff members all report that the units are adequately staffed, and they can take time off without it impacting care of the youth. One staff member did point out the difference between being adequately staffed vs. being in ratio per state guidelines.

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2.3 Client Services

2.3.1 Overview

A review of the clinical record provided was conducted by Dr. [redacted] with Seattle Children's Hospital. Additional findings from the clinical record review conducted by independently licensed mental health professional [redacted] MBA, LPC, follow Dr. [redacted] report.

2.3.2 Psychiatric Record Review Findings – Appendix E

WBI Case reviews April 2022

By Robert Hilt, MD

Redacted - PII **admitted 2/14/22**

12-year-old was admitted for suicidality after an altercation with her family, with that altercation severe enough to result in a renal injury to a grandmother. She was reported by family to have been infatuated with boys, engaging in inappropriate relationships, so her father took away her phone, then she escalated to aggression toward father and other family members, made suicidal threats, running away. Has a history of refusing outpatient therapy. She had prior WBI stays. History of physical, sexual and emotional abuse. Mom lives in Missouri. History of opiate, EtOH and THC use.

She was admitted taking Abilify 5mg nightly, Zoloft 50mg daily, Strattera 60mg daily, Melatonin 5mg nightly, plus Vitamin D and Multivitamin supplements

Weight 90 pounds on admission (described as "underweight")

Provider notes discussed her as having bulimia tendencies, having repeated refusals to go to groups on the unit, and encouragements from them to engage in care. She discussed that she thought her meds had helped with tics and moods, and she had a desire to be on Strattera

On 2/18/22 shortly after admission they noted she had some changes like grandiosity, so she was weaned off the Zoloft, recommended to be increased on her Abilify, and was started on a wean down of Strattera. These were appropriate medication change recommendations, given the report at that time. The outcome of these changes was unclear from the provider notes themselves, as of the last date of record. There were also no medication administration records provided to review, so I cannot tell what actually occurred.

Bulimia records were kept by the unit due to reports of emesis behaviors prior to admission.

--oddly, I did not see any weight records in the provided notes outside of her admission weight, which is something which would need to be occasionally tracked (not needed daily, but at least weekly) for someone with bulimia or other eating disorder during a hospitalization.

I reviewed four restraint/seclusion records, which were all documented appropriately.

She refused many groups, was notably quite hostile to staff and peers in the milieu, but eventually appeared to engage more as time went along. Despite Redacted - PII sometimes refusal to engage, a lot of the key issues for this admission were worked on actively within the family therapy sessions.

There was no discharge summary, as she apparently remained on the unit at the time of this record request for review.

Redacted - PII admitted 2/17/22

13-year-old, admitted for an overdose on about 11 sleeping pills as a suicide attempt, told her school counselor that the attempt had failed the next day. Says both her sister and brother had attempted suicide in front of her in the previous month. Had multiple past suicide attempts by cutting. Depressed overall for a long time, plus hallucinations for about 3 years, both visual and auditory. History of shoplifting, legal involvement for that. No substance abuse, no abuse history known. Weight 157 pounds (BMI 26), HgA1C 5.4, TRG 63, Chol 181, HDL 43, LDL-C 126, TSH 1.6

Admission meds included Strattera 80mg daily, Lexapro 20mg daily, guanfacine XR 1mg daily, hydroxyzine 25mg nightly, and Latuda 40mg nightly.

Weekly psychiatric medication provider notes were reviewed, and there were no medication changes. It was discussed in one of these appointments the traumatic events of the rape of her sister and of a friend having died from a MVA, so these were not all just simple 'med checks.'

I reviewed individual, group, family, trauma, OT and music therapy group notes, all appropriately recorded and involving appropriate topics.

There was no discharge summary, as she apparently remained on the unit at the time of this record request for review.

Redacted - PII admitted 2/10/22

14-year-old girl, admitted for suicidal thoughts. History of self-harming with a razor blade, visual and auditory hallucinations, nightmares and flashbacks. Sexually abused, history of foster care placements, now in an adoptive home. Bio mom with severe methamphetamine use.

Past diagnoses of MDD with psychotic features, PTSD, ADHD, ODD, acute stress disorder. Denies substance abuse history.

Admitted taking Prozac 20mg daily, Strattera 100mg daily, Latuda 40mg daily.

On admission was overweight at 195 pounds, BMI 32.4, HgbA1C ordered and lipid panel ordered on admit—results not in provided notes.

One restraint order 3/21/22 for a physical hold then seclusion for assault toward staff and peers, followed by a treatment plan update also on 3/21/22.

No medication changes/adjustments were described in her psychiatrist weekly visit notes. However, on 3/8/22—possibly around this visit Latuda was increased to 60mg (though not really described in this note), as at 3/13 visit noted dose as 60mg and before that dose was listed as 40mg. I can't tell from the notes the rationale for the change in dose, so have no opinion over its appropriateness. There was no subsequent notation over a Latuda dose increase to 60mg being effective or not for its desired effect in the psychiatrist notes, which would have been appropriate to include.

I noted that she discussed her grief with psychiatrist 3/13/22 and 3/16/22, so these were not simple "med checks."

On 3/4/22 the patient requested Latuda to be changed to nighttime dosing, presumably because she thought it made her feel more sleepy—however because there was no medication administration record provided, I don't know when her daily doses were actually being administered or if that change occurred.

I reviewed individual, group, family, trauma, OT and music therapy group notes, which recorded appropriate discussion themes.

Family therapy notes provided described some pretty significant family work taking place—far from completion to resolution of family issues but this is not a completed hospital stay.

3/23/22 patient revealed she had been inducing emesis, refusing to eat and losing weight. There were no provided weight records for me to review. During a prolonged residential stay I would imagine there would be a routine of something like weekly weights, if not happening more often than that, for someone with eating concerns. Perhaps that is in records not provided to me for review.

The records provided did not include any medication administration records, so I could not double check any medication changes versus the psychiatric medication provider records of the chart.

There was no discharge summary, as she apparently remained on the unit at the time of this record request for review.

Redacted - PII **admitted 2/25/22**

14-year-old girl admitted for suicidality, depression, after being picked up by police for an argument with foster parent over watching Anime. She says she and her foster mother began an argument over what she was watching, it escalated quickly and patient bit foster parent, grabbed a knife and hid in a closet saying later she took the knife "in case I needed to kill myself with it." Police arrived and put her on a hold for safety. Things had actually been going OK before this particular incident, though she had reportedly had a seizure about 1 week before the incident after which she went to the ER, and for the subsequent week she had just seemed a bit "off." Says when she gets angry she feels like she is watching herself and not the real me. Says she has been joking around in therapy over time and not really working on true issues or feelings. Wants to live with bio family in Oklahoma but due to her long history of aggression is unable to do so—had lived for a time with aunt in Oklahoma for 2 years but was sent back to WY 8 months ago due to that aggression. History of 5 foster care homes, and history of physical, emotional and sexual abuse as a child. Removed from mom's care at age 10, won't speak of past trauma. Moved to Wyoming with mother and mother's boyfriend from Oklahoma, and mother's boyfriend reportedly abandoned them shortly after they arrived in Casper. 5 prior psych hospitalizations.

Past psychiatric diagnoses: MDD, PTSD, Bipolar, OCD

Admit meds: Prozac 60mg daily, Oxcarbazapine 150mg twice daily, Prazosin 1mg at bedtime, melatonin 10mg at bedtime. Concerta 54mg daily appeared on one record by [redacted] not on another H/P by [redacted]

Weight 102, BMI 19.7

On 3/22/22 she had an MRI for a diagnosis of partial complex seizure of the temporal lobe, per an outpatient neurologist, with a plan by that Neurologist to increase Oxcarbazapine to 225mg twice daily.

---I would note that etiologically, if she in fact was actually having true epileptic seizures that does destabilize a person psychiatrically for some time afterword and might have been a reason why she was not her usual self for a week after a seizure occurred before her admission. This does get confusing admittedly because highly traumatized individuals, even with true seizure disorders, may have occasions of emotional seizures which are not epileptic in nature.

As she signed forms on file at WBI refusing lab draws, her seizure medication choice of oxcarbazepine is additionally understandable as that can be utilized without requiring blood tests unlike many other seizure medications.

No restraint reports were provided during her stay on the unit.

I reviewed individual, group, family, trauma, OT and music therapy group notes, which recorded appropriate discussion themes. In her case "family therapy" was apparently

not happening in the usual way because per the individual therapy notes it looked like her plan had changed such that she was going to have to go to a different foster care home (rather unprovoked aggression toward the foster parent may have been the last straw).

Redacted - PII **admitted 2/18/22**

13-year-old with depression and suicidality, self-harming for the past month and therapist felt this hospitalization was the only option for stabilization. History of DFS custody because of history of "severe neglect" age 7 to 12, mother would leave her at home alone for days to a week to take care of herself and her 3-year younger brother, and eventually mother dropped her off at dad's house for a visit last summer and did not come back. She was sexually abused at age 10 by an older neighbor. Has a history of refusing school, locks herself in her room or simply refuses to go, DFS says may take her back into custody due to school refusal. Dad says he consented on admission to initiating Prozac for treatment of depression.

Weight 137, BMI 24.3

2/15/22 ordered to start fluoxetine 20mg QAM and Strattera 60mg QAM for ADHD (an apparent new start of both medications)

Ordered to increase Strattera to 80mg QAM and melatonin to 3 mg on 3/10, after which the patient reports that her Strattera "is not working" due to having trouble sleeping, continuing to have impulse control problems, though noted that her depression is doing a little bit better.

No restraint incidents were documented for this patient.

I reviewed individual, group, family, trauma, OT and music therapy group notes, which discussed appropriate themes.

Family therapy notes provided described some pretty significant family work taking place—far from completion to resolution of family issues but this is not a completed hospital stay.

----I do have some prescriber-level feedback about the choice to initiate Strattera (atomoxetine) for ADHD symptoms along with fluoxetine for depression symptoms for this patient. Atomoxetine and fluoxetine have a drug-drug interaction in which the fluoxetine can inhibit atomoxetine's metabolism via a 2D6 metabolic pathway interaction. As such, it is either not advised to administer these medications together, or to administer them at lower than usual doses. So, if selection of an alternative ADHD medication is not considered a reasonable option, I would typically use lower doses of Strattera in this situation (perhaps ½ what I might normally prescribe). This particular patient's report of Strattera "not working" and experiencing some agitation and trouble sleeping while on it might have been related to having a higher blood level of Strattera than would have happened otherwise due to the co-administration of fluoxetine.

Overall:

I would note that the facility used medication consent forms, which is good practice to ensure families have been routinely informed of the most common reasons for use of the medication and most common side effect risks.

Each of these 5 cases shared for a review were in-process care reviews, and as such there are no discharge summaries or treatment course conclusions to review for their care.

I would reflect that the therapy notes I reviewed (ex. group therapy, individual therapy, family therapy) indicated very appropriate treatment work being done for these youth. The family therapy in particular seemed to be well done and doing the work necessary to try to move these family systems forward in a way that would hopefully prevent an immediate decompensation as soon as these kids leave the hospital and get re-introduced into a family system that needs to be prepared for them.

There was not indiscriminate medication adjustment being done for these children, again which I would commend for these cases. For the most part the main intervention of need for these five cases was to provide trauma-oriented support, counseling, and family therapy much more so than the need to find the 'right' medication or medication adjustment to make a difference.

I did have a few points of specific feedback about individual cases, which I called out within the case descriptions.

2.3.3 Additional Findings – Appendix E

In one of the five clinical records reviewed, the initial discharge plan on the psychosocial assessment stated "deferred." This is not compliant with the PRTF expectation that discharge planning begins at admit.

Five out of five records reviewed did not include documentation regarding legal custody. It was explained by the leadership team that Wyoming did not differentiate between legal custody and physical custody and that if parental rights have not been legally terminated, both parties listed on the birth certificate are considered to have equal rights.

Two out of the five records reviewed indicated that the youth had taken day passes with a parent or guardian. In both records, documentation did not include reference to the youth's mental status upon return from the pass. In one record, one pass did not have any information regarding which member of the clinical staff had approved the pass.

One of the five records reviewed included detailed information regarding a neurological evaluation conducted by an outside provider. The documentation included a level of detail that would allow the PRTF to provide appropriate follow up care. In the second of the five records reviewed, the youth had a neurological evaluation within one week of the OSCR, so the documentation was not as thorough as the results had not yet been forwarded by the neurologist.

2.3.4 Resident Interview Findings – Appendix F

As previously reported, five WY Medicaid enrolled youth were selected for interviews; however, only four residents participated in the interview process.

When asked about how comfortable they felt going to staff with concerns, three out of the four youth interviewed reported it depended upon which staff member was available. They stated that some staff seem more interested in helping them than others.

All four youths interviewed could give the names, doses, frequency, and reason for their medications. None of the youth could name the potential side effects. Documentation in the Doctor Group notes indicates that all four youth were asked about potential side effects.

All four youth interviewed stated they reviewed their treatment plan with their therapist but did not participate in the treatment team meetings with parents, therapists, and prescribers. One of the youths interviewed stated they had no idea what their tentative discharge date was. One youth knew exactly what date was planned but acknowledged this was based on a variety of things. The other two youth interviewed stated they did not know their tentative discharge dates but that they had copies of their treatment plans and it was on there if they wanted to know.

In response to being asked if they had ever submitted a grievance, one youth interviewed reported an incident in which they observed a staff member physically pushing a youth into a wall after the youth asked if they could move to an alternate area because they were overstimulated. The youth stated several other youths had also submitted complaints about this, but nothing was done. The leadership team was able to identify the incident due to the submission of complaints by various youth and stated

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it had been investigated, including review of the video footage, and that the complaints were unfounded.

3 Summary

3.1 Overview

In summary, it appears that Wyoming Behavioral Institute is meeting the needs of WY Medicaid enrolled youth.

Strengths of the program include:

- Placing the priority of WBI programming on youth and staff safety.
- The monetary investment WBI makes in training of clinical staff to ensure TIC care is provided.
- Use of trauma packets that youth can choose to share with family and staff to increase an understanding of their therapeutic work.
- DBT and TF-CBT use to address trauma symptoms.

Challenges of the program include:

- Lack of measurable goals in the treatment plan limits a reviewer's ability to accurately assess progress in treatment.
- Limited information on therapeutic passes regarding youth's mental status upon return. This information would be important in planning future passes and to family therapy goals.
- Lack of youth participation in treatment plan meetings limits input into goal setting and reduces youth buy in to the therapeutic process.

The PRTF OSCR instrument was completed, and the tallied scores for the different sections are attached in the Appendices section of this report.

The combined administrative score based on this tool was **2.93**.

The record review score was **2.83**.

This gives Wyoming Behavioral Institute a status of **Approved.**

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3.2 Items with Unacceptable Score of 1

In the following sections, items scored an unacceptable score of 1 on the PRTF Compliance Review Instrument. This requires immediate corrective action.

3.2.1 Client Services: Resident Record Review Appendix E

10. Treatment Planning: Reviews

    c. The progress in relation to projected discharge date, as measured by meeting measurable goals/objectives, is assessed

    d. Goals, measurable objectives, target dates for completion are incorporated into the treatment plan

23. Medication

    a. All orders are in chart

24. Medication Monitoring: Required Elements

    a. Rationale behind the medication plan is discussed

    g. Metabolic parameters obtained per best practice guidelines

26. Care of the Whole Person

    e. Biometrics changes are addressed by the psychiatrist and/or dietician

28. Therapeutic Leave

    a. Authorized by physician's or PMHNP's orders

    c. Date/Time patient checked out/in is documented

    h. Resident's condition at check-out-in and mental status is documented

34. Provisional discharge/aftercare plan developed at intake and updated throughout treatment episode to reflect resident progress

3.2.2 Clinical Services: Resident Interviews Appendix F

3. Residents participate in treatment team meetings. They are knowledgeable about their treatment goals and have helped to set them

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3.3 Items with Substandard Score of 2

In the following sections, the items scored a 2, which is sub-standard of care. These items are concerning and require action steps to correct.

3.3.1 Facility Site Tour Tool: Appendix B

1. The physical treatment environment is:

   a. Attractive (clean, pleasant décor)

3.3.2 Clinical Services: Resident Record Review Appendix E

1. Resident Record

   b. Copies of documents verifying custody

5. Assessment: Required Elements

   d. Documentation of efforts to obtain collateral information from previous treatment providers and parent/guardian

   f. There is evidence that initial coordination of care has occurred.

3.3.3 Clinical Services: Resident Interviews Appendix F

2. Residents feel like they can safely bring concerns and challenges to staff without fear of consequences

13. Residents have a positive perception of the facility's program and how they are being treated. They perceive staff as genuinely interested in their welfare and capable of helping them

14. Residents feel they are making progress in their treatment and can explain why

15. Resident feels the facility is warm, safe, and comfortable.

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3.4 Next Steps

The OSCR team requests that Wyoming Behavioral Institute provide a written corrective action plan to address any items that scored a 1 or 2 or are identified for additional action within 10 days of receipt of this report. The corrective action plan should contain the specific steps and/or changes that will be implemented to achieve acceptable standards of care.

Note: Please send the action steps that will be put into effect to correct the sub-standard and unacceptable findings to WY Medicaid by XXX. The report can be emailed to [redacted]

We want to take the opportunity to thank the team at Wyoming Behavioral Institute for your cooperation and assistance in completing this OSCR.

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Appendices

Appendix A — Administrative Document Review

Mental Health/PRTF

PRTF CRI

Administrative Section: Document Review

Rating Scale includes the following:
4–Exceeds Standards
3–Meets Standards
2–Sub Standard
1–Unacceptable

Note:
If an item was not applicable and the tool required a score, a score of 3 or "yes" was given.

For yes/no questions, "yes" = 3 and "no" = 1.

	Element	Rating
1.	The facility is COA, CARF, or Joint Commission accredited.	Y
2.	The facility's PRTF license is current.	Y
3.	The licenses of professional staff are current.	Y
4.	A roster of all staff, divided by discipline, who provide direct services to residents, was provided with staff signatures.	Y
5.	The facility meets State-staffing requirements as outlined in 42 CFR Part 441, Subpart D-Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.	Y
6.	The facility has informed WDH of any changes in PRTF administrator, Medical Director, or Clinical Director within 72 hours of effective date of change.	Y
7.	Records and documentation requested by WDH were provided at the time requested. An index or key was provided to locate required information.	Y
8.	The facility's policies and procedures are in accordance with WDH requirements.	Y
9.	The facility's policy and procedures for transfer, discharge, and provision of services are the same for all residents, regardless of payment source.	Y
10.	The facility does not accept new residents who have attained the age of 21 or maintained past the age of 22.	Y
11.	The facility has a signed transfer agreement with one or more general hospitals to provide any needed diagnostic and medical services to residents (Facility to provide an example of a chart note/documentation as evidence of arrangement).	Y
12.	The facility has arrangements with community providers to provide specialized medical care to residents when needed (facility to provide an example of a chart note/documentation as evidence of arrangement).	Y
13.	Personnel records verify that all licensed and provisionally licensed staff/providers who participate in treatment planning have a minimum of one-year experience in treating children and adolescents who are emotionally disturbed.	Y

	Element	Rating
14.	The facility has informed WDH in writing of the occurrence of any serious incidents as defined in Section 18.18 within one working day following their occurrence.	Y
15.	Records and documentation are maintained per the facility record retention policy.	Y
16.	The facility has a policy in place and a committee that meets regularly regarding policies on trauma informed care, and bullying.	Y

Appendix B — Facility Tour

Mental Health/PRTF

PRTF CRI

Program Section A: Facility Tour

Rating Scale includes the following:
4–Exceeds Standards
3–Meets Standards
2–Sub Standard
1–Unacceptable

Note:
If an item was not applicable and the tool required a score, a score of 3 or "yes" was given.

For yes/no questions, "yes" = 3 and "no" = 1.

Element	Rating
1. The physical treatment environment is as follows:	
a. Attractive (clean, pleasant décor)	2
b. Warm, child-friendly (pictures, plants, home-like atmosphere)	3
c. Treatment-oriented (educational/motivational posters, treatment reminders)	3
2. Program information (activity schedules, unit rules, requirements for level system) are posted in public spaces for resident reference.	3
3. Program information for residents (e.g., unit rules, behavior care plans, and other treatment information posted on units or given to children) is as follows:	
a. Clear, specific	3
b. In age-appropriate language	3
c. Worded respectfully	3
d. Expressed in positive terms	3
4. Staff's verbal communication with children is observed to be the following:	
a. Clear, specific	3
b. In age-appropriate language	3
c. Respectful	3
d. Expressed in positive terms	3
e. Delivered in friendly voice tones	3
f. Reflects patients individualized behavior care plan	3
5. The physical arrangement of the units indicates a high level of staff/resident interaction (professional offices located on units or close to them, no unnecessary physical barriers between staff and residents).	3

	Element	Rating
6.	Random checks of residents' behavior program documentation (point sheets or similar documents) indicate that compliance feedback is being provided in a timely manner.	Y
7.	Effective safety precautions are in place for monitoring reactive children. There is a sensory room or other physical space (or items such as a sensory chart) to help children de-escalate.	Y
8.	Nighttime bed-monitoring procedures are established and documented. These are individualized to the needs of each resident.	Y
9.	Each unit has identified an appropriate place/procedure for responding to residents' physical/medical complaints.	Y
10.	Rules and schedules for the use of personal hygiene facilities provide adequately for the safety of residents.	Y
11.	Areas set aside for seclusion/restraint are clean and well lighted/ventilated.	Y
12.	All actions in each seclusion/restraint room can be continuously monitored.	Y
13.	The facility has adequate areas for indoor/outdoor recreation.	3
14.	The facility provides an accredited school for residents.	Y
15.	There is a designated area for the provision of well-balanced meals. The menu is posted in public areas.	Y
16.	Areas designated for the provision of group therapy and community meetings are conducive to therapeutic interaction.	3
17.	There is evidence of adequate facility security to minimize elopement risk.	3
18.	There are designated warm places where the residents can meet their families when they visit.	Y
19.	There is HIPAA compliant video conferencing availability with family for therapy sessions.	Y
20.	Evidence the facility follows their written policy/procedures was observed.	Y

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Appendix C — Program Document Review

Mental Health/PRTF

PRTF CRI

Program Section B: Document Review

Rating Scale includes the following:
4–Exceeds Standards
3–Meets Standards
2–Sub Standard
1–Unacceptable

Note:
If an item was not applicable and the tool required a score, a score of 3 or "yes" was given.

For yes/no questions, "yes" = 3 and "no" = 1.

Element	Rating
1. Behavior program(s) used as a part of treatment is as follows:	
a. Clear and specific	3
b. Age-appropriate to the targeted group	3
c. Reasonable and workable in the normal course of treatment	3
d. Reflective of a trauma informed culture	3
2. Adequate staff in-service training is provided, as evidenced by the following:	
a. Orientation and supervised on-the-job training is provided to new staff prior to being assigned independent responsibilities.	Y
b. A minimum of 20 hours of in-service training (excluding training described in item 3 below) are received by each staff member per year.	Y
c. Training topics are appropriate to the needs of residential treatment staff.	Y
d. Trainers are qualified in training they provide.	Y
e. Reflect a trauma-informed care approach to treatment.	Y
3. All direct care staff are trained and certified in a professionally recognized method of milieu management, de-escalating problem behaviors, applying physical restraints when necessary, and providing trauma-informed care.	Y
4. There is documentation that adequate clinical supervision is provided. Therapists, nursing staff, and direct care staff receive a minimum of four (4) hours of clinical supervision per month, provided through a combination of individual supervision, group supervision, and participating in treatment team meetings. This requirement is not satisfied through training.	3
5. All occurrences of seclusion/restraint are documented in a facility-wide log and must be reported to the State through utilization review.	Y
6. An interdisciplinary team that looks specifically at patterns and/or trends (for staff, shifts, etc.) reviews all occurrences of seclusion/restraint monthly. The team will then develop an appropriate action plan, as appropriate, to address these occurrences, as an on-going process.	Y

	Element	Rating
7.	Incident reports (accidents, injuries, allegations of staff misconduct) are maintained according to policy. Documentation indicates that incidents have been handled appropriately by the PRTF staff and are reported as required.	Y
8.	Child abuse allegations are reported to proper authorities.	Y
9.	Standards have been developed for evaluating the effectiveness of the facility's program. The evaluation protocol includes the following, at a minimum:	
	a. A comparison of each resident's pre- and post-treatment functional status.	Y
	b. There is a standardized process for discharge planning and development of an aftercare plan.	Y
	c. A comparison of prescribed medications, pre- and post-treatment.	Y
10.	The therapeutic curriculum used by the facility is trauma-informed and evidence-based for the population and age range being served.	Y
11.	Documentation indicates that the facility follows its policies and procedures in practice.	Y

Appendix D — Staff Interviews

Mental Health/PRTF

PRTF CRI

Program Section C: Staff Interviews

Rating Scale includes the following:
4–Exceeds Standards
3–Meets Standards
2–Sub Standard
1–Unacceptable

Note:
If an item was not applicable and the tool required a score, a score of 3 or "yes" was given.

For yes/no questions, "yes" = 3 and "no" = 1.

	Element	Rating
1.	Staff can explain ways the facility's culture and philosophy are trauma-informed.	3
2.	Staff understands the facility's behavior program and can explain it.	3
3.	Staff participates regularly in community meetings with residents on the treatment unit.	3
4.	Staff reports receiving adequate clinical supervision. Staff can identify their primary supervisor and at least two (2) other people with supervisory training and/or experience to whom they can turn for information, support, and guidance. Staff perceives supervision as helpful to them in improving the quality of services they provide to residents.	3
5.	Staff reports receiving adequate in-service training. Staff can summarize the salient points of at least one (1) training provided within the last year. Staff perceives the training they have received as relevant to their job responsibilities.	4
6.	Staff perceives professional working relationships as cooperative and collaborative.	3
7.	Staff communication is timely, accurate, and works for the benefit of the residents.	3
8.	Staff perceives the facility's administration as supportive of the clinical program and responsive to its needs and problems.	3
9.	Staff understands the proper use and documentation of special procedures (seclusion, and restraint), when and how they should be used, which staff are authorized to apply them, and what other less restrictive techniques might be attempted to de-escalate difficult situations or behavior.	3
10.	Staff is aware of the proper procedure for handling medical/physical complaints of residents.	3
11.	Staff believes that treatment units are adequately staffed, a policy is in place to ensure there is coverage for individual and family therapy when staff is on leave.	3

Appendix E — Resident Record Review

Mental Health/PRTF

PRTF CRI

Program Section C: Staff Interviews

Rating Scale includes the following:
4–Exceeds Standards
3–Meets Standards
2–Sub Standard
1–Unacceptable

Note:
If an item was not applicable and the tool required a score, a score of 3 or "yes" was given.

For yes/no questions, "yes" = 3 and "no" = 1.

Element	Rating
1. Resident Record is as follows:	
a. Well organized and legible with a key identifying the location of all required documents make key a separate section	Y
b. Copies of documents verifying custody	N
2. Admission is as follows:	
a. Documentation of MD recommendations and psychiatric evaluation for admission to PRTF within 30 days prior to admit.	Y
b. If admission is for a Sexually Acting Out or SO program, then a current and independent Psychosexual Assessment should be completed in advance and the findings should be reflected in the Psychiatric Recommendations.	Y
c. Parents or guardians were informed regarding medication policies (permission for medication changes, or any PRN changes), seclusion and restraint procedures, and requirements for family involvement separate questions add question: screen for pregnancy.	Y
3. At admission, less restrictive treatment is not appropriate as follows:	
a. Resident failed to respond to less restrictive treatment.	Y
b. Symptom severity warrants residential treatment.	Y
c. Resident is being stepped-down from acute care or symptoms could not be controlled at lower level of care.	Y
4. Assessment: Timelines	
a. Psychiatric evaluation completed within seven (7) days of admit	Y
b. Medical history and physical exam provided within seventy-two (72) hours of admission including medication history	Y
c. Escalation risk/safety plan, trauma assessment, risk of sexual offense, and acting out behavior are addressed	Y
d. Psychosocial assessment per LOC	Y
e. Provisional discharge plan completed at intake	Y
5. Assessment: Required Elements	

Element	Rating
a. A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).	3
b. Documentation of presence or absence of any current medical conditions.	3
c. A complete mental status exam, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.	3
d. Documentation of efforts to obtain collateral information from previous treatment providers and parent/guardian.	2
e. Adequate information in the record to make a careful diagnostic assessment or resolve differences in diagnostic impressions separate question Education assessment including barriers to progress.	3
f. There is evidence that initial coordination of care has occurred.	2
6. Psychosocial Assessment: Required Elements	
a. Includes developmental profile.	3
b. Includes behavioral assessment.	3
c. Includes details regarding onset of symptoms.	3
d. Assesses potential family resources.	3
e. Trauma Assessment.	3
f. Risk of sexual offense and acting out behavior.	3
g. For patients 12 and older, a substance abuse screening occurs. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.	3
7. Treatment Planning: Team Composition	
a. Psychiatrist or PMH-NP/psychologist and physician separate PCP from psych.	Y
b. LCSW, PLC, LMFT, LAT, Provisionally Licensed Staff/Providers, and Licensed Psychologists.	Y
8. Treatment Planning: Time Lines Met	
a. Initial plan completed at intake	Y
b. Comprehensive plan within fourteen (14) days	Y
c. Reviews: once at end of first month of stay	Y
d. Reviews: once monthly after first month of stay	Y
e. Treatment plans are updated within 24 hours following seclusion or restraint	N
9. Treatment Planning: Required Elements	
a. If trauma and/or sexual acting out behavior has been identified, it is reflected in the treatment plan goals and interventions.	Y
b. Both resident's strengths and problem areas are addressed.	Y
c. Both family's strengths and problem areas are addressed.	Y

Element	Rating
d. The treatment plan is individualized and consistent with diagnosis.	Y
e. Short and long-term goals are objective and measurable.	N
f. Treatment plan addresses each diagnosis specifically.	Y
g. Treatment modalities and clinicians responsible are identified. Realistic and obtainable goals are put in place for kids with self-harm history.	Y
h. Family therapy goals/objectives are explained.	Y
i. Discharge plan and estimated discharge date are identified.	Y
j. If a SUD is identified, it is reflected in the treatment plan goals and interventions.	Y
10. Treatment Planning: Reviews	
a. Identify changes in treatment, if needed, to addresses goals where progress is minimal.	Y
b. The need for residential versus less-restrictive treatment is reassessed.	Y
c. The progress in relation to projected discharge date, as measured by meeting measurable goals/objectives, is assessed.	N
d. Goals, measurable objectives, target dates for completion are incorporated into the treatment plan.	N
e. Treatment successes are noted.	Y
11. Evidence that resident and parent/guardian actively participate in treatment goals.	Y
12. Evidence that psychiatrist directs treatment through comprehensive notes and participation in staffing.	Y
13. Evidence of interdisciplinary collaboration in planning.	Y
14. Treatment Documentation: Required Elements	
a. Summary of content/process is detailed enough to provide an accurate clinical picture to those outside the treatment team.	3
b. Sessions clearly have therapeutic focus.	3
c. Outcome of session and plan for time between sessions and next session.	3
d. Documentation that goals of treatment are communicated with all direct care staff.	2
15. Treatment Documentation for all Modalities	
a. Therapist's name and signature is present on treatment documentation.	Y
b. Date/length of session add question for supervisory oversight for unlicensed staff is present.	Y
16. Individual Therapy: Required Elements	
a. Progress towards treatment goals is identified.	3
b. Progress in relation to discharge date and plan for future sessions is addressed at least monthly.	3
c. If trauma has been identified, there is evidence it is being addressed.	3

Element	Rating
d. The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.	3
e. Treatment modalities are evidence-based and appropriate for the diagnoses.	3
f. Progress notes contain a level of detail sufficient for those not directly involved in treatment to have an accurate clinical picture.	3
g. Mental status and depression assessment.	3
17. Individual Therapy is provided a minimum of one hour per week.	Y
18. Family Therapy: Required Elements	
a. Resident's response to family.	3
b. Documentation supports family therapy focus on addressing presenting problems prior to admission and preparing for a successful transition home.	3
c. If family is not actively involved in treatment, therapeutic intervention is addressed.	3
d. Evidence of alternative treatment interventions when there is minimal or no progress.	3
e. If trauma has been identified, there is evidence it is being addressed.	3
19. Family Therapy is provided a minimum of one hour per week.	Y
20. Group Therapy: Required Elements	
a. Activities are therapeutic in nature and relate to treatment goals.	Y
b. There is evidence of resident's participation in groups.	N
21. Group Therapy is provided a minimum of 3 hours in at least three sessions per week.	Y
22. Therapeutic Milieu is provided 24 hours per day seven days per week.	Y
23. Medication	
a. All orders are in chart.	N
b. Evidence of PRN orders routinely reviewed and updated (PRN follows WDH guidelines).	Y
c. There was informed consent for meds properly executed.	Y
d. The resident was assessed for side effects.	Y
e. Administration is timely and accurate (MAR).	Y
f. There is documentation of medical history.	Y
g. Reasons for, and response to, PRN medication use is documented in MAR.	Y
h. There is no evidence of chemical restraints being used.	Y
24. Medication Monitoring: Required Elements	
a. Rationale behind the medication plan is discussed.	N
b. When medication does not appear to be therapeutically effective, there is an aggressive plan to address.	Y

Element	Rating
c. Evidence the lab results were received and reviewed by the clinician.	Y
d. Evidence of progress documented by the physician/addictionologist at regular intervals, appropriate to the rendered service.	Y
e. Record of previous medication trials.	Y
f. Documentation of monitoring for boxed warnings for medication.	Y
g. Metabolic parameters obtained per best practice guidelines.	N
h. Rule out diagnoses confirmed or eliminated.	Y
i. Record contains documentation of a differential diagnosis when medical conditions are present.	Y
25. There is evidence that frequency of client visits with psychiatrist is appropriate to the intensity of treatment and current risk issues.	Y
26. Care of the Whole Person	
a. Residents have access to a primary care physician.	Y
b. Residents have access to dental/vision.	Y
c. PRTF is ensuring resident is current with EPSDT.	Y
d. PRTF is providing health care education (STDs, birth control, etc.).	Y
e. Biometrics changes are addressed by the psychiatrist and/or dietician.	N
27. Therapeutic Pass	
a. Goals for pass are identified based on clinical need not programmatic standards.	Y
b. Evidence that goals were discussed with resident and family/guardian.	Y
c. Evidence of evaluation of the pass.	Y
28. Therapeutic Leave	
a. Authorized by physician's or PMHNP's orders.	N
b. Not taken during 14-day assessment.	Y
c. Date/Time patient checked out/in is documented.	N
d. Medication instructions given using non-medical language.	Y
e. Therapeutic goals for leave are discussed with resident and family/guardian.	Y
f. Required time of return is identified and documented.	Y
g. Name of person with whom leave will be spent with is documented.	Y
h. Resident's condition at check-out-in and mental status is documented.	N
i. Name/signature of person with whom child is leaving/returning with is documented.	Y
j. There is documentation that goals were discussed with the child and their family.	Y
k. Name/signature of staff checking child out/in is documented.	Y
l. Medication provided/returned are noted and include number of doses.	Y

Element	Rating
m. Outcome of leave is assessed by therapist within 72 hours of return.	Y
n. UDS completed upon return when clinically indicated.	Y
29. Prior to a seclusion/restraint, the least restrictive effective intervention was used.	
a. Prior to seclusion/restraint, were less restrictive attempts to de-escalate behavior utilized.	3
b. Documentation of which less restrictive measures were used and how they failed.	3
30. Seclusion/Restraint: Required Elements	
a. Seclusion/restraint initiated and ended only by a state approved professional.	Y
b. Personal seclusion/restraint administered by trained personnel.	Y
c. Seclusion/restraints only used for imminent threat.	Y
31. Seclusion/Restraint: Documentation	
a. Date/Time procedure started/ended.	Y
b. Names of staff involved in applying or monitoring seclusion/restraint.	Y
c. Was the precipitating event for the escalating behavior identified?	Y
d. Order obtained from state approved professional within one hour.	Y
e. Orders for children under the age of 9 are no more than one hour, 9-17 year old children are two hours, and orders for 18-21 year olds are four hours.	Y
f. Order was renewed when original order expired and why a renewal was needed was documented.	Y
g. Clear criteria for ending seclusion/restraint was identified.	Y
h. Resident's health/comfort was assessed every 15 minutes.	Y
i. Vital signs were taken every hour.	Y
j. In-person assessment conducted by physician, PMHNP, or RN within one hour, regardless of length of procedure.	Y
32. Seclusion/Restraint: Assessment of Outcome	
a. Resident's physical/psychological status.	3
b. Resident's response to the restraint.	3
c. Resulting complications.	3
d. Seclusion/restraint ended at the earliest possible time.	3
33. Seclusion/Restraint: Timelines	
a. The treatment plan was modified within one working day of incident as indicated.	N
b. Parents or guardian notified within 24 hours of the incident.	Y
c. The incident was processed with the resident by staff within 24 hours.	Y

	Element	Rating
34.	Provisional discharge/aftercare plan developed at intake and updated throughout treatment episode to reflect resident progress.	N
35.	Provisional Aftercare plan: Required Elements	
	a. Anticipated date of discharge.	Y
	b. Recommendations for parents/caregivers.	Y
	c. Educational summary and recommendations.	Y
	d. Recommendations for mental health providers.	Y
36.	Final Aftercare Plan: Required Elements	
	a. Person/agency to who resident will be released.	Y
	b. Address where resident will reside.	Y
	c. Documentation that coordination of care was attempted by PRTF therapist.	Y
	d. Names, addresses, and phone numbers, of follow-up mental health care providers was documented.	Y
	e. Recommendations and briefing of safety plan with parents/caregivers.	Y
	f. Follow up appointment with PCP, psychiatrist, therapist, and primary care physician including date, time, and provider name documented.	Y
	g. Documentation of functional impairments preventing completion of activities of daily living and ongoing risk.	Y
37.	Final Aftercare Plan: Timelines Met	
	a. Follow up therapy appointment within 7 days of discharge.	Y
	b. Medication management appointment scheduled within 30 days of discharge.	Y
38.	Final Discharge Summary: Required Elements	
	a. Dates of admission and discharge.	Y
	b. Progress towards treatment goals.	Y
	c. Summary of reason(s) for discharge.	Y
39.	Parents/guardians received	
	a. Minimum of one-week supply of medications.	Y
	b. Written prescription for 30-day supply of medications.	Y
	c. Copy of aftercare plan.	Y
40.	Documentation that educational summary and recommendations were mailed to the resident's school within 24 hours post-discharge.	Y
41.	Documentation that aftercare plan and discharge summary were mailed to follow-up mental health care providers within 2 weeks post-discharge.	Y
42.	Documentation indicates that the facility follows its policy and procedures in practice.	Y

Appendix F — Resident Interviews

Mental Health/PRTF

PRTF CRI

Clinical Services Section B: Resident Interviews

Rating Scale includes the following:
4–Exceeds Standards
3–Meets Standards
2–Sub Standard
1–Unacceptable

Note:
If an item was not applicable and the tool required a score, a score of 3 or "yes" was given.

For yes/no questions, "yes" = 3 and "no" = 1.

	Element	Rating
1.	Residents can explain how they are encouraged to participate freely in community meetings. Residents perceive open, collaborative communication between themselves and staff.	3
2.	Residents feel like they can safely bring concerns and challenges to staff without fear of consequences.	3
3.	Residents participate in treatment team meetings. They are knowledgeable about their treatment goals and helped set them.	2
4.	Residents understand their behavior program(s). They know what phase they are on and what is required to reach the next phase.	3
5.	Residents report receiving timely feedback on their progress towards treatment goals.	3
6.	Residents are knowledgeable about their medications (i.e., names, strengths, frequency of dosages, and which symptoms are targeted). They can explain possible side effects of their medications.	3
7.	Residents are aware of the goals they need to meet before going home, targeted discharge date, and current discharge date.	1
8.	If residents have been secluded or restrained, they understand why the seclusion/restraint was used and understood their release criteria at the time the procedure was in progress.	3
9.	A staff member helped them to process the incident after its conclusion.	3
10.	Resident could name their triggers and at least two coping skills they can try in the future when feeling upset or out of control.	3
11.	Does the resident feel safe when others are out of control?	3
12.	Residents believe that medical complaints are handled in a timely and appropriate manner.	3
13.	Residents have a positive perception of the facility's program and how they are being treated. They perceive staff as genuinely interested in their welfare and capable of helping them.	2
14.	Residents feel they are making progress in their treatment and can explain why.	2

	Element	Rating
15.	Resident feels the facility is warm, safe, and comfortable.	2
16.	Resident feels satisfied with how the facility reacts with their family and they are able to contact their family regularly.	3
17.	Residents understand the grievance policy and how to submit a complaint if they have a grievance.	3

Appendix G — OSCR PRTF Status Determination

Status	Defining Conditions	CAP Required	Next OSCR
COMMENDED	Minimum overall score of 2.90, and Minimum area scores of 2.75, and No citations.	NO	2 years
APPROVED	Minimum area scores of 2.75.	NO	1-2 years
	Minimum area scores of 2.50, and No citations in areas that reflect on safety/well-being of residents.	YES for citations	1-2 years
REVIEW	Minimum overall scores of 2.50, and Minimum area scores of 2.25, and No citations.	NO	9-15 months
	Any citations	YES	6-12 months
PROBATION	Overall score below 2.50, and Any area scores below 2.25. AND/OR Conditions exist which could jeopardize the safety/well-being of residents. AND/OR Facility was on Review Status and failed to show sufficient improvement in a follow-up OSCR.	YES	3-6 months after implementation of a CAP
SUSPENSION	Overall score below 2.25, and AND/OR Conditions exist which could jeopardize the safety/well-being of residents. AND/OR Facility received Probation Status in two consecutive OSCR's and failed to show sufficient improvement in the next follow-up OSCR.	YES	No later than 30 days after implementation of an approved CAP
Each facility will be reviewed on-site at least every two years. Other reviews may be conducted off-site at the discretion of Division of Medicaid, except for facilities that are on probation or suspension status.			

Appendix H — Acronyms

Below is a list of acronyms used within this document.

Acronym	Term
CABA-I	Child and Adolescent Behavior Assessment by Informant
CABA-Y	Child and Adolescent Behavior Assessment by Youth
DBT	Dialectical Behavior Therapy
OSCR	On-Site Compliance Review
PTRF	Psychiatric Residential Treatment Facility
SUD	Substance Abuse Disorder
TIC	Trauma Informed Care
TF-CBT	Trauma Focused Cognitive Behavior Therapy
WBI	Wyoming Behavioral Health
WDH	Wyoming Department of Health

OSCR Site Survey Plan of Correction 2022

Wyoming Behavioral Institute

Finding	Correction	Responsible	Date of Completion	Measurement
3.2.1 Client Services: Resident Record Review Appendix E:				
10. Treatment Planning: Reviews c. The progress in relation to projected discharge date, as measured by meeting measurable goals/objectives, is assessed d. Goals, measurable objectives, target dates for completion are incorporated into the treatment plan	Re-train Therapists on documenting progress towards discharge and making goals specific, measurable and include target dates. Forms will be audited for completion until three consecutive months of 90% compliance has been achieved.	[redacted] Dir. of Clinical Services	May, 2022	Training minutes Monthly Tx Plan audits
23. Medication a. All orders are in chart	WBI has an electronic medication record called HCS. When a patient discharges, those records are printed off and included in the record. For the next OSCR audit, Med Records will ensure HCS med records are included in the open charts requested for audit.	[redacted] Dir of HIM	May, 2022	Medical Records complete

Finding	Correction	Responsible	Date of Completion	Measurement
24. Medication Monitoring: Required Elements a. Rationale behind the medication plan is discussed g. Metabolic parameters obtained per best practice guidelines	Review the OSCR Audit findings with physicians to ensure they include the rationale for all medications ordered and plans. Also reviewed obtaining metabolic labs for all patients at admission.	[redacted] Assoc. Administrator; Physicians	May, 2022	Med Exec Minutes
26. Care of the Whole Person e. Biometrics changes are addressed by the psychiatrist and/or dietician	Review the OSCR Audit findings with physicians to ensure they include biometric changes in their notes.	[redacted] Assoc. Administrator; Physicians	May, 2022	Med Exec Minutes
28. Therapeutic Leave a. Authorized by physician's or PMHNP's orders c. Date/Time patient checked out/in is documented h. Resident's condition at check-out-in and mental status is documented	Leave Forms will be revised to include a physician's authorization and will be audited for completion until a 90% or above compliance rate is achieved for three consecutive months .	[redacted] CNO [redacted] Nursing Supervisor	May, 2022	Audit results, PI Minutes
34. Provisional discharge/aftercare plan developed at Intake and updated throughout treatment episode to reflect resident progress.	Therapists will be retrained to not write "deferred" on the initial discharge plan on the psychosocial assessment, but complete it with preliminary DC Plans. Audits will be conducted until three consecutive months. of 90% or above compliance has been achieved.	[redacted] Dir. of Clinical Services	May, 2022	Audit Results, PI Minutes

Finding	Correction	Responsible	Date of Completion	Measurement
3.2.2 Clinical Services: Resident Interviews Appendix F:				
3. Residents participate in treatment team meetings. They are knowledgeable about their treatment goals and have helped to set them.	Treatment Team will ensure the patient is present and participating in Treatment Team sessions monthly.	[redacted]	May, 2022	Tx Plans signed by patients
3.3.1 Facility Site Tour Tool: Appendix B:				
1. The physical treatment environment is: a. Attractive (clean, pleasant décor)	Environmental Rounds will continue to be conducted monthly to ensure paint is touched up and may look to add additional murals on walls to enhance appearance.	Leadership Team	May, 2022	Rounds Audits
3.3.2 Clinical Services: Resident Record Review Appendix E:				
1. Resident Record b. Copies of documents verifying custody are in the chart.	Staff will implement use of the Legal Form on Residential Services to document the guardian/custody status. If patient is transferred from Acute, the Form will be forwarded by Med Records to the new chart.	Nursing Supervisor, [redacted] Dir. of HIM	May, 2022	Audit results, PI Minutes

Finding	Correction	Responsible	Date of Completion	Measurement
5. Assessment: Required Elements d. Documentation of efforts to obtain collateral information from previous treatment providers and parent/guardian. f. There is evidence that initial coordination of care has occurred.	Re-train Therapists on documenting collaboration with supports on the Psychosocial Forms. Forms will be audited for completion until three consecutive months of 90% compliance has been achieved.	[redacted] Dir. of Clinical Services	May, 2022	Audit results, PI Minutes
3.3.3 Clinical Services: Resident Interviews Appendix F:				
2. Residents feel like they can safely bring concerns and challenges to staff without fear of consequences.	Establish a weekly Community Mtg. to address patient concerns around safety and programming, perception of program.	Nursing Supervisor, [redacted]	May, 2022	Notes of meetings and concerns addressed
13. Residents have a positive perception of the facility's program and how they are being treated. They perceive staff as genuinely interested in their welfare and capable of helping them.	Establish a weekly Community Mtg. to address patient concerns around safety and programming, perception of program.	Nursing Supervisor, [redacted]	May, 2022	Notes of meetings and concerns addressed
14. Residents feel they are making progress in their treatment and can explain why	Patients meet with Nursing Supervisor to review the individual Level achievement and progress in treatment. Pt. will attend Treatment Team Mtgs. monthly.	Nursing Supervisor, [redacted]	May, 2022	Level Documentation
15. Resident feels the facility is warm, safe, and comfortable.	Establish a weekly Community Mtg. to address patient concerns around safety and programming, perception of program.	Nursing Supervisor, [redacted]	May, 2022	Notes of meetings and concerns addressed

OPTUM®

6/7/2022

Wyoming Behavioral Institute
[redacted]
Casper, WY [redacted]

Dear Ms. [redacted]

On behalf of WY Medicaid, thank you for your submission of the corrective action plan that was requested following the OSCR for Wyoming Behavioral Institute conducted on March 29th and 30th, 2022.

The plan has been reviewed and it has been determined that it adequately addresses the deficient areas identified during the review. During the review period the Corrective Action Plan has been accepted.

The final rating assigned to Wyoming Behavioral Institute by the Wyoming Department of Health is as follows:

- Administrative Review: 2.93
- Clinical Record Review: 2.83
- Status: Approved

If you have any questions, please feel free to contact me by phone at [redacted] or via email at [redacted]

Sincerely,

[redacted] LCSW
Senior Manager, Commercial Audits

United Behavioral Health, operating under the brand Optum

SCL - 300
(07/2018)
Services

STATE OF WYOMING
Department of Family

Substitute Care
Facility Site Visit Form

Facility Name	Wyoming Behavioral Institute
Facility Address	[redacted] Casper WY. [redacted]
Director	[redacted]
Date & Time of Visit	8. 24. 2022
Staff met with during the visit	

Facility Type:

- [x] Residential Treatment
- [ ] Detention Center
- [ ] Group Home
- [ ] Crisis Center
- [ ] Other_____

Reason for Visit:

- [x] Unannounced Visit
- [ ] Investigation
- [ ] Change Request
- [ ] Compliance Monitoring
- [ ] Other_____

Current Resident Census: 27

Describe Visit and Areas Inspected:

South wing door added at entry
walk through of bedrooms
walk through of seclusion ~~living~~ rooms

Rule Violation(s) and Action Needed:

A representative of the Department of Family Services has observed an alleged violation of Wyoming Substitute Care Licensing Rules or Certification Law. **This form serves as notice of observation of alleged non-compliance for the below-listed rules.** The Department requests your cooperation. In the absence of such cooperation, the Department may take whatever steps are necessary to assure the safety of children. The Department's information may be shared with authorized individuals or agencies, which include but are not limited to, the Attorney General, County Attorney, and law enforcement. A Notice of Non-Compliance (SCL-305) will follow to notify you of Licensing's findings. A corrective action plan and/or additional verifications may need to be submitted.

Description of Observation:	Chapter and Section:	Action Needed:

Corrective Action Plan Due Date: [redacted]

Facility Staff Signature [redacted]

Licensor Signature [redacted]

Wyoming Department of Family Services
Recertification Site Visit Corrective Action Plan 2022

Finding:	Specific Action:	Responsible / Dates
A review of the staff files found that not all the out of state Central Registry's were completed for staff that lived in another state within five years of hire date	Audit all files for any who have "out of state" Central Registry checks that have not been done (among all current files) and complete them. And- Identify a "Central Registry" renewal date – all staff will need to fill out a new Central Registry form during a particular week identified for every staff member every year.	Human Resources-April 2022
A review of the staff files found that staff did not have an annual TB Assessment completed in their files	Amend the Flu Shot form to have (on the reverse) the TB Risk Assessment to ensure all is completed every year – Implement at beginning of flu season, Oct 2022. Completion of this Assessment will be added to our HealthStream Annual Required Assessment– which will allow it to be tracked – Already tracking it in Lawson as per CORP Requirements	Infection Control Nurse and Human Resources-October 2022 Human Resources – April 2022
Documentation verifying staff had successfully completed restraint training was not available.	Set up Seclusion and Restraint Training days at the beginning of the year, to occur each quarter. Schedule all staff who need to complete these skills demos so they get done before end of year. Plan a HWC Train the Trainer event to have certain leaders get up to date on HWC certification. Create a HealthStream training description of the various types of Handle With Care and Seclusion and Restraint Training and the increments of time (6 hours, 2 hours, etc.) for better accuracy of training times on the HS Transcript	Staff Development Committee – Meet in March, formulate Calendar-March 2022 CNO-March 2022

Finding:	Specific Action:	Responsible / Dates
A review of the staff files found that a majority of the staff did not have documented required 20 hours of training documented in their file.	Update and send out to ALL MANAGERS a "In-Service / Staff Meeting" form and "Staff Meeting Attendance" form where managers can list the topics they are addressing during the In-Service and we can get those transmitted to individual employee's HS transcripts. Those In-Service Events will then be condensed to individual employee's transcripts. Each Unit will reinstitute a "Communication Book" to list the information from the In-Services and Staff meetings for all to review and sign off on. (As people "sign off" on reading the Communication Book, RN Manager will send updates to Staff Development so transcripts can be updated). Assign required Education Modules all at the beginning of the quarter. Employees encouraged to do the assigned modules per quarter. Run HS Printout each month to track progress before everyone is delinquent. Remind managers to follow up with staff at least once or twice per month.	Human Resources-March 2022 Staff Development and RN Manager, Education Coordinator –March 2022 Human Resources-March 2022
A walk through of the facility found that one window of the seclusion door was covered.	The covering was removed during survey. Staff were educated that all windows to seclusion or timeout rooms must be kept clear and in good repair at all times.	Nursing Management-march 2022
As of September 2022, all staff will need to have a finger print check every five years	Pull list of everyone who hasn't had fingerprints done in the past 5 years. Work on getting all three employee in the Human Resources Department "certified" (by DCI) to be able to take fingerprints internally. Take all fingerprints here (in HR) on an off Orientation week and send them all at once.	Human Resources -June 2022 Human Resources-July 2022 Human Resources-August 2022

STATE OF WYOMING
Department of Family Services

SCL-305
(8/21)

NOTICE OF NON-COMPLIANCE

Notice to Director:	[redacted]	Notice To Board of Directors:	
Facility Name:	Wyoming Behavioral Institute	Facility Name:	
Mailing Address:	[redacted]	Mailing Address:	
City:	Casper, WY [redacted]	City:	

The Department of Family Services has completed the investigation/inspection regarding alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children received on:04/25/2023

The following finding(s) have been found on the alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children:

Allegation:	It is alleged numerous organization's staff working with youth before finger print based national criminal history record check is returned with an eligible to work status.	Reported
Date of Allegation:	04/25/2023	
Finding:	**Evidence supports findings of non-compliance.**	
Rules Violated:	Chapter 3 Section 10. Background Checks. A Wyoming abuse and/or neglect Central Registry check, an abuse and/or neglect Central Registry check from any other state lived in for the past 5 years, and a finger print based national criminal history record check shall be completed for all employees (including employees who do not work directly with children), foster parents, and adoptive parents before they begin working in the facility. In cases where a child abuse and/or neglect registry request was made to another state and a denial of that request has been received, a notarized affidavit from the staff person shall be required, certifying to the best of his/her knowledge, he/she has not appeared upon a child abuse and/or neglect registry in the state of previous residence. These same checks are necessary for adult household members in the case of foster homes, adoptive homes, and facilities that are operated in an individual's home, including any new adult proposing to move into the foster home, adoptive home or facility operated in an individual's home. Background checks for any new adult proposing to move into the foster home, adoptive home or facility operated in an individual's home, shall be completed prior to the adult moving in.	
Explanation for findings:	Staff files audit revealed the organization allows staff to work with youth prior to a returned clear to work national fingerprint criminal history background checks returned and no requested variance. Additionally, the organization met with the Certifying Authority on November 15, 2022, discussing the requirements of all background checks and the variance process.	
Recommendations for Compliance:	The organization's corrective action plan shall include development, adoption, follow-up and monitoring of written policies and procedures governing all elements of completing all required background checks prior to staff working with youth.	
Corrective Action Plan (CAP) Due Date:	30 – days.	

Per the Administrative Rules for Certification of Providers of Substitute Care Services for Children, the corrective action plan (CAP) to address the issues of non-compliance, must be submitted for approval within thirty (30) days of the below date.

If you disagree with the Department's finding of non-compliance of the Administrative Rules for Certification of Providers of Substitute Care Services for Children, you may request an administrative hearing within ten (10) days of your receipt of this letter (W.S. 14-4-108). Administrative Hearing procedures are included in the Department's "Contested Case Hearing" Rules, Chapter 2 and based upon the above statute. If you need a copy of the Rules or assistance in requesting an administrative hearing, you may contact your Licenser or Supervisor listed below.

Licenser/Investigator:	[redacted]		
Address:			
City:	Cody	**State:**	Wyoming
Telephone:	[redacted]	**Zip Code:**	[redacted]

[redacted]

(Licenser) 5.2.2023 (Date)

[redacted]

(Manager) 05-04-2023 (Date)

cc: Substitute Care Facility
Licenser

SCL - 300
(10/2022)
Services

STATE OF WYOMING
Department of Family

Substitute Care
Facility Site Visit Form

Facility Name	Wyoming Behavioral Institute
Facility Address	[redacted] Casper, WY [redacted]
Director	
Date & Time of Visit	4.25.2023
Staff met with during the visit	Redacted - PII
Facility Type	RTC BOCES Detention Center Group Home Crisis Center Other_____
Reason for Visit	Unannounced Visit Investigation Change Request Compliance Monitoring Other_____

Required Observations:

- ☑ Practices within the facility & general compliance
- ☐ Talk to children
- ☐ Compliance Monitoring
- ☐ Investigation
- ☐ Technical assistance and support
- ☐ Review and verify Staff Summary Record (check new staff requirements) - staff files
- ☑ Talk to staff

Other Observations:

- ☐ Medication log
- ☑ Fire drill log
- ☐ Child files
- ☐ Bed check log
- ☐ Crisis or Emergency Plan
- ☑ Seclusion & Time Out Room log
- ☐ Vehicle Check
- ☐ Change Request
- ☐ Other_____

Current Resident Census: [redacted]

Describe Visit and Areas Inspected:

walk through at Pathways
Youth in group and/or school during visit.
DCI checks need to be returned clear before being with youth or a variance request needs submitted.

Facility Staff Signature: [redacted] Date: 4.25.2023

Licensor Signature: [redacted] Date: 4.25.2023

Wyoming Behavioral Institute
Dept. of Family Services Notice of Non-Compliance
Plan of Correction for April 25, 2023 Complaint Investigation Survey

Deficiency Identified	Plan of Correction	Responsible Party	Date of Completion
Chapter 3, Section 10: Employee Background Checks **Complaint Substantiated: Staff files revealed the Organization allowed new employees to work with youth prior to a returned clear to work national fingerprint criminal history background check was returned with no requested variance.**	Employment Background Screening Policy and Procedure #2000.20 was revised to include the following: "For all new PRTF staff that have met all required background check requirements with no derogatory reports, but still with a pending national criminal background check, WBI will request in writing from Department of Family Services 24-Hour Substitute Care Licensing & Child Care Licensing Dept. a variance review. Those staff will not be allowed to work with youth in the PRTF setting prior to receiving variance approval and/or receiving a returned fingerprint criminal history background check."	Tammy Quinn, Human Resources Director, Miranda Blajszczak, CNO, Michele Burnett, Assoc. Administrator	May 15, 2023
	Revised Policy and Procedure #2000.20 was reviewed and approved by Medical Executive Committee on 05/24/23.	Assoc. Administrator	May 24, 2023
	Human Resources Director and CNO will monitor compliance with the revised procedures for all staff hired to work the PRTF Unit until 100% compliance is achieved for three consecutive months.	Dir. Of Human Resources, Chief Nursing Officer	

[redacted]

From: [redacted]
Sent: Wednesday, May 24, 2023 3:10 PM
To: [redacted]
Subject: [EXTERNAL] Re: POC for 04/25/23

This Message Is From an External Sender
This message came from outside your organization.
DO NOT CLICK links or attachments unless you recognize the sender and know the content is safe. REPORT any suspicious emails by clicking the 'REPORT SUSPICIOUS' button.
Report Suspicious

Thanks, [redacted] this is great, nothing further needed.
[redacted]

On Wed, May 24, 2023 at 2:51 PM [redacted] wrote:

Hi [redacted] –

Attached please find the Plan of Correction in response to the findings from your April 25, 2023 site survey.

Please let me know if you need anything further.

Thank you,

STATE OF WYOMING
Department of Family Services

SCL-305
(8/21)

NOTICE OF NON-COMPLIANCE

Notice to Director:	[redacted]	Notice To Board of Directors:	
Facility Name:	Wyoming Behavioral Institute	Facility Name:	
Mailing Address:	[redacted]	Mailing Address:	
City:	Casper, WY. [redacted]	City:	

The Department of Family Services has completed the investigation/inspection regarding alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children received on: 05/09/2023

The following finding(s) have been found on the alleged violation(s) of the Administrative Rules for Certification of Providers of Substitute Care Services for Children:

Allegation:	It is alleged that the organization failed to provide supervision in that two youth were sexual assaulted by another youth while at the facility.	Reported
Date of Allegation:	05/09/2023	
Finding:	**Evidence does not support findings of non-compliance.**	
Rules Violated:	Section 9. Staff Supervision. (a) The program shall have a chart delineating supervision for each program. (b) During every shift, there must be a designated individual responsible for that shift (and at a minimum available by phone). (c) A direct care staff member shall always be present when a child resident is in the facility or living unit, off ground activity or appointments which require direct care and supervision. (i) Except as otherwise provided by this rule, children shall be supervised at all times. Short breaks in direct supervision shall be therapeutically indicated or necessary for the child to gain independence. (ii) Youth actively working toward independence shall be permitted short breaks in supervision to pursue recreation, employment or educational opportunities that complement his or her plan of care. (iii) The organization shall have sufficient staff to allow the number of children being served to be adequately supervised, taking into consideration the complexity of the needs of the children. The organization shall consider appointments requiring staff supervision, staff leave, possible illness of children and other relevant factors when scheduling staff and child activities. (d) The organization shall not use electronic surveillance equipment devices in place of personal direct care staff supervision.	
Explanation for findings:	Interviews with youth and staff reveal the organization's staff did provide the needed supervision and responsive to youth's welfare.	
Recommendations for Compliance:	N/A	
Corrective Action Plan (CAP) Due Date:	N/A	

Allegation:	It is alleged the organization has a youth stay in the seclusion room overnight and/or the hallway overnight.	Reported
Date of Allegation:	05/09/2023	
Finding:	**Evidence does not support findings of non-compliance.**	
Rules Violated:	Section 25. Emergency Safety Interventions (A) The facility shall have written policies and procedures for dealing with children who are temporarily beyond control and are a danger to themselves or others. These shall include identifying, developing, and promoting preventive strategies and the use of safe and effective alternatives to using the Seclusion Room (C) Use of the Seclusion Room is expressly prohibited as a means of dealing with non-violent or non-assaultive behaviors. (A) One (1) hour for children nine (9) years of age and under; and (B) Two (2) hours for children ten (10) years of age and above Section 21. Bedrooms. (c) Each child shall be provided with room and board and is to be assigned a bedroom which shall include, as a minimum, an individual bed, mattress, mattress cover, pillow, supply of bed linen and space for the storage of personal items. There shall be no more than four (4) children to a facility or foster home bedroom.	
Explanation for findings:	Interviews with youth and staff reveal the youth was placed in the hallway and/or seclusion room as a temporary sleeping arrangements as the room flooded and needed repair. The youth used a portable bed and bedding.	
Recommendations for Compliance:	N/A	
Corrective Action Plan (CAP) Due Date:	N/A	

Per the Administrative Rules for Certification of Providers of Substitute Care Services for Children, the corrective action plan (CAP) to address the issues of non-compliance, must be submitted for approval within thirty (30) days of the below date.
If you disagree with the Department's finding of non-compliance of the Administrative Rules for Certification of Providers of Substitute Care Services for Children, you may request an administrative hearing within ten (10) days of your receipt of this letter (W.S. 14-4-108). Administrative Hearing procedures are included in the Department's "Contested Case Hearing" Rules, Chapter 2 and based upon the above statute. If you need a copy of the Rules or assistance in requesting an administrative hearing, you may contact your Licenser or Supervisor listed below.

Licenser/Investigator:	[redacted]		
Address:			
City:	Cody	**State:**	Wyoming
Telephone:	[redacted]	**Zip Code:**	[redacted]

[redacted] 5-18-2023
(Licenser) (Date)

[redacted] 05-18-2023
(Manager) (Date)

cc: Substitute Care Facility
Licenser

UHS-FINHELP-00008890 [Redacted]

Colorado Department of Human Services
Division of Child Welfare
1575 Sherman Street-Fourth
Denver, CO 80203-1714

REPORT OF INSPECTION

Name of Facility:	*Cedar Springs Hospital*	**License #:**	[redacted]
Facility Address:	[redacted]	**City:**	*Colorado Springs*
Zip Code:	[redacted]	**County:**	*El Paso County*
Visit Purpose:	*In–person supervisory*		
Division Representative(s):	[redacted]	**Date(s):**	*January 25, 2023*
Person Interviewed:	[redacted]	**Title:**	*Chief Executive Officer, Director of Performance Improvement and Risk Management*

This was an unannounced supervisory visit where 6 youth files, 4 staff files were reviewed along with emergency drills and mandatory inspections were reviewed and a facility, vehicle, and grounds inspection was completed. The following items were observed and are violations for:

7.701 GENERAL RULES FOR CHILD CARE FACILITIES
7.705 RULES REGULATING RESIDENTIAL CHILD CARE FACILITY
7.714 QUALITY STANDARDS FOR 24-HOUR CHILD CARE

Technical assistance provided on the following:
7.701.300 Four hours initial training on Cultural Responsiveness and two hours on going training for all staff. **7.701.400** Four hours initial training on Trauma Informed Care and two hours on going training for all staff.

1.)	**Observed:**	No documentation of background checks completed on one of the administrators for Cedar Springs Hospital.
	Rule Reference:	This is a violation of 7.701.33 D 4a & 7.701.32 D2
	Corrective Action:	**Immediate Action**: Submit to CDHS by 2/6/2023 the receipt for the electronic fingerprints and a copy of the submitted BIU application and an action plan for maintaining future compliance.

2.)	**Observed:**	No documentation of place of birth in 2 of the 6 child files.
	Rule Reference:	This is a violation 7.714.932 C1

I have read and understand the above violations. I will send **written verification** of the correction of these violations by **3/3/23.** If I have any problems completing the corrections by this date, I will respond in writing and state the planned date of completion. At that time a follow-up letter will be sent stating all corrections have been made.

Signature:		Date:	
Title and Position:			

If you feel a regulation presents undue hardship or that it has been too stringently applied, you have a right to appeal (see regulation number 7.701.13 of the General Rules for Child Care Facilities).

Colorado Department of Human Services
Division of Child Welfare
1575 Sherman Street-Fourth Floor
Denver, CO 80203-1714

REPORT OF INSPECTION

Name of Facility:	*Cedar Springs Hospital*	**License #:**	[redacted]
Facility Address:	[redacted]	**Date(s):**	*January 25, 2023*

	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

3.)	**Observed:**	No documentation of the child's orientation to the facility within 24 hours of admission in 2 of the 6 files and 2 other child's orientations were late.
	Rule Reference:	This is a violation of 7.714.2 H 1-7
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

4.)	**Observed:**	Late documentation of the Child's Individual Plan which must be developed within 14 days of the child's admission to the facility.
	Rule Reference:	This is a violation of 7.714.4D
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

5.)	**Observed:**	No documentation of fostering community involvement in the Child's Individual Plan in 3 of the 6 child files.
	Rule Reference:	This is a violation of 7.714.4D 2 d
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

6.)	**Observed:**	No documentation in the physical management reports which must have each staff document their involvement in the restraint. Also must include a more descriptive narrative on what the imminent risk is to justify a physical management.
	Rule	This is a violation of 7.714.53 E8

I have read and understand the above violations. I will send **written verification** of the correction of these violations by **3/3/23.** If I have any problems completing the corrections by this date, I will respond in writing and state the planned date of completion. At that time a follow-up letter will be sent stating all corrections have been made.

Signature:		Date:	
Title and Position:			

If you feel a regulation presents undue hardship or that it has been too stringently applied, you have a right to appeal (see regulation number 7.701.13 of the General Rules for Child Care Facilities).

Colorado Department of Human Services
Division of Child Welfare
1575 Sherman Street-Fourth Floor
Denver, CO 80203-1714

REPORT OF INSPECTION

Name of Facility:	*Cedar Springs Hospital*	**License #:**	[redacted]
Facility Address:	[redacted]	**Date(s):**	*January 25, 2023*

	Reference:	
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

7.)	**Observed:**	Observed the children's rights and grievance not posted in an area that is frequented by youth.
	Rule Reference:	This is a violation of 7.714.31A 1-17 & 7.714.32A 1-4
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

8.)	**Observed:**	Observed no hand towels in youth's bathrooms. Several holes, damaged ceiling tiles, and some graffiti in the unit.
	Rule Reference:	This is a violation of 7.714.512A
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

Report of inspection sent to Cedar Springs Hospital on 2/2/2023

Fire inspection expires on 11/15/2024
Health inspection expires on 3/2/2023

[redacted]
[redacted]**24-Hr Licensing Specialist**
[redacted] **or** [redacted]
Provider Services, CDHS Division of Child Welfare
[redacted]
Denver, CO [redacted]

I have read and understand the above violations. I will send **written verification** of the correction of these violations by **3/3/23.** If I have any problems completing the corrections by this date, I will respond in writing and state the planned date of completion. At that time a follow-up letter will be sent stating all corrections have been made.

Signature:		Date:	
Title and Position:			

If you feel a regulation presents undue hardship or that it has been too stringently applied, you have a right to appeal (see regulation number 7.701.13 of the General Rules for Child Care Facilities).

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CEDAR SPRINGS HOSPITAL
Creating hope. Saving lives. Healing families.

REPORT OF INSPECTION AND FACILITY RESPONSE

Name of Facility	*Cedar Springs*	**License #:**	[redacted]
Facility Address:	[redacted]	**City:**	*Colorado Springs*
Zip Code:	[redacted]	**County:**	*El Paso County*
Visit Purpose:	*In-person supervisory*		
Division Representative(s):	[redacted]	**Date(s):**	*January 25, 2023*
Person Interviewed:	[redacted]	**Title:**	*Director of Performance Improvement and Risk Management, Clinical Director*

This was an unannounced supervisory visit where 6 youth files, 4 staff files were reviewed along with emergency drills and mandatory inspections were reviewed and a facility, vehicle, and grounds inspection was completed. The following items were observed and are violations for:

7.701 GENERAL RULES FOR CHILD CARE FACILITIES
7.705 RULES REGULATING RESIDENTIAL CHILD CARE FACILITY
7.714 QUALITY STANDARDS FOR 24-HOUR CHILD CARE
Technical assistance provided on the following:

7.701.300 Four hours initial training on Cultural Responsiveness and two hours on going training for all staff.
7.701.400 Four hours initial training on Trauma Informed Care and two hours on going training for all staff.

1.)	**Observed:**	No documentation of background checks completed on one of the administrators for Cedar Springs Hospital.
	Rule Reference:	This is a violation of 7.701.33 D 4a & 7.701.32 D2
	Corrective Action:	**Immediate Action**: Submit to CDHS by 2/6/2023 the receipt for the electronic fingerprints and a copy of the submitted BIU application and an action plan for maintaining future compliance.
	Cedar Springs Response:	Administrator completed background check and results were submitted to CDHS. Cedars Springs will require that all administrators completed onboarding that will include electronic fingerprints and submission of the BIU application prior to starting employment.
2)	**Observed:**	No documentation of place of birth in 2 of the 6 child files.
	Rule Reference:	This is a violation 7.714.932 C1
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.
	Cedar Springs Response:	The place of birth information is collected on the Patient Information Sheet during the admission process. Intake staff have been re-educated on completion of the Patient Information sheet, to include completion of notating place of birth. The Patient Information sheet will be placed in the medical record. Audits will be conducted to ensure place of birth is part of the medical record.

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REPORT OF INSPECTION AND FACILITY RESPONSE

3)	**Observed:**	No documentation of the child's orientation to the facility with 24 hours of admission in 2 of the 6 files and 2 other child's orientations were late.
	Rule Reference:	This is a violation of 7.714.2 H 1-7
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.
	Cedar Springs Response:	Orientation was completed 2/18/23. Staff were re-educated on completing the facility orientation within 24 hours of admission. Audits will be completed to ensure the orientation has been completed timely and re-education will be done as needed.
4)	**Observed:**	Late documentation of the Child's Individual Plan which must be developed within 14 days of the child's admission to the facility.
	Rule Reference:	This is a violation of 7.714.4D
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.
	Cedar Springs Response:	Re-education was completed with therapist on timely completion of treatment plans. Audits will be completed to ensure the treatment plans have been completed timely and re-education will be done as needed.
5)	**Observed:**	No documentation of fostering community involvement in the Child's Individual Plan in 3 of the 6 child files.
	Rule Reference:	This is a violation of 7.714.4D 2 d
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.
	Cedar Springs Response:	Re-education was completed with therapist on proper completion of treatment plans to include goals for fostering community involvement. Audits will be completed to ensure the treatment plans have been completed to include fostering community involvement and re-education will be done as needed.
6)	**Observed:**	No documentation in the physical management reports which must have each staff document their involvement in the restraint. Also, must include a more descriptive narrative on what the imminent risk is to justify a physical management.
	Rule Reference:	This is a violation of 7.714.53 E8
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.
	Cedar Springs Response:	Seclusion and restraint packets have been revised. The Clinical Review sheet has been revised to include auditing for individual documentation as well as description of the imminent risk requiring a physical restraint. Individual re-education will be completed as needed.
7)	**Observed:**	Observed the children's rights and grievance not posted in an area that is frequented by youth.
	Rule Reference:	This is a violation of 7.714.31A 1-17 & 7.714.32A 1-4
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.

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REPORT OF INSPECTION AND FACILITY RESPONSE

	Cedar Springs Response:	Patient rights and grievance procedure were posted by 2/27/23. The patient advocate will ensure that patient rights and the grievance procedure stay posted by conducting a daily check Monday through Friday. If the rights or grievance procedure are missing, the advocate will repost the signs.
8)	**Observed:**	Observed no hand towels in youth's bathrooms. Several holes, damaged ceiling tiles, and some graffiti in the unit.
	Rule Reference:	This is a violation of 7.714.512A
	Corrective Action:	Submit in writing to CDHS by 3/3/2023 as to how this was addressed and an action plan for maintaining future compliance.
	Cedar Springs Response:	Holes, damaged ceiling tiles and graffitied walls were repaired. Laundry service was notified to provide hand towels to the program. Unit staff will provide clean hand towels to all patients daily. Environmental rounds will be completed to ensure that that physical environment is in good condition and the hand towels are being provided.

[redacted] Director of Performance Improvement

3/3/23
Date

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UHS-FINHELP-00008896 [Redacted]

Final Accreditation Report

Cedar Springs Hospital
[redacted]
Colorado Springs, CO [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 1/2/2020

ESC Programs Reviewed
Hospital
Behavioral Health

Final Report: Posted 1/8/2020

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The Joint Commission
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The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	1/2/2020	No Requirements for Improvement	None	None
Behavioral Health	1/2/2020	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.01.11	Compliant
CTS.03.01.03	Compliant
CTS.04.03.17	Compliant
EC.02.04.03	Compliant
EC.02.06.01	Compliant
IC.02.02.01	Compliant
MM.03.01.01	Compliant

Final Accreditation Report

Cedar Springs Hospital
[redacted]
Colorado Springs, CO [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 10/16/2019 - 10/18/2019

Programs Surveyed
Hospital
Behavioral Health

Final Report: Posted 10/28/2019

Appendix 64.

The Joint Commission
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The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	10/16/2019 - 10/18/2019	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date
Behavioral Health	10/16/2019 - 10/16/2019	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

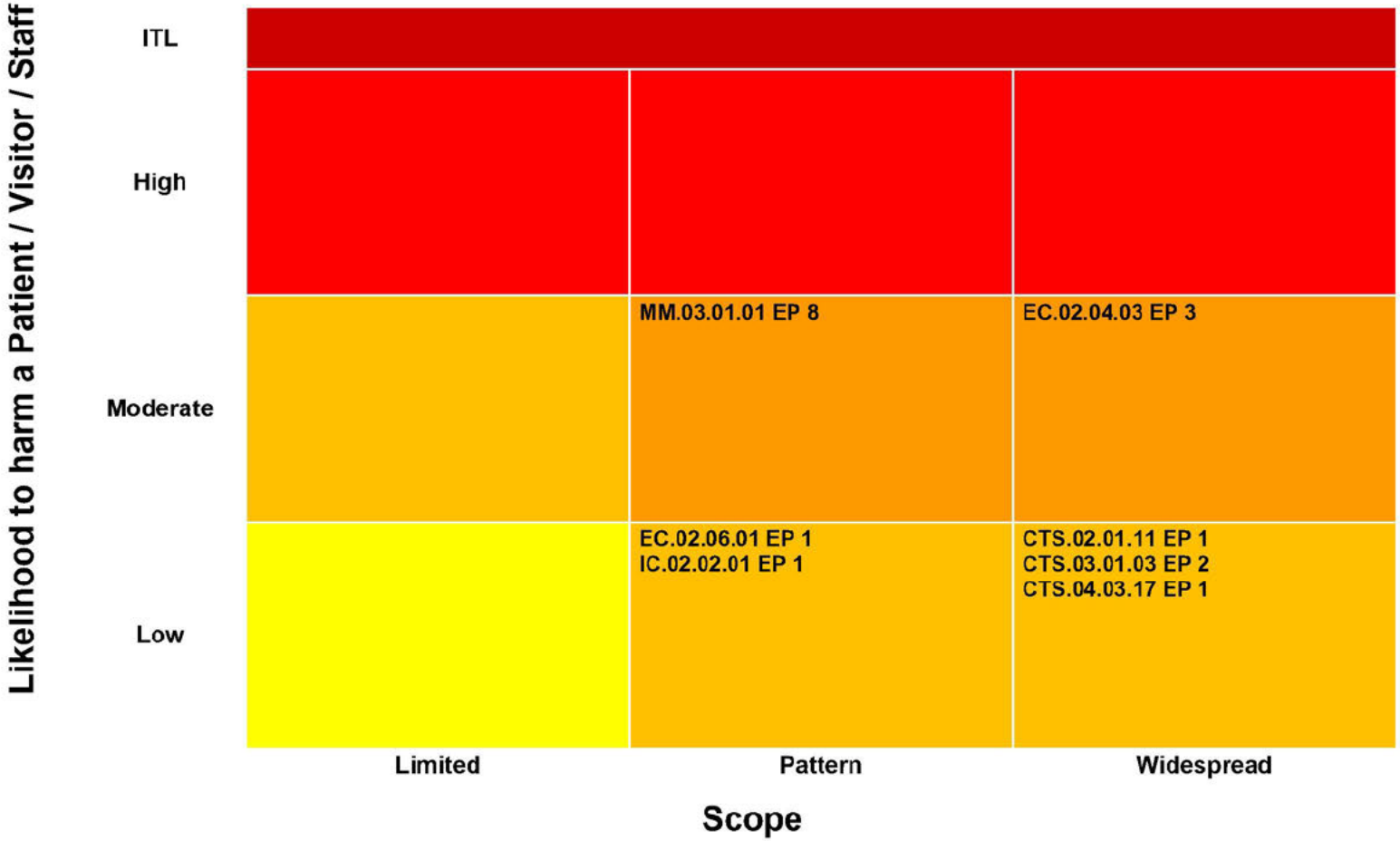
The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.01.11	1	Low / Widespread	✓
CTS.03.01.03	2	Low / Widespread	✓
CTS.04.03.17	1	Low / Widespread	✓
EC.02.04.03	3	Moderate / Widespread	✓
EC.02.06.01	1	Low / Pattern	✓
IC.02.02.01	1	Low / Pattern	✓
MM.03.01.01	8	Moderate / Pattern	✓

The Joint Commission
SAFER™ Matrix

Program: Behavioral Health



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The Joint Commission
Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.11	1	Low Widespread	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of ten pounds or more in the last three months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting	1). Observed in Individual Tracer at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . The nutrition screen include weight gain of ten pounds or more in the last three months but did not include weight loss for the same period of time as acknowledged by Clinical Services Program Manager. This finding applied to all records as they used the same nutrition screening document.
CTS.03.01.03	2	Low Widespread	The plan for care, treatment, or services includes the following: - Goals that are expressed in a manner that captures the individual's words or ideas - Goals that build on the individual's strengths - Factors that support the transition to community integration when identified as a need during assessment - The criteria and process for the individual's expected successful transfer and/or discharge, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01) Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors. Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.	1). Observed in Individual Tracer at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . Short and long term goals contained in the Master Treatment Plan were in the voice of the therapist and began with, "patient will . . . " or "Develop health and positive patterns of thinking and beliefs about herself." This was acknowledged by the Clinical Services Program Manager and would apply to all outpatient records.
				2). Observed in Individual Tracer at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . Treatment plan goals were not expressed in a manner that captured the patient's words or ideas, as acknowledged by the Clinical Services Program Manager.
CTS.04.03.17	1	Low Widespread	For organizations that use activity therapies: The individual's plan for care, treatment, or services identifies activity therapies provided to support achievement of a specific goal(s).	1). Observed in Individual Tracer at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . The patient participated in Equine Therapy but the Master Treatment Plan did not include the activity therapy as a treatment modality, as acknowledged by the Clinical Services Program Manager. It was

Appendix 64.

CONFIDENTIAL UHS-FINHELP-00008905

Standard	EP	SAFER™ Placement	EP Text	Observation
				also acknowledged that Equine Therapy would not appear on the treatment plans of other patient participants as well.
EC.02.04.03	3	Moderate Widespread	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.	1). Observed in Building Tour at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . The organization used 'Breathalyzers' to determine patient use of alcohol but was not able to show the surveyor the frequency of recalibration required to maintain the devices used prior to the surveyor's departure, as acknowledged by the Clinical Services Program Manager.
EC.02.06.01	1	Low Pattern	Interior spaces meet the needs of the individuals served for safety and suitability for the care, treatment, or services provided.	1). Observed in Building Tour at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . In the Nutrition Center, the cover of an electrical junction box in the ceiling was missing, which provided access to exposed electrical wiring as acknowledged by the Clinical Services Program Manager.
				2). Observed in Building Tour at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . Ripped wall covering was noted in the area of the bathroom sink in Room #230 and a hole, approximately an inch in diameter was noted in the shower ceiling, in Room #221. These findings were acknowledged by the Clinical Services Program Director.
IC.02.02.01	1	Low Pattern	The organization implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical supplies and devices. * Note: Low-level disinfection is used for items such as blood glucose meters. Additional cleaning and disinfecting is required for medical supplies and devices used by individuals who require the use of other precautions in addition to standard precautions. These "other precautions" are also known as "transmission-based" precautions. Footnote *: For further information regarding cleaning and performing low-level disinfection of medical supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3.	1). Observed in Building Tour at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . The patient clothes washer was not sanitized between loads by different patients as acknowledged by the Clinical Services Program Director.
				2). Observed in Building Tour at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . The patient clothes washer was not sanitized between loads by different patients as acknowledged by the Clinical Services Program Director.
MM.03.01.01	8	Moderate Pattern	For organizations that store medications: The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for	1). Observed in Building Tour at Cedar Springs Hospital [redacted] Colorado Springs, CO) site . Five bottles out of five bottles of Hydrogen Peroxide 3%, in a storage closet, had

Standard	EP	SAFER™ Placement	EP Text	Observation
			administration. (See also MM.05.01.19, EP 1) Note: This element of performance is also applicable to sample medications.	either expired in February 2016 or in January 2018. This was acknowledged by The Clinical Services Program Director. In the Medication Room, a tube of Hydrocortisone Cream USP 1%, lableled 'not floor stock,' stored in a patient medication cubby, had expired 6/2019. This was acknowledged by the RN.

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Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

UHS-FINHELP-00008911 [Redacted]

PRINTED: 11/04/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYNN MARR HOSPITAL	[redacted]

(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
V 000	INITIAL COMMENTS An annual, follow up, and complaint survey was completed on October 20, 2021. The complaint was substantiated (intake #NC00182259). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105		

[redacted]

11-18-21

PRINTED: 11/04/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYNN MARR HOSPITAL	[redacted]

(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
V 105	Continued From page 1 recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges; (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

PRINTED: 11/04/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYNN MARR HOSPITAL	[redacted]

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice for use of restrictive interventions as planned interventions, assessment post seclusion or restraint, and reporting serious occurrences to the State designated Protection and Advocacy system. The findings are: A. Review on 10/6/21 of the Code of Federal Regulations (CFR) revealed -"§483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility..." Reviews between 10/6/21 and 10/20/21 of the facility's North Carolina Incident Response Improvement System (IRIS) reports dated 6/2/21 through 10/20/21 revealed: -6/2/21 client #3 had been placed in a standing restraint and seclusion. -7/2/21 client #1 had been placed in a standing restraint and seclusion with 3 staff involved in the intervention (Staff #11, Registered Nurse (RN) Supervisor #2, and a Teacher). -7/2/21 client #2 had been placed in a standing restraint and seclusion with 3 staff involved in the intervention (Staff #11, Staff #14, RN Supervisor #2).	V 105	All staff involved in the use of restraint or seclusion will participate in patient debriefing completed within 24 hours of the intervention, with the exception of when the presence of a particular staff member may jeopardize the wellbeing of the patient. Patient Debriefing forms were updated to include a designated area for all staff names involved in the restrictive intervention. Forms were implemented on 11/8/21. All direct care staff have been educated and trained on this requirement in their November staff meetings on 11/15/21 and 11/17/21. Ongoing coaching and education will occur following any restrictive intervention. The Director of Risk Management/ Performance Improvement or designee audits 100% of all restrictive interventions on a monthly basis to monitor compliance with staff involvement in patient debriefing. Data analysis will be reported monthly in Patient Safety Council. All reportable occurrences to IRIS and DRNC will include names of all staff directly involved in the incident.	11/17/21 10/21/21 10/21/21

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V 105	Continued From page 3 -7/19/21 client #2 had been placed in a standing restraint and seclusion with 5 staff involved in the intervention (RN Supervisor #4, RN #1, RN #3, RN #5, and Staff #9). -7/24/21 client #1 had been placed in a standing restraint and seclusion with 5 staff involved in the intervention (RN Supervisor #2, RN #3, RN #5, Staff #12, Staff #13). -9/15/21 client #3 had been placed in a standing and face up restrictive interventions with 5 staff involved in the intervention (Staff #10, RN #1, RN Supervisor #4, RN Supervisor #5, RN Supervisor #6). Review on 10/6/21 and 10/11/21 of client #1's record revealed: -7/3/21 debriefing documented Staff #8 was the only staff involved in the post-debriefing for the restrictive intervention that occurred on 7/2/21. (Staff #8 was not listed in IRIS as a person involved in the intervention.) -7/24/21 debriefing documented RN #2 was the only staff involved in the post-debriefing of the restrictive intervention that occurred on 7/24/21. (RN #2 was not listed in IRIS as a person involved in the intervention.) -There was no documented reasons the other staff involved in the restrictive interventions were not present for the debriefings on 7/3/21 or 7/24/21 with client #1. Review on 10/11/21 of client #2's "Physical Intervention - Patient Debriefing" documentation for interventions on 7/2/21 and 7/19/21 revealed: -Debrief dated 7/3/21 documented Staff #8 was the only staff involved in the post-debriefing of the restrictive intervention that occurred on 7/2/21. (Staff #8 was not listed in IRIS as a person involved in the intervention.) -Debrief dated 7/19/21 documented RN #1 was	V 105		

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V 105	Continued From page 4 the only staff involved in the post-debriefing of the restrictive intervention that occurred on 7/19/21. -There was no documented reasons the other staff involved in the restrictive intervention were not present for the debriefings on 7/3/21 or 7/19/21 with client #2. Review on 10/11/21 of client #3's "Physical Intervention - Patient Debriefing" documentation for interventions on 9/15/21 revealed: -Debrief dated 9/15/21 documented RN #6 was the only staff involved in the post-debriefing of the restrictive intervention that occurred on 9/15/21. (RN #6 was not listed in IRIS as a staff involved in the intervention.) -There was no documented reasons the other staff involved in the restrictive intervention were not present for the debriefing on 9/15/21 with client #3. Interview on 10/8/21 Staff #2 stated the client debrief following a restrictive intervention was usually done by 1 staff and the client. Interview on 10/8/21 Staff #1 stated the client debrief was done by the nurse or supervisor. He participated in the staff debrief but never in the client debrief. B. Review on 10/6/21 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities (PRTF)" dated 5/11/18 revealed: -" ...Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC § 483.374 specifies that facilities must report each Serious	V 105	The Director of Risk Management & Performance Improvement or designee will be responsible for submitting all reportable occurrences through the IRIS system and verify submission by printing out the confirmation page. Reports will also be faxed to DRNC by the Director of Risk Management & Performance or designee and will be documented and verified by the fax transmission form. All reports and verifications are filed by date and maintained by the Director of Risk Management/Performance Improvement.	10/21/21

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V 105	Continued From page 5 Occurrence to both the State Medicaid agency (Division of Medical Assistance - DMA) and, unless prohibited by State law, the State-designated Protection and Advocacy system (Disability Rights North Carolina - DRNC)." -"DRNC reports are to be faxed to (919) 856-2244." Review on 10/11/21 of facility reports to the state designated protection and advocacy system revealed: -No report had been submitted for the restrictive interventions of client #1 on 7/24/21. -No report had been submitted for the restrictive interventions of client #3 on 6/2/21.	V 105	The Director of Risk Management & Performance Improvement has been provided with the IRIS reporting manual and has reviewed said manual for training on occurrences that are reportable to both IRIS and DRNC.	10/22/21
	C. Review on 10/6/21 of CFR §483.356(a)(2) revealed: -"An order for restraint or seclusion must not be written as a standing order or on an as-needed basis." Review on 10/6/21 and 10/11/21 of client #1's record revealed: -"Crisis Prevention and Intervention Plan" dated 7/15/21, "Strategies for crisis response and stabilization" read, "In the event of imminent danger ... the use of restrictive intervention will be used..." Interview on 10/11/21 Director of Risk Management stated: -She was unable to confirm transmission of facility reports to the state designated protection and advocacy system for restrictive interventions administered on 6/2/21 for client #3 and 7/24/21 for client #1. -She was aware restrictive interventions were not		Brynn Marr Hospital does not employ the use of a standing order for restraint and seclusion. All physician orders for restrictive interventions are obtained within 30 minutes of the intervention and are only utilized when other least restrictive interventions have failed and in the event of imminent risk of harm to self or others. The Crisis Prevention and Intervention Plan for Client #1 has been amended to remove the language stating that the use of restrictive interventions are used on an as-needed basis. All PRTF Clinical staff have been educated on this standard, and attended a training on 11/3/21 facilitated by the Director of Clinical Services and Clinical Services Manager on the treatment planning policy and process.	10/21/21 11/12/21 11/3/21

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V 105	Continued From page 6 to be a part of a client treatment plan and would follow up on client #1's plan. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	The Clinical Services Director and Nurse Managers conducted an audit of 100% of all current PRTF patient medical records to verify proper assessment of all high-risk behaviors and corresponding precautions to inform treatment goals and interventions. All PRTF therapists were provided with individual re-education on 10/22/21 regarding this standard of care, and treatment plans were updated as needed to reflect all identified high-risk behaviors. PRTF therapists attended and completed a training on the treatment planning process and policy facilitated by the Director of Clinical Services and Clinical Services Manager. Direct care staff to include Intake, Nursing, Mental Health Technicians, Therapeutic Intervention Coordinators, PRTF Therapists, Recreational Therapists, and teachers reviewed facility policy on Patient Precautions/ Restriction Level and Levels of Observation and signed an attestation acknowledging review and understanding of the policies.	10/22/21 11/3/21 11/12/21

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V 112	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement strategies based on assessment for 1 of 6 audited clients (#4). The findings are: Review on 10/15/21 and 10/18/21 of client #4's record revealed: -17 year old female admitted 6/10/21. -Discharged 10/13/21 as a result of client #4's elopement from the facility on 10/12/21. -Diagnoses included disruptive mood dysregulation disorder; post-traumatic stress disorder; conduct disorder, adolescent onset type; cannabis use disorder; sedative, hypnotic or anxiolytic use disorder. -Client #4 was a voluntary admission due to increased aggression, suicide attempts and false accusation of sexual assault by a family member. -Client #4 had a history of multiple elopements from home with the most recent having been 1 month prior to admission. -6/10/21: Nursing Admission Assessment (check list format) documented "Substance abuse" to be an elopement risk factor, but did not select "History of elopement" to be a risk factor. -6/11/21: Psychosocial Assessment quoted client #4, "I feel like I have a lack of communication with my mother. I don't feel like I can control my impulses." -6/11/21: Psychiatrist Admission History documented client #4's mood lability going between "really irritable to really happy...," physical aggression, periods of elevated mood, and increased risk taking behaviors such as running away. -6/24/21: Neuropsychiatric Evaluation documented client #4 told her mother of sexual	V 112		

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V 112	Continued From page 8 abuse by a family member in March 2021, had made suicide attempts in March and April 2021, had been "running away" because her mother had taken the client's phone and client #4 was trying to get away from the accused family member. -Neuropsychiatric Evaluation (dated 6/24/21) Treatment recommendations included individual therapy focused on impulsive decision making, need to elope, and substance use. Review on 10/15/21 of client #4's treatment plan signed 7/8/21 revealed: -Goals and strategies included client #4 would identify triggers/stressors /underlying causes of her suicide attempts; participate in cognitive behavioral therapy to learn how to manage her depressed mood; implement new methods of effective communication and problem solving between family members. -There were no goals or strategies to address elopement behavior, aggressive behavior, or substance use. Review on 10/15/21 and 10/18/21 of client #4's "Master Treatment Plan Update/Clinical Staffing Worksheet dated 9/30/21 revealed: -Tentative discharge date, 11/18/21. -"[Client #4] presents with a fluctuating/labile mood and is making minor progress towards her treatment goals." -9/19/21 client #4 "attempted to encourage a peer to attack a peer on her behalf." -9/23/21 client #4 "used selective peers medication." -"On the unit, [client #4] requires frequent redirection AEB (as evidenced by) her poor boundaries with a select peers, instigating, and writing letters to peers encouraging them to partake in breaking rules. She is reported to be manipulative at times AEB: encouraging peers to	V 112		

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V 112	Continued From page 9 seek medication on her behalf, encourage peers to fight, encouraging peers to not follow direction ... [Client #4] has engaged in aggression AEB: attacking a peer on the unit causing physical injuries." Review on 10/18/21 of the facility's incident reports from 7/1/21 through 10/18/21 revealed: -9/11/21 client #4 "jumped" a peer, began kicking the peer lying on the floor, kicking staff, and was placed in a 2 person physical restraint. -9/18/21 client #4 got into a "physical confrontation" and kicked client #5 in the upper right cheek and eye. Client #5 was seen in the emergency room and diagnosed with a corneal abrasion of the right eye. -10/12/21 client #4 and client #5 had assaulted Staff #3 and eloped. Reviews on 10/18/21 - 10/20/21 of the facility's internal Investigation Summary dated 10/13/21 revealed: -On 10/12/21 at 8:29 pm client #4 and client #5 assaulted Staff #3, took the staff's keys, and exited the facility through a courtyard. -Interviews with other clients on 10/13/21 documented: -Client #6 and client #2 had heard client #4 and client #5 talking about a plan to elope about 1 month ago. -Client #1 had heard client #4 and client #5 talking about a plan to elope about 2 weeks prior to the incident. Interview on 10/15/21 Nursing Supervisor #2 stated client #4 was not considered to be an elopement risk. Interview on 10/15/21 Nursing Supervisor #4 stated:	V 112		

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V 112	Continued From page 10 -Client #4 did not have a history of elopement. -The plan was to discharge client #4 "in the near future." -Client #4 was upset about her upcoming discharge when she would have to return home to live with the family member she had accused of rape. Client #4 was "stressing" because her mother took the family member's "side" and she felt she had no one to support her. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to hold disaster drills or fire drills that simulated fire emergencies, at least quarterly on	V 114		

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V 114	Continued From page 11 each shift. The findings are: Interview on 10/6/21 the Chief Nursing Officer stated there were 2 shifts, 7 am - 7 pm, and 7 pm - 7 am. Review on 10/6/21 of the facility fire and disaster drills from 10/1/20 - 9/30/21 revealed: -No fire drill documented on the 7 am - 7 pm shift between 1/1/21 - 3/31/21. -There was 1 disaster drill documented 5/25/21. Interview on 10/7/21 the Plant Operations Manager stated: -One of his responsibilities was to coordinate emergency plans. -On the night shift, 7 pm - 7 am, the fire drills documented were "silent" fire drills. -A "silent" fire drill did not include a practice of client evacuation. -He had not understood that disaster and fire drills were not one in the same. -The facility followed the requirements of the facility's national accrediting body that required 2 disaster drills a year. -The facility was counting the facility's response to the coronavirus pandemic as 1 disaster drill. -In addition to the coronavirus pandemic, the most recent disaster drill was held 5/25/21. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	The Director of Plant Operations or designee will conduct a minimum of 2 fire drills and 2 disaster drills time per shift per quarter as required. The 7pm-7am shift drills will no longer be silent and shall include the practice of patient evacuation to simulate a fire emergency. Both a fire drill and disaster (tornado) drill were conducted on 10/21/21. Evidence of drills are reported quarterly in Environment of Care meetings by the Director of Plant Operations to ensure compliance.	10/21/21
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be	V 123		

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V 123	Continued From page 12 reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. .	V 123		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist and refusals charted affecting 3 of 3 clients audited (#1, #2, #3). The findings are: Finding #1: Review on 10/6/21 of client #1's record revealed a 15 year old female admitted 4/24/21 with diagnoses that included major depressive disorder, recurrent; anxiety; post traumatic stress disorder (PTSD); attention deficit hyperactive disorder (ADHD); schizo-affective disorder. Reviews between 10/6/21 and 10/11/21 of client #1's Medication Administration Records (MARs) for 7/1/21-9/30/21 revealed the following medications documented "NA": -Paliperidone ER (extended release) 6 mg (milligrams) on 7/1/21 and 7/2/21 at 9 pm. (Antipsychotic) -Lithium ER 450 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Depakote ER 500 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Cyclobenzaprine 5 mg on 9/28/21 and 9/29/21 at 7 pm. (Antidepressant)		The Chief Nursing Officer and Nurse Managers provided re-education during Nursing staff meetings on 10/18/21, 10/20/21, 11/15/21, and 11/17/21 regarding the policy and practice of ensuring medication errors are reported to a physician or pharmacist immediately and medication refusals are charted. Nurses were instructed to document in the daily nursing progress note and the electronic medical record (HCS). Nursing leadership will begin auditing a random sample of patients refusing medication on a monthly basis and report findings in Quality Council and Medical Executive meetings. Data will include compliance with proper documentation and physician notification of patient medication refusals.	12/1/21

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V 123	Continued From page 13 -Flonase 5 mcg (micrograms) nasal spray was documented as "NA" for 66 doses between 7/1/21 and 9/30/21. (Allergy Symptoms) -Lactase 3,000 units was documented as "NA" for 74 doses between 7/1/21 and 9/30/21. (Lactose Intolerance) Finding #2: Review on 10/8/21 of client #2's record revealed a 16 year old female admitted 10/17/20 with diagnoses that included bipolar 1 disorder, and ADHD. Reviews between 10/8/21 and 10/11/21 of client #2's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Aripiprazole 15 mg on 7/18/21 at 9 am. (Mental/mood disorders) -Benztropine 1 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am; and, 8/1/21 at 5 pm. (Involuntary movements) -Clozapine 25 mg on 7/14/21 at 9 pm. (Antipsychotic) -Clozapine 150 mg on 7/19/21 at 9 pm. -Clozapine 300 mg on 7/125/21 at 9 pm. -Depakote ER 1250 mg on 7/14/21, 8/20/21, and 8/21/21. -Docusate 100 mg on 7/31/21 and 8/23/21 at 9 am; 8/25/21 and 8/26/21 at 5 pm; 8/1/21, 8/21/21, and 8/22/21 at 9 am and 5 pm. (Constipation) -Ethnyl at 9 am on 7/8/21, 7/27/21, 7/31/21, 8/1/21, 9/4/21-9/6/21, 9/8/21-9/18/21. -Eucerin Cream scheduled applications were documented "NA" for 48 of 62 doses in July 2021, 44 of 62 doses in August 2021, and 57 of 60 doses in September 2021. (Dry skin) -Guanfacine 4 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am. (ADHD) -Hydroxyzine 50 mg on 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; 7/18/21, 7/27, and 7/31/21 at	V 123		

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	[redacted]	A. BUILDING: _____ B. WING _____	10/20/2021

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V 123	Continued From page 14 9 am; and 8/1/21 at 5 pm. (Mental/Mood disorders) -Loratadine 10 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am. (Allergy symptoms) -Oxcarbazepine 300 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am; 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; and, 8/1/21 at 5 pm. (Mood stabilizer) -Clotrimazole topical 1% cream was documented "NA" for 26 of 28 scheduled applications between 9/1/21 and 9/14/21. (Antifungal) -Metformin 500 mg on 7/27/21, 7/31/21, and 8/1/21 at 9 am; 7/17/21 and 8/1/21 at 5 pm. (Appetite suppressant) Finding #3: Review on 10/8/21 of client #3's record revealed a 15 year old female admitted 1/12/21 with diagnoses of disruptive mood Dysregulation disorder, pre-diabetes, obesity, and bipolar disorder. Reviews between 10/8/21 and 10/11/21 of client #3's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Eucerin Cream was documented "NA" for 152 scheduled applications between 7/01/21 and 9/30/21. -Duloxetine DR 60 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and 9/25/21 at 9:00am. (Antidepressant) -Duloxetine DR (delayed release) 30 mg, 7/03/21, 7/13/21, 7/17/21,7/21/21, 7/23/21, 7/26/21 at 9:00am -Metformin 500 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and 9/25/21 at 9:00am. -Melatonin 6 mg on 7/02/21 T 9:00pm. (Sleep aid)	V 123		

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V 123	Continued From page 15 -Thorazine 300 mg, 8/02/21 at 9:00pm. (Antipsychotic) -Thorazine 100 mg on 7/03/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, and 8/15/21 at 9:00am; 7/05/21 and 8/09/21 at 1:00pm. -Thorazine 50 mg on 7/05/21 and 7/12/21 at 1:00pm; and 7/09/21, 7/13/21, and 9/17/21 at 9:00am. -Cogentin (Benztropine) 1 mg on 7/03/21, 7/13/21, and 7/17/21 at 9:00am. (Tremors) -Cogentin 0.5 mg on 7/21/21, 7/23/21, and 7/26/21 at 9:00am. -Abilify (Aripiprazole) 5 mg on 9/16/21 at 9:00am. (Bipolar disorder) -Abilify 10 mg on 9/21/21 and 9/25/21 at 9:00am. -Topamax 200 mg on 9/15/21 at 9:00pm. (Bipolar disorder) Review on 10/8/21 of the facility policy, "Medication Administration" dated 8/12/21 revealed: -Policy for late, refused, or withheld doses read, "Notify the provider if medication is late, withheld, or refused." -Policy did not include directions to document medications not administered in a way that would differentiate refusals from other reasons medications were not given. Interview on 10/8/21 the Pharmacist stated "NA" on the MARs meant the medication was "not administered." Interview on 10/8/21 the Registered Nurse #3 stated: -When a client refused their medications she would try to "educate" them. -She would not call the provider to report refusals. -The majority of medications refused were	V 123	The Chief Nursing Officer will conduct a review of the facility's Medication Administration policy to determine if changes are necessary to accurately reflect how staff document medications not administered. Nursing staff to be trained on any changes made to the policy following policy approval by Medical Executive Committee and Board of Governors.	11/19/21

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V 123	Continued From page 16 Eucerin cream and Flonase. Interview on 10/8/21 the Director of Nursing stated: -She could not identify what the MAR acronym "NA" stood for. -"NA" would be used to document medication refusals. -The nurses were not required to call a provider or pharmacist when a client refused a medication. -The providers were on site daily and had access to the electronic MARs.	V 123		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential	V 314		

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V 314	Continued From page 17 to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to provide a structured living environment to meet the supervision needs for 2 of 6 clients audited (client #4 and #5). The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TEATMENT/HABILITATION OR SERVICE PLAN (V112) Based on record reviews and interviews the facility failed to develop and implement strategies based on assessment for 1 of 6 audited clients (#4). Cross Reference: 10A NCAC 27G .1901 STAFF (V315) Based on record reviews and interviews, the facility failed to ensure at least 2 direct care	V 314		

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V 314	Continued From page 18 staff were present with every 6 children or adolescents at all times. The findings are: Review on 10/20/21 of the Plan of Protection dated 10/20/21 signed by the Director of Clinical Services revealed: -"What immediate action will the facility take to ensure the safety of the consumer's in your care? 10/13/2021 a memo was posted to 1 East nursing station indicating that the practice of taking patients off Unit for restroom use was to be discontinued immediately. Memo also indicated that 1 East patients were to use an interior courtyard with all staff present. An additional memo will be posted on 10/20/2021 to unit nursing station. Memo to indicate a minimum of 2 direct care staff members present at all times with patients. Additionally information to be shared via shift hound, shift report and email to staff members responsible for patient care. Nursing leaders will communicate with all 1 East staff per shift for the next 7 days face to face as noted above. All high risk behaviors will be assessed and included in treatment plan." -"Describe your plans to make sure the above happens. Verify that all nurse leaders are communicating the above mentioned through the use of a signature log of all staff that are educated. Nursing Supervisors to monitor staff to patient compliance ratios one time per shift. This will be documented. During morning flash meetings, senior leadership will complete random video reviews. This will be reviewed daily (business days) for the next 2 weeks. Information to be shared with CEO (Chief Executive Officer). 100% of all PRTF (psychiatric residential treatment facility) patients treatment plan will be audited for inclusion of high risk behavior." Client #4 was a 17 year-old female admitted	V 314	A memo was posted on the PRTF unit indicating 2 direct care staff members will be present with up to 6 patients at all times. This information was disseminated via Shifthound and email as well as verbally via shift report and individually by Nurse Leaders. Direct care staff signed an attestation verifying they had been educated on the staff to patient ratio requirements. The Clinical Services Director and Nurse Managers conducted a review of 100% of all current PRTF patient medical records to verify proper assessment of all high-risk behaviors and corresponding precautions to inform treatment goals and interventions. All PRTF therapists were provided with individual re-education on 10/22/21 regarding this standard of care. PRTF therapists attended and completed a training on treatment planning facilitated by the Director of Clinical Services and Clinical Services Manager. Nursing Supervisors review and monitor compliance with staff to patient ratio at least once per shift. Director of Risk Management/ Performance Improvement conducted random camera audits between 10/21/21 and 11/5/21 to ensure proper staff to patient ratio was maintained at all times. All findings were compliant and shared with the CEO and leadership team.	10/20/21 10/22/21 11/3/21 Ongoing 11/5/21

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V 314	Continued From page 19 6/10/21 with diagnoses of Post-Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, and Major Depressive Disorder. Client #5 was a 17 year-old female admitted 8/10/21 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder Unspecified, and Cannabis Use Unspecified. Client #4 had a history of elopement which had not been documented on her current treatment plan or patient observation record. Client #4 also had a history of assault, including an assault on client #5 which resulted in medical treatment by a local hospital on 9/18/21. Due to inappropriate activity in the bathrooms on the 1E (East) unit, a verbal directive was issued on 9/23/21 to escort clients by groups off the unit to use the educational hall restroom. In the following weeks the verbal order expanded to include a 9:00pm curfew and a staff ratio of 1 staff per 3 clients. The verbal orders were passed between staff on the 1E unit and the point of origin was not identified. On 10/12/21, at approximately 8:30pm, staff #3 conferred with staff #6 and RN #4 prior to escorting clients #4 and #5, and #6 to the adjacent administrative hall. While transitioning to the administrative hall, client #6 was stopped from leaving the 1E unit due to an observation protocol following medication consumption and remained behind on the 1E unit. Staff #3 continued to the administrative hall with clients #4 and #5. Once the group reached the end of the administrative hall, staff #3 was placed in a chokehold by client #5 and the facility keys were taken from her by client #4. The facility keys were used to exit the facility and gain access to a court yard and parking lot where clients #4 and #5 fled on foot. Shortly following the elopement, two girls fitting the description of clients #4 and #5 were	V 314	Direct care staff to include Intake, Nursing, Mental Health Technicians, Therapeutic Intervention Coordinators, PRTF Therapists, Recreational Therapists, and teachers reviewed facility policy on Patient Precautions/ Restriction Level and Levels of Observation and signed an attestation acknowledging review and understanding of the policies. Administrators on Call conduct weekly in-person audits and camera reviews across multiple shifts to monitor compliance with the facility Patient Observation policy. Findings that are out of compliance are reported to the direct supervisor. Aggregate data is analyzed and reported monthly in Patient Safety Council by the Director of Risk Management/ Performance Improvement.	11/12/21 ongoing

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V 314	Continued From page 20 Identified in the theft of a vehicle at a nearby gas station. Clients #4 and #5 had not been located as of 10/20/21. Following the elopement, the facility restricted bathroom use to the 1E unit, but staff continued to escort multiple clients off the unit in a ratio of one staff up to three clients. Failure to meet the supervision and treatment planning needs of two clients resulted in the assault of staff #3 and the serious neglect of clients #4 and #5 with their elopement from the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility.	V 315		

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V 315	Continued From page 21 (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure at least 2 direct care staff were present with every 6 children or adolescents at all times. The findings are: Review on 10/15/21 - 10/18/21 of client #4's record revealed: -17 year-old female. -Admission date of 6/10/21. -Diagnoses of Post-Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, and Major Depressive Disorder. -History of elopement. -Discharged 10/13/21 due to an elopement from facility. Review on 10/15/21 - 10/18/21 of client #5's record revealed: -17 year-old female. -Admission date of 8/10/21. -Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder- Unspecified, Cannabis Use-Unspecified. -Discharged 10/13/21 due to an elopement from facility. Review on 10/18/21 of staff #3's personnel record revealed: -Date of hire: 9/13/21. -Position Description: Mental Health Technician	V 315	Nursing Leaders to ensure the unit maintains a 2 to 6 staff to patient ratio at all times. The Chief Nursing Officer, Nurse Leaders, and/or Staff Coordinator review the unit schedule at a minimum of 3 times per shift to verify staff to patient ratio. Director of Risk Management/ Performance Improvement conducted random camera audits between 10/21/21 and 11/5/21 to ensure proper staff to patient ratio was maintained at all times. All findings were compliant. Administrators on Call conduct weekly in-person audits and camera reviews to ensure Patient Observation policy is followed at all times. Findings that are out of compliance are reported to the direct supervisor. Aggregate data is analyzed and reported monthly in Patient Safety Council by the Director of Risk Management/ Performance Improvement.	10/20/21 11/5/21 ongoing

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V 315	Continued From page 22 (MHT). Review on 10/18/21- 10/19/21 of facility's internal investigation dated 10/13/21 revealed: -Camera Review Notes: "8:27pm MHT [staff #3] leaves the group room with patients [client #5], [client #4], and [client #6] and all 4 begin to walk down the hallway...8:28pm [Client #6] can be seen stopping in the middle of the hallway, turning around, and returning to the group room. MHT [staff #3] appears to say something to [client #6], then continues walking down the hallway with [client #5] and [client #4] behind her as they exit the 1 East (E) door onto the Administrative hallway...8:29pm [Staff #3] is attacked by [client #4] and [client #5] from behind around her neck while she is trying to open the door leading into the sublobby with her keys. It appears that [client #4] attacked MHT [staff #3] around the neck area first, then [client #5] holds the MHT while [client #4] takes her keys. [Client #4] runs back down the hallway towards the exterior door with MHT [staff #3]'s keys, then [client #5] runs after her. MHT [staff #3] composes herself within seconds and runs after them, stopping to pick up something from the floor (unknown what the items is she picks up)...8:29.38 [Client #4] uses MHT [staff #3]'s keys to unlock the exterior door. [Client #4] and [client #5] exit the door. " -Administrator on Call Report: "Met with [staff #3]. Per [staff #3], the following occurred: She left the unit with [client #4] and [client #5] to escort them to the restroom in the school hallway due to patients taking showers in their bathrooms. After leaving the unit with the girls, she reports having been attacked from behind by [client #5] as they approached the second locked door. She stated [client #5] put her 'in a headlock.' At this time [client #4] grabbed her blue key ring in an attempt to steal her keys. The ring broke leaving the keys	V 315		

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V 315	Continued From page 23 in [staff #3] MHT's hand. [Client #5] noticed the broken key ring and keys still in [staff #3]'s hand, at which time she began to choke her harder while [client #4] reached for the keys. Once the girls obtained the keys, both girls ran down the hallway and exited out to the gazebo courtyard. [Staff #3] ran to the unit door yelling for staff to call a code E." -1 East Interview on October 13, 2021: "[Client #6] at 1405 (2:05pm) - when asked if she knew anything about the incident [client #6] said 'yeah, I was supposed to go too.' [Client #6] said she knew about it for a month but too afraid to tell anyone. When asked what [client #4] and [client #5] were talking about she said 'they were talking about running away to FL (Florida) or NJ (New Jersey). They talked about selling their bodies to make money. They were going to wait until shower time then choke a staff. They talked about hiding in a yard until they could steal a car. They said they were going to call ex-boyfriends to help them. [Client #5] talked about [unknown] or an active duty guy. [Client #4] had an ex-boyfriend she was going to try to call. When asked about her going with them she said he had just took her night meds and had to stay in the lounge so she couldn't go. [Client #6] said she is glad she didn't go.....[Client #2] at 1425 (2:25pm) - when asked if she knew anything about the incident [client #2] said she heard them talking about jumping the fence in the courtyard with the gazebo for the past month but didn't think they would do anything...[Client #1] at 1430 (2:30pm) - when asked if she knew anything about the incident [client #1] said she heard them talking 2 weeks ago about busting out a bedroom window then running to Topsail, Charlotte or Florida." Review on 10/18/21 of a North Carolina Incident Response Improvement System (IRIS) report	V 315		

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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
V 315	Continued From page 24 completed by the facility for client #5 revealed: -Date of Incident: 10/12/21. -Time of incident: 8:30pm. -Incident Comments: "[client #5] and another consumer assaulted a staff member, took her keys, and eloped from the facility using the staff member's keys. Patients were last seen stealing a car from a convenience store 1 block from the facility. A BOLO (be on lookout) has been issued for all of Eastern US. Patients are considered missing at the time of this report." -Cause of Incident: "A Mental Health Technician was attacked from behind by 2 patients while escorting them to a patient bathroom. The patients placed the MHT in a chokehold and took her keys from her and used them to elope from the facility. Upon search of patient belongings, a premeditated plan was found in both patients' journal." -Incident Prevention: "The MHT could have requested a second staff member assist her or only taken 1 patient to the restroom at a time." Observation on 10/15/21 at approximately 2:45pm of the hallway where incident occurred revealed: -Exiting the 1E unit required inserting a key into a wall adjacent to wood double doors. The doors were each approximately 48" in width and had a small pane of glass on each door that was approximately 4-5" width and 36" in height providing approximately 10' of visibility into the corner of the administrative hallway. -Upon entering the administrative hallway there was a metal door that exited to a courtyard to the right and doors to the left. -Approximately 10' from the 1E doors was a second hallway that extended around a corner and to the left. -The second hallway was approximately 80' in	V 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	10/20/2021

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V 315	Continued From page 25 length and was connected to a common area by a second locked door. -The second locked door, connecting the common area to the administrative hallway, was a single wood door approximately 48" in width with a small windowpane for visibility into the common area. -No staff were observed during tour of the administrative hallway with visibility and vocalizations limited by layout of the hall. Interview on 10/18/21 staff #3 stated: -She was working on 1E unit the night of the incident 10/12/21. -She had been working at the facility for approximately 30 days. -She was approached by client #4 and client #5 to use the restroom. -She learned from a lead technician that clients were not allowed to use the restrooms on the 1E unit due to inappropriate conduct in the showers, and were being taken off the unit to the school bathrooms. -Staff ratio was up to 3 clients per 1 staff. -She notified staff #6 and Registered Nurse (RN) #4 of her intent to take clients #4, #5, and #6 off the unit to use the restroom and received approval. -Client #6 was not allowed to go with the group due to a required observation following medication consumption. -She felt "uneasy" taking clients #4 and #5 back by herself but trusted lead staff to let her know if this was not an approved practice. -She escorted client #4 and client #5 off the 1E unit and down the administrative hallway. -As she approached the second door at the end of the administrative hall, she was placed in a chokehold by client #5. -As client #5 maintained the chokehold, client #4	V 315		

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V 315	Continued From page 26 then attempted to take her keys but was unable to gain access to the keys. -Client #5 then applied additional pressure to the chokehold and she asked "If I give you the keys will you let me go?" -Client #4 and client #5 stated they would release her if she gave up the keys which she did. -She ran to the 1E unit door and banged on the door to notify other staff of the elopement. Interview on 10/18/21 RN #4 stated: -She was working on 1E unit the night of the incident 10/12/21. -On 9/23/21 the directive was given for 1E unit to begin using the restrooms off the unit due to the "cheeking" of medications. -At some point between 9/23/21 -9/30/21 the directive changed to using the school bathrooms until 9:00pm. -She originally understood that staff were to escort clients off the unit in groups. -At some point the protocol to escort clients off the units in groups changed to a ratio of 3 clients per 1 staff. -She could not recall where she had learned of the protocols and changes, as they were verbalized to her from other staff working the unit. -She had viewed a memo posted on the back of the 1E door at one point that stated the clients were to be escorted off the unit up until 9:00pm, but the memo did not include details for the process. - Staff #3 approached her on 10/12/21 to notify her of the intent to take clients #4, #5, and #6 off the unit to use the restroom. -She understood that staff #3 had notified other staff working the unit of her intent to take clients #4, #5, and #6 off the unit to use the restroom. -She informed staff #3 that client #6 had just taken medications and could not use the	V 315		

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V 315	Continued From page 27 restroom off the unit due to further observation. -Staff #3 was a newer staff person working with other staff who were not typically working that unit on the evening of 10/12/21. -She had not witnessed 1 staff escort more than 1 client off the unit prior to the evening of the elopement. -She learned of the elopement through an elopement code using the intercom system. -The 1E unit no longer takes the girls off the unit to use the restroom. -A new memo dated 10/14/21 was posted on the back of the 1E door stating that all patients were to use the unit bathrooms effective immediately. Interview on 10/18/21 staff #5 stated: -She was on 1E unit the night of the incident 10/12/21. -She normally worked day shift and was not familiar with the nightly routine for the 1E unit. -Staff ratio was up to 3 clients per 1 staff. -She had accompanied 2 clients by herself that day off the unit and had not seen staff working the administrative hall (10/18/21). -She would not have taken client #4 and client #5 off the unit to use the bathroom that evening by herself, as she felt they could have waited. -She had never taken any of the clients from unit 1E to a restroom off the unit by herself. She had always completed this task in tandem with another staff and it was always in the afternoon when there were more people around. -She was taught to always keep the clients to the side of her so that she could properly observe them. -She witnessed client #5 ask staff #3 if she could use the restroom with client #4 and client #6. Client #6 then had to remain behind, and it was just the two clients. -She does not recall body positioning of clients to	V 315		

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V 315	Continued From page 28 staff when they exited the unit. -She did not realize anything was wrong until staff #3 returned to the unit and began banging on door. -She had observed a memo in the nurses station since the incident detailing how clients could no longer be taken off the unit to use the bathroom. Interview on 10/15/21 RN Supervisor #2 stated: -Due to clients on the 1E unit locking themselves in their rooms and participating in inappropriate conduct during times of showering, they were discouraged from entering their rooms until approximately 9:00pm in the evening. -Staff ratio was up to 3 clients per 1 staff. -With the exception of a client who was on protocol, staff could escort 2 clients by themselves. -The girls had detailed plans for their elopement in their journals. -Neither one of the girls was under elopement protocol at the time of the elopement. Interview on 10/15/21 RN Supervisor #4 stated: -He was the on-call RN supervisor on the evening of 10/12/21. -He heard a Code E called, suggesting a possible elopement, and responded to the appropriate unit. -He was informed that clients #4, #5, and #6 had requested to use the restroom. -Staff #3 notified RN #4 and another MHT of her intent to take the 3 clients off the unit to use the restroom. -Client #6 had recently taken medication and was unable to go off unit with the group and had to remain behind. -Staff #3 then escorted client #4 and client #5 off the 1E unit and down the administrative hallway. -Staff #3 was able to get her key into the lock, to	V 315		

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V 315	Continued From page 29 exit the administrative hallway, when she was placed in a chokehold by client #5. -As client #5 maintained a chokehold, client #4 then attempted to take staff #3's keys but was unable to gain access to the keys. -Client #5 then applied additional pressure to the chokehold and staff #3 asked "If I give you the keys will you let me go?" -Client #4 and client #5 stated they would release staff #3 if she gave up the keys and the keys were then released by staff #3. -He was not certain what the staffing ratio was for the 1E unit at night. -He had previously seen larger groups escorted off the unit but could not recall ever seeing one staff take multiple clients off the unit by themselves. That was "not normally the process we use." -He was not aware of a prior elopement history with client #4 or client #5. -Client #4 had expressed concerns with returning home and was nervous about upcoming discharge. Interview on 10/15/21 Director of Intake and Admissions stated: -She was notified by RN Supervisor on-call at 8:25pm on 10/12/21 of an elopement from the facility involving two adolescent girls. -Staff #3 stated in interview that she was accompanying two clients to a bathroom off the unit, as there had been inappropriate behaviors in the showers on the unit. Due to the recent inappropriate behaviors in the showers, clients on the 1E unit were being escorted to bathrooms off the unit. -Staff #3 escorted two clients off the first unit to a second area. -One of the clients then choked staff #3 while the second client attempted to take staff keys and	V 315		

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V 315	Continued From page 30 run. -Following a failed attempt to gain control of staff #3's keys, a second set of keys was observed in staff #3's hand and the choke was applied with more force. -Staff #3 asked the clients "If I give you the keys will you not hurt me?" -The clients agreed to the request not to hurt staff #3 if she gave them the keys and staff #3 released her grip on a second set of keys. -The two clients then fled from the facility grounds on foot before stealing a car at a local convenience store. -She attempted to locate the keys to the facility but had been unsuccessful in locating the keys. Interview on 10/18/21 Director of Risk Management stated: -A team meeting resulted from the elopement on 10/12/21. -As a result of the team meeting, protocol was changed so that clients on 1E unit were given an opportunity to use the restroom prior to hygiene. -Clients were no longer allowed to be removed from the 1E unit to adjacent units for purposes of using the restroom. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 and must be corrected within 23 days.	V 315		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies	V 366		

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V 366	Continued From page 31 shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team;	V 366		

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V 366	Continued From page 32 (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if	V 366		

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V 366	Continued From page 33 different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies for reporting/response to level I incidents of medications not administered. The findings are: Reviews between 10/6/21 and 10/11/21 of facility incident reports between 7/1/21 - 10/6/21 revealed no level 1 incident reports for medications documented as not administered (NA). Finding #1: Review on 10/6/21 of client #1's record revealed a 15 year old female admitted 4/24/21 with diagnoses that included major depressive disorder, recurrent; anxiety; post traumatic stress disorder (PTSD); attention deficit hyperactive disorder (ADHD); schizo-affective disorder. Reviews between 10/6/21 and 10/11/21 of client #1's Medication Administration Records (MARs) for 7/1/21-9/30/21 revealed the following medications documented NA (not administered):		The Chief Nursing Officer and Director of Risk Management/ Performance Improvement will review the facility policy on Healthcare Peer Review Incident Reporting Process for revisions as necessary relative to reporting medications not administered.	11/19/21

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V 366	Continued From page 34 -Paliperidone ER (extended release) 6 mg (milligrams) on 7/1/21 and 7/2/21 at 9 pm. (Antipsychotic) -Lithium ER 450 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Depakote ER 500 mg on 8/1/21 at 5 pm. (Mood Stabilizer) -Cyclobenzaprine 5 mg on 9/28/21 and 9/29/21 at 7 pm. (Antidepressant) -Flonase 5 mcg (micrograms) nasal spray was documented as "NA" for 66 doses between 7/1/21 and 9/30/21. (Allergy Symptoms) -Lactase 3,000 units was documented as "NA" for 74 doses between 7/1/21 and 9/30/21. (Lactose Intolerance) Finding #2: Review on 10/8/21 of client #2's record revealed a 16 year old female admitted 10/17/20 with diagnoses that included bipolar 1 disorder, and ADHD. Reviews between 10/8/21 and 10/11/21 of client #2's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Aripiprazole 15 mg on 7/18/21 at 9 am. (Mental/mood disorders) -Benztropine 1 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am; and, 8/1/21 at 5 pm. (involuntary movements) -Clozapine 25 mg on 7/14/21 at 9 pm. (Antipsychotic) -Clozapine 150 mg on 7/19/21 at 9 pm. -Clozapine 300 mg on 7/125/21 at 9 pm. -Depakote ER 1250 mg on 7/14/21, 8/20/21, and 8/21/21. -Docusate 100 mg on 7/31/21 and 8/23/21 at 9 am; 8/25/21 and 8/26/21 at 5 pm; 8/1/21, 8/21/21, and 8/22/21 at 9 am and 5 pm. (Constipation) -Ethnyl at 9 am on 7/8/21, 7/27/21, 7/31/21,	V 366		

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V 366	Continued From page 35 8/1/21, 9/4/21-9/6/21, 9/8/21-9/18/21. -Eucerin Cream scheduled applications were documented "NA" for 48 of 62 doses in July 2021, 44 of 62 doses in August 2021, and 57 of 60 doses in September 2021. (Dry skin) -Guanfacine 4 mg on 7/18/21, 7/27/21, 7/31/21 at 9 am. (ADHD) -Hydroxyzine 50 mg on 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; 7/18/21, 7/27, and 7/31/21 at 9 am; and 8/1/21 at 5 pm. (Mental/Mood disorders) -Loratadine 10 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am. (Allergy symptoms) -Oxcarbazepine 300 mg on 7/18/21, 7/27/21, and 7/31/21 at 9 am; 7/12/21, 7/13/21, 7/21/21, and 8/1/21 at 1 pm; and, 8/1/21 at 5 pm. (Mood stabilizer) -Clotrimazole topical 1% cream was documented "NA" for 26 of 28 scheduled applications between 9/1/21 and 9/14/21. (Antifungal) -Metformin 500 mg on 7/27/21, 7/31/21, and 8/1/21 at 9 am; 7/17/21 and 8/1/21 at 5 pm. (Appetite suppressant) Finding #3: Review on 10/8/21 of client #3's record revealed a 15 year old female admitted 1/12/21 with diagnoses of disruptive mood Dysregulation disorder, pre-diabetes, obesity, and bipolar disorder. Reviews between 10/8/21 and 10/11/21 of client #3's MARs for 7/1/21-9/30/21 revealed the following medications documented, "NA." -Eucerin Cream was documented "NA" for 152 scheduled applications between 7/01/21 and 9/30/21. -Duloxetine DR 60 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and	V 366		

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V 366	Continued From page 36 9/25/21 at 9:00am. (Antidepressant) -Duloxetine DR (delayed release) 30 mg, 7/03/21, 7/13/21, 7/17/21,7/21/21, 7/23/21, 7/26/21 at 9:00am. -Metformin 500 mg on 7/03/21, 7/13/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, 8/15/21, 9/16/21, 9/21/21, and 9/25/21 at 9:00am. -Melatonin 6 mg on 7/02/21 T 9:00pm. (Sleep aid) -Thorazine 300 mg, 8/02/21 at 9:00pm. (Antipsychotic) -Thorazine 100 mg on 7/03/21, 7/17/21, 7/21/21, 7/23/21, 7/26/21, 8/01/21, 8/09/21, 8/14/21, and 8/15/21 at 9:00am; 7/05/21 and 8/09/21 at 1:00pm. -Thorazine 50 mg on 7/05/21 and 7/12/21 at 1:00pm; and 7/09/21, 7/13/21, and 9/17/21 at 9:00am. -Cogentin (Benztropine) 1 mg on 7/03/21, 7/13/21, and 7/17/21 at 9:00am. (Tremors) -Cogentin 0.5 mg on 7/21/21, 7/23/21, and 7/26/21 at 9:00am. -Abilify (Aripiprazole) 5 mg on 9/16/21 at 9:00am. (Bipolar disorder) -Abilify 10 mg on 9/21/21 and 9/25/21 at 9:00am. -Topamax 200 mg on 9/15/21 at 9:00pm. (Bipolar disorder) Interview on 10/8/21 the Pharmacist stated NA on the MARs meant the medication was "not administered." Interview on 10/8/21 the Staff Nurse #3 stated: -When a client refused their medications she would try to "educate" them. -She would document the refusal in the electronic MAR and make a nursing note. -She would not complete an incident report or medication error report.	V 366		

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	[redacted]	A. BUILDING: _____ B. WING _____	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYNN MARR HOSPITAL	[redacted]

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V 366	Continued From page 37 Interview on 10/8/21 the Director of Nursing stated: -NA would be used to document medication refusals. -The nurses are not required to complete an incident or medication error report for medication refusals. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified	V 367		

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V 367	Continued From page 38	V 367		

or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the

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V 367	Continued From page 39 definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report Level II incidents as required to the LME (Local Management Entity) within 72 hours. The findings are: Review on 10/18/21 of facility incident reports from 7/1/21 through 10/18/21 revealed: -9/11/21 client #4 was placed in a 2 person restraint and seclusion for aggression/assault of a peer. -9/18/21 client #4 grabbed client #5 by the hair and kicked client #5 in the cheek and eye. -9/18/21 client #5 was sent to the local emergency room for an eye injury caused by client #4's kicks to her right cheek and eye, diagnosed with a corneal abrasion and prescribed eye drops.		The Director Risk Management/ Performance Improvement will ensure any Level II incidents are reported to IRIS and DRNC within 72 hours of occurrence. All reports and verifications are filed by date and maintained by the Director of Risk Management/ Performance Improvement. The Director of Risk Management/ Performance Improvement has been provided with the IRIS reporting manual and has reviewed said manual for training on reporting criteria and requirements. 100% of all incident reports are discussed and reviewed daily by leadership in Flash meetings.	10/21/21 10/22/21 10/21/21

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V 367	Continued From page 40 -10/7/21 client #6 walked up behind a peer and grabbed her buttocks. A report was filed with the local police department. -10/7/21 client #4 had her buttock grabbed by a peer. A report was filed with the local police department. Reviews between 10/6/21 and 10/20/21 of the facility's North Carolina Incident Response Improvement System (IRIS) reports from 7/1/21 through 10/18/21 revealed no level 2 incidents had been reported for the 5 incidents listed above dated 9/11/21, 9/18/21, and 10/7/21. Interview on 10/18/21 the Director of Risk Manager stated: -The listing and descriptions given to the surveyors was the incident reports for the facility. -The internal system of leveling incident reports had not identified the 5 incidents listed above on 9/18/21 and 10/7/21 to be level 2 incidents. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights	V 525		

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V 525	Continued From page 41 Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to include all required information in the restrictive intervention log. The findings are: Review on 10/11/21 of the facility restrictive intervention logs from June 2021 - September 2021 revealed: -13 restrictive intervention episodes were documented to include 4 seclusions, 6 physical restraints, and 1 chemical restraint. -The log did not include the following required documentation: -reason for use of the intervention.	V 525	Chief Nursing Officer and Director of Risk Management/Performance Improvement have revised the Restrictive Intervention log to include all required components per State regulation. The updated log was implemented for use by staff on 11/1/21.	11/1/21

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V 525	Continued From page 42 -positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used. -debriefing and planning conducted with the client, legally responsible person, and staff. -The log included names of "Initiating Staff," but did not document the "responsible professional." -The log included "injury" but did not document negative effects on the psychological well-being of the client. Interview on 10/11/21 the Director of Risk Management stated: -Restrictive intervention data was reviewed and analyzed quarterly. -The information not included on the log would be available on the restrictive intervention forms completed by staff.	V 526		
V 722	27G .0302 (a) DHSR Construction Approval 10A NCAC 27G .0302 FACILITY CONSTRUCTION/ALTERATIONS/ ADDITIONS (a) When construction, use, alterations or additions are planned for a new or existing facility, work shall not begin until after consultation with the DHSR Construction Section and with the local building and fire officials having jurisdiction. Governing bodies are encouraged to consult with DHSR prior to purchasing property intended for use as a facility. This Rule is not met as evidenced by: Based on interview and observation, the facility failed to consult with the DHSR Construction Section prior to making facility alterations. The findings are: Observations during facility tour between 2 pm	V 722	The Director of Plant Operations will consult with the DHSR Construction Section prior to making any future facility construction, use, alterations, or additions. Work will not commence until after consultation with and approval by DHSR Construction Section, with Onslow County building and fire officials having jurisdiction.	10/21/21

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V 722	Continued From page 43 and 3 pm on 10/6/21 revealed: -A total of 6 client bedrooms. -A window approximately 24 inches wide and 6 inches tall had been installed in each bedroom entry door. Interviews on 10/7/21 and 10/11/21 the Director Operations Manager stated: -The clients on the unit had to be quarantined around August 2021 due to positive COVID (Coronavirus) cases. -Equipment was mounted in the ceilings to provide negative pressure in the client rooms. -The only way to maintain negative pressure was to keep the doors closed. -The windows were installed in the doors so the clients could be monitored during this time the doors had to remain closed. -No one had consulted with the DHSR Construction Section about installation of the windows.	V 722		

Appendix 65.

UHS-FINHELP-00008995 [Redacted]

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on February 28, 2023. The complaints were substantiated (intakes #NC00196823, #NC00197887 and #NC00197960). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 18 and currently has a census of 12. The survey sample consisted of audits of 3 current clients and 2 former clients. This survey was originally closed on 2/23/23 but was re-opened on 2/28/23 due to additional information provided.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including:	V 110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE [redacted] Director of Risk Management and Performance Improvement (X6) DATE 3-31-23

STATE FORM [redacted] If continuation sheet 1 of 25

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V 110	Continued From page 1 (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews 1 of 4 Mental Health Technicians (MHT #4) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 2/20/23 of MHT #4's personnel record revealed: - Hire date 9/26/22. - Training included: 9/29/22 Diagnosis Training; Milieu Management: and Preventing Hands-On Interventions; 9/26/22: Therapeutic Boundaries; 1/19/23 Get SMART (Safety, Mentoring, Advocacy, Recovery and Treatment) Training. During interview on 2/20/23 MHT #4 stated: - If direct care staff saw clients "crossing sexual boundaries" protocol was to "notify a nurse." - She had worked 1:1 with client #1, but had "never been in the situation when anyone was sexually aggressive toward" client #1 or when	V 110	The Chief Nursing Officer and Risk Manager reviewed and affirmed the following policy contained correct instruction to staff: "Psychiatric Emergency Code AIMZ PC-1-008 – revised to provide additional guidance regarding assessment and identification of imminent risk to self/others, role of leader during crisis situation, decision making and proactively responding to crisis. The Chief Nursing Officer, Human Resources Director and Clinical Training Coordinator reviewed and revised Crisis Intervention training to include an additional eight (8) hours for a total of sixteen (16) hours of training at the time of new hire orientation to allow for content learning, application opportunities, and skills practice. CPI recertification training (the crisis intervention training) is provided every 6 months for direct care staff. A four (4) hour abbreviated version of this training was provided to current direct care staff (RNs, LPNs, MHTs) by the certified trainers. Any staff member not completing this training by 3/10/23 is not allowed to work until training has been completed.	3/2/23 3/6/23 3/10/23

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V 110	Continued From page 2 client #1 was sexually aggressive toward a peer. - She had "been there when they tried; they played to get a reaction." - She once put her "clip board between their faces" when 2 clients were trying to kiss. - She was not trained to put her clip board between clients' faces. During interview on 2/23/23 the Director of Risk Management and Performance Improvement stated no staff were trained to put clip boards between the faces of clients.	V 110	The Chief Nursing Officer implemented monthly unannounced Mock Code Drills to simulate crisis situations and to allow staff continued opportunities to practice crisis management skills developed during new hire and annual Milieu Management/Crisis Intervention training including but not limited to identification of escalating behaviors/imminent risk, proactive responses to crisis, decision making and use of non-restrictive and restrictive interventions. The Chief Nursing Officer and Risk Manager are using the Mock Code Drills to assess staff performance, coach staff, and identify additional training needs such as revisions to training materials, assigning additional training for individual staff members, or increasing the frequency of mock drills to practice skills obtained in Milieu Management/Crisis Intervention training . Aggregated data on mock drills, including recommendations for training or other actions is submitted monthly to the Quality Council, MEC, and Governing Body.	3/8/23 Ongoing
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record	V 133		

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V 133	Continued From page 3 check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider.	V 133		

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V 133	Continued From page 4 All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith,	V 133		

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V 133	Continued From page 5 complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public	V 133		

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V 133	Continued From page 6 Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)	V 133		

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V 133	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to request a national criminal background check with fingerprints for 3 of 4 Mental Health Technicians (MHT) (#1, #2, and #3) who had been a resident of North Carolina for less than 5 years at the time of employment. The findings are: Review on 2/17/23 of MHT #1's personnel record revealed: - Hire date 11/14/22. - Online resume and application for employment included employment in another state 11/2021 - 4/2022. - Online criminal background check 10/24/22. - No documented evidence of a national criminal background check with fingerprints. During interview on 2/20/23 MHT #1 stated: - She had worked at the facility for about 3 months and had lived in state for about 5 months. - She did not submit fingerprints for a national criminal background check prior to her employment. Review on 2/20/23 of MHT #2's personnel record revealed: - Hire date 11/14/22. - Copy of driver's license from another state. - Online criminal background check 10/20/22 included address in another state. - No documented evidence of a national criminal background check with fingerprints. Review on 2/15/23 of MHT #3's personnel record revealed: - Hire date 9/13/21.	V 133	The Human Resources Director/designee audited 100% of direct care staff personnel records and compiled a list of current staff that do not require fingerprinting and are approved to work on the PRTF unit and a list of current staff that meet the criteria for fingerprinting and will need it completed. The list of approved staff will be maintained on a daily basis by the Human Resources Director/designee. The Human Resources Director reviewed and revised the New Hire Checklist to include the requirement for fingerprinting any non-licensed direct care employee that has been a resident of North Carolina for less than 5 years at the time of employment. Effective with 4/3/23 New Hire Orientation, all non-licensed direct care employees who have been a resident of North Carolina for less than 5 years at the time of employment will have consent signed for a national criminal background check to be completed that includes fingerprinting at the time of employment. Staff are not permitted to train on PRTF or be assigned to PRTF until fingerprinting has been completed. Once fingerprinting is completed, those staff will be added to the list authorized to work on PRTF by the Human Resources Director/ designee. The Staffing Coordinator and/or House Supervisors maintain the daily schedule and will audit and monitor on a daily basis to ensure unauthorized staff are not assigned to work on the PRTF unit. Aggregated data on compliance will be reported monthly in Quality Council, Medical Executive Committee, and to the Governing Body.	3/27/23 3/27/23 4/3/23 4/28/23 Ongoing

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V 133	Continued From page 8 - Resume included documentation of employment in another state 3/2018 - 6/2021. - No documented evidence of a national criminal background check with fingerprints. During interview on 2/15/23 MHT #3 stated she did not submit fingerprints for a national criminal background check prior to employment. During interview on 2/23/23 the Director of Risk Management and Performance Improvement stated the Personnel Director was not aware of the requirement for fingerprints to be used for national criminal background checks for applicants who had lived in state for less than 5 years.	V 133		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive	V 314		

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V 314	Continued From page 9 community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide required supervision and specialized interventions to ensure the safety of clients on a 24-hour basis affecting 3 of 3 audited clients (#1, #2, #3).and 2 of 2 audited former clients (#4, #5). The findings are: Cross Reference 10A NCAC 27G .1902 Staff (Tag V315). Based on record reviews and interviews the facility failed to ensure at least 2	V 314		

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V 314	Continued From page 10 direct care staff were present with every 6 children or adolescents at all times. Review on 2/14/23 of client #1's record revealed: - 17 year old female admitted 3/24/22. - Diagnoses included Disruptive Mood Dysregulation Disorder (DMDD), Attention Deficit Hyperactivity Disorder (ADHD), combined type, and Post-Traumatic Stress Disorder (PTSD). - Documented history of suicidal thoughts, self-harm (cutting), physical aggression; medication non-compliance; sexualized behaviors including sexual aggression and poor judgment. - Client #1 was placed on continuous 1:1 supervision on 12/08/22 for her safety due to her self-injurious behaviors. Review on 2/14/23 of client #2's record revealed: - 16 year old female admitted 4/24/21. - Diagnoses included Schizoaffective Disorder, bipolar type; Major Depressive Disorder; and PTSD, chronic. - Documented history of self-harm, suicide attempts, paranoia, and command hallucinations. Review on 2/14/23 of client #3's record revealed: - 17 year old female admitted 3/25/22. - Diagnoses included Bipolar Disorder, unspecified type; PTSD; and ADHD, combined type. - Documented history of elopements; risk taking behaviors; suicidal ideation; and sexual trauma. Review on 2/14/23 of former client (FC) #4's record revealed: - 15 year old female admitted 1/24/22 and discharged 2/01/23. - Diagnoses included DMDD; Generalized Anxiety Disorder; PTSD; Impulse Control Disorder; and ADHD.	V 314	Memorandum is clearly posted by the staff time clock and in the PRTF nurse's station advising all staff of the requirement for 2 staff to 6 patient ratio at all times that does not include the nurse in the ratio. The Chief Nursing Officer and Director of Risk Management provided reeducation to direct care staff on the requirement that the nurse does not count towards the 2 staff to 6 patient ratio. Training was verified by written and attestation and provided in small groups or individually shift to shift. The Human Resources Director and Director of Risk Management verified the policy attestation is contained in new hire orientation materials so that all direct care staff are educated on the 2 staff to 6 patients ratio on PRTF and agree to maintain the required ratio at all times. The Staffing Coordinator and/or the House Supervisors maintain and monitor the daily schedule and verify the PRTF unit has a minimum of 2 staff to every 6 patients at all times, including verification that the staff to patient ratio does not include the unit nurse. Staffing is reviewed and verified by the Chief Nursing Officer during daily operations meetings. Nursing leaders conduct rounds on their assigned shifts and senior leaders conduct rounds during their assigned Administrator on Call day either in person or via camera to ensure PRTF remains in ratio of 2 staff to every 6 patients at all times. Noncompliance will be reported immediately to the CEO, CNO and/or Risk Manager and corrective action to maintain ratio will take place immediately.	2/23/23 Ongoing 3/1/23 Ongoing Ongoing

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V 314	Continued From page 11 - Documented history of suicidal and homicidal ideations; physical aggression; self-injurious behaviors; and impulsivity. - "Patient Observation Records" 1/02/23 - 1/31/23 included documentation that FC #4 had visual checks every 15 minutes, but was not 1:1 supervision.. Review on 2/14/23 of FC #5's record revealed: - 17 year old female admitted 7/01/22 and discharged 2/11/23. - Diagnoses included Bipolar Disorder, unspecified; ADHD, unspecified; and Oppositional Defiant Disorder. - Documented history of suicide attempt; depressive symptoms; disruptive behaviors; elopement; and manipulation. Review on 2/14/23 of incident reports submitted to the North Carolina Incident Response Improvement System 1/1/23 - 2/14/23 for clients #1, and #2, and FC #4 revealed: - 1/27/23 clients #1, #2, and FC #4 "attacked a staff member" (Mental Health Technician #1) (MHT #1) in an attempt to "take her keys in order to elope;" the staff member was "hit in the head, arms, and upper body." - Client #1 "was on 1:1 observation level prior to the incident and remains on 1:1 observation level . . . " - Client #2 was placed on "unit restriction." - FC #4 was placed on "unit restriction due to elopement concern. DJJ (Department of Juvenile Justice) and DSS (Department of Social Services) involvement . . . as she continues to verbalize intent to harm staff and elope . . . " - 1/28/23 clients #1, #2 became physically and verbally aggressive toward staff after being redirected from tampering with "fire sprinklers and exit signs;" client #1 stated she wanted "to	V 314		

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V 314	Continued From page 12 catch charges." - 1/07/23 FC #4 became physically aggressive toward FC#5; FC #4 stated she intended to continue such behaviors in an effort to "be discharged from PRTF to Juvenile Detention." - 1/03/23 FC #4 became physically aggressive toward House Supervisor #1; "hitting, kicking, punching, and spitting food and saliva on staff and pulled staff hair." Review on 2/22/23 of the facility "One-to-One Audit" for January 2023 revealed client #2 and FC #4 did not receive 1:1 supervision. During interview on 2/15/23 client #1 stated: - She was placed on 1:1 supervision in December 2022 because she doesn't "have good boundaries" and she tries to hurt herself; "I tried to choke myself a couple of weeks ago. My 1:1 was watching, but didn't see. I stopped myself." - She and client #2 and FC #4 "attacked" MHT #1. - MHT #1 was her 1:1 staff at the time of the incident. - She and her peers wanted to get MHT #1's facility keys to elope. - "I didn't hit her, I went through her pockets, that was about it. I didn't hit her." - At the time of the incident other staff "came running down the hallway" but she could not recall how many staff responded. - MHT #1 pressed charges against her. - She had a sexual encounter with a peer "in December, but that doesn't go on anymore." During interview on 2/15/23 client #2 stated: - She and client #1 and FC #4 attacked MHT #1 because they "wanted to run." - The attack "was [FC #4's] idea"; client #1 poured water on MHT #1 and FC #4 was "going	V 314		

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V 314	Continued From page 13 through her pockets to get her keys. They called a code and staff were holding me back. I started hitting [MHT #1] because she was in front of me . . . I never wanted to hurt her." - She wanted to apologize but she heard MHT #1 "was in the hospital with a concussion." - "We all put our hands on her." - "Staff came up behind me and touched me . . . I just started beating on her . . . " - "I think she (MHT #1) knew it was about to happen because she didn't have her keys on her." - "There was no one in the hall except for us." - She had not seen any sexual behaviors between clients. - "I think the ones that started that have been discharged and it's been pretty good now . .. " - She thought the required staff to client ratio was 2 staff per 6 clients. - There were usually "2 nurses and 4 or 5 MHTs" on the unit, but "it depends on how many are on 1:1." During interview on 2/20/23 client #3 stated: - She was not involved in the incident in which MHT #1 was attacked; she separated herself from her peers when she learned of their plan to attack staff to get keys. - She was involved in an incident in which she and clients #1, #2, and FC #4 were kissing. - "They were trying to pull us apart and were verbally telling us we needed to stop." - She was kissing client #1; client #1's 1:1 staff was trying to separate and verbally redirect them. - She could not remember any other incidents of sexual aggression during the month of January 2023. - Her sexual encounters with peers were consensual. - None of her peers had been sexually aggressive	V 314		

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V 314	Continued From page 14 toward her. - She was currently 1:1 for self-harm; she scratched herself with her fingernails. - There were supposed to be 5 staff on the unit with 12 clients. During interview on 2/15/23 FC #4 stated: - She did not recall hitting FC #5 or pulling her hair, but she "probably threw a shoe at her or something." - "It was [client #1's] idea to attack [MHT #1]." - She wanted to "wait until we were off unit restriction to go outside and jump the fence." - "I told [client #1] to grab her [MHT #1's] arms and I would go for the keys, but she didn't have any keys on her. [Client #1] poured water on her and pinned her against the wall and [client #2] started hitting her and I went for her pockets to get keys . . . " - There were no staff in the hallway at the time of the incident; staff were with clients in the "lounge." - She was not 1:1 at the time of the incident. - "They don't put me on 1:1 because I hit my 1:1 because I feel like it's a violation of my privacy." - Staff were unaware of sexual behaviors because "they barely watch us." - Clients engaged in sexual behaviors "in the quiet room; they do it in the lounge; in bedrooms at night; nobody be paying attention." During interview on 2/20/23 MHT #1 stated: - She was working 1:1 with client #1 on 1/27/23. - Client #2 and FC #4 approached client #1 and they had been "whispering to each other all morning;" she attempted to redirect them but they did not respond. - "All 3 of them jumped on me." - The incident occurred in the main hallway near the unit entrance.	V 314		

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V 314	Continued From page 15 - During the incident she hit her head on the wall and suffered a concussion. - There were 4 other MHTs working that day; she was the only staff working 1:1. - The staff assigned as "hall monitor" was present in the hall at the time of the incident, but the other staff were in the lounge with the other clients. - If other clients approached a 1:1 client, the only thing the 1:1 staff could do was provide verbal redirection. - "At this point they honestly don't even care what we say. They pretty much do what they want to do." - "We don't know what to do anymore." During interview on 2/21/23 House Supervisor #1 stated: - She was involved in 2 incidents with FC #4, but she could not recall the dates. - The facility had a staff client ratio of 1:3. - Direct care staff were expected to keep the clients physically separated. - "Our job is to keep every patient safe." - Staff putting hands on clients was the "last resort." - "A lot of our staff don't want to put hands on; the patients say it's their right to call Disability Rights if we put hands on." - "People are afraid to put hands on the patients." During interview on 2/20/23 the Therapist stated: - "I feel like we never have enough staff on the unit; we either have just enough to be in ratio, but not enough to escort patients around the building." - "We have just enough (direct care staff) to be in ratio, but not enough that we can do our jobs. If I need an escort (for a client) I have to page overhead to request assistance and usually wait 30 - 45 minutes, which cuts into sessions"	V 314		

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V 314	Continued From page 16 - The Therapists' offices were not close to the residential unit or the school facility. - The Therapists were recently directed to conduct therapy sessions "in the gym, the rec (recreation) room, or a classroom" for safety, but the change "helps with the ratio and staff escorts." During interview on 2/20/23 the Director of Risk Management and Performance Improvement stated: - Each client had a Person Centered Plan and a multi-disciplinary treatment plan that addressed the clients' individual needs. - FC #4 was involuntarily committed and admitted to the Licensee's Acute Care unit on 2/01/23. - Additional staff were added to coverage 2/23/23 to meet the required staff client ratio. - The "Physical Aggression" and "Sexual Acting Out Allegations" reports were the facility's level 1 incident reports. Review on 2/28/23 of the Plan of Protection dated 2/28/23 and signed by the Director of Risk Management and Performance Improvement and the Chief Executive Officer (CEO) revealed: - "What immediate action will the facilty take to ensure the safety of the consumers in your care? Immediately upon notification on February 23, 2023, additional staff members were added to the residential unit to maintain ratio of 2:6, not including the nurse. An updated Assignment sheet was provided prior to the survey exit. Memos about the ratio not including the nurse have been posted in the nursing station and at all time clocks. - Describe your plans to make sure the above happens. Training of staff on PRTF ratio requirements began on February 23, 2023, confirmed with written attestations. The Staffing	V 314		

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	[redacted]	A. BUILDING: _____ B. WING _____	02/28/2023

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BRYNN MARR HOSPITAL	[redacted]

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V 314	Continued From page 17 Coordinator responsible for the daily schedule ensures the ratio is maintained per the unit census and observation level on a daily basis with the assistance of the House Supervisor on weekends and evenings. Staffing is verified by House Supervisors or Nurse Managers who round the unit. Staffing is reviewed during daily operations meetings by the CEO, CNO (Chief Nursing Officer) and Risk Manager." Clients #1,#2, #3, and Former Client #4 had diagnoses that included Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Impulse Control Disorder, Bi-Polar Disorder, and Schizoaffective Disorder. The clients had documented histories of physical aggression, self-injurious behaviors, elopements, suicide attempts and sexualized behaviors and sexual trauma. Clients #1, #2, and FC #4 were involved in multiple incidents of physical aggression in the facility. During one of the incidents MHT #1 was assaulted by clients #1, #2, and former client #4 and sustained a concussion and was hospitalized. Clients #1, #2, and FC #4 had legal charges filed against them as a result of the incident; FC #4 also had legal charges filed against her for a previous incident during which she hit, threatened and pulled FC #5's hair. From 1/01/23 - 2/14/23 the required direct care staff to client ratio of 2:6 was not met for 80 of 90 possible shifts. During the month of January 2023, the facility reported 8 incidents of sexual acting out, with clients #1, #2, #3 and FC #4 being involved in 7 of the incidents. The facility failed to ensure adequate staffing at all times to ensure the safety of the clients and staff and to implement preventive measures and specialized interventions to meet client needs. This deficiency constitutes a Type A1 rule	V 314		

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V 314	Continued From page 18 violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $3000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure at least 2 direct care staff were present with every 6 children or adolescents at all times. The findings are:	V 315	See responses in V 314	

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V 315	Continued From page 19 Reviews on 2/15/23, 2/17/23, and 2/23/23 of the facility's "Daily Assignment Sheets" 1/01/23 - 2/14/23 revealed: - Facility census as follows: 16 clients 1/01/23 - 1/21/23 day shift 15 clients 1/21/23 evening shift 16 clients 1/22/23 - 2/01/23 day shift 15 clients 2/01/23 evening shift - 2/03/23 day shift 14 clients 2/03/23 evening shift 15 clients 2/04/23 day shift - 2/10/23 day shift 14 clients 2/10/23 evening shift - 2/11/23 day shift 13 clients 2/11/23 evening shift - 2/13/23 day shift 12 clients 2/13/23 evening shift - 2/14/23 evening shift. - 1/01/23 - 1/31/23: 59 of 62 shifts had less than 2 direct care staff for every 6 children or adolescents at all times. - 2/01/23 - 2/14/23: 21 of 28 shifts had less than 2 direct care staff for every 6 children or adolescents at all times. Reviews on 2/15/23, 2/17/23, and 2/23/23 of the facility's "Daily Assignment Sheets" 1/01/23 - 1/21/23 revealed: - 1/03/23 evening shift (7:00 pm - 7:00 am) 16 clients on the unit: 1 direct care staff assigned 1:1; 4 direct care staff assigned to work 7:00 pm - 7:00 am; 2 direct care staff worked a split shift, 7:00 pm - 11:00 pm and 11:00 pm - 3:00 am; 1 Registered Nurse. - 1/05/23 day shift (7:00 am - 7:00 pm) 16 clients on the unit: 1 direct care staff assigned 1:1; 4 direct care staff assigned to work 7:00 am - 7:00 pm; one direct care staff assigned to work 8:00 am - 3:00 pm; 1 direct care staff assigned to work with a discharged client while awake).	V 315		

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V 315	Continued From page 20 - 1/07/23 day shift 16 clients on the unit: 1 direct care staff assigned 1:1; 3 direct care staff (2 Mental Health Technicians and 1 Licensed Practical Nurse/Licensed Vocational Nurse) assigned to work 7:00 am - 7:00 pm; 2 staff split the shift 7:00 am - 1:00 pm and 1:00 pm - 7:00 pm; 1 Registered Nurse. - 1/10/23 day shift 16 clients on the unit: 2 direct care staff assigned to work 1:1; 2 direct care staff assigned to work 7:00 am - 7:00 pm; 2 direct care staff split the shift 7:00 am - 3:00 pm and 3:00 pm - 7:00 pm; 2 direct care staff split the shift 7:00 am - 9:00 am and 9:00 am - 7:00 pm; 1 Registered Nurse. - 1/25/23 day shift, 16 clients on unit; 3 direct care staff assigned to work 1:1 7:00 am - 7:00 pm; 4 direct care staff assigned to work 7:00 am - 7:00 pm; 1 Registered Nurse. - 1/26/23 5:17 pm day shift, 16 clients on the unit; 3 direct care staff assigned to work 1:1 7:00 am - 7:00 pm; 3 direct care staff assigned to work 7:00 am - 7:00 pm and 1 direct care staff assigned to work 10:00 am - 2:00 pm; 1 Registered Nurse. - 1/27/23 day shift, 16 clients on unit: 4 direct care staff assigned to work 1:1 7:00 am - 7:00 pm; 1 direct care staff assigned to work 1:1 7:00 am - 11:45 am; 2 direct care staff assigned to work 7:00 am - 7:00 pm; 3 direct care staff split a shift from 11:45 am - 7:00 pm; 1 Registered Nurse. Review on 2/14/23 of level II incident reports completed by the facility 1/01/23 - 1/31/23 revealed: - 1/03/23 7:25 pm Former Client #4 (FC #4) hit, kicked, punched, spat on, and pulled House Supervisor (HS) #1's hair. - 1/07/23 8:24 am FC #4 hit, kicked, and pulled FC#5's hair and hit and kicked staff. - 1/27/23 11:00 am client #1, client #2 and FC #4 attacked Mental Health Technician #1 (MHT #1)	V 315		

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V 315	Continued From page 21 in an attempt to get her keys to elope. Review on 2/20/23 of a facility "Sexual Acting Out Allegations" report for January 2023 revealed: - 1/05/23 FC #4 opened the curtain when client #3 was using the restroom. - 1/10/23 FC #4 was encouraging client #1 to "engage in sexual intercourse" with a peer; client #1 was with 1:1 staff. - 1/25/23 clients #1, #2, #3 and FC #4 became "argumentative and verbally aggressive toward staff" and were "holding hands ran up and down the hall ;" client #1 "had peer (client #3) sit on her lap . . . ;" client #1 was "1:1 observation level;" client #2 was placed on "Unit Restriction and sharps restriction . . . had sexual aggression precautions added . . .;" client #3 was on ". . . sexual aggression and victim of sexual aggression precautions and was on a 1:1 observation level at the time of the incident and remains post incident . . . also placed on Unit Restriction . . . ;" FC #4 was "on assault and sexual aggression precautions. Place on Unit Restriction and sharps precaution . . . for safety." - 1/26/23 client #1 kissed client #3 "in front of 1:1 staff" and then exposed her breast to client #3; client #1 was "on sexual aggression precautions and remains on 1:1 patient observation level . . . ;" client #3 was on "sexual aggression and victim of sexual aggression precautions. Patient is on Unit Restriction. . . " - 1/27/23 clients #1, #2, #3 and FC #4 went into FC #4's bedroom and began to kiss; client #1 was on "sexual aggression precautions and remains on 1:1 observation level . . . " Review on 2/20/23 of a facility "Physical Aggression" report for January 2023 revealed: - 1/27/23 ". . . [local police department] plans to forward petition for assault to DJJ (Department of	V 315		

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V 315	Continued From page 22 Juvenile Justice) for incident" for clients #1, #2, and FC #4. - 1/28/23 FC #4 was involved in the incident in which clients #1 and #2 were physically and verbally aggressive toward staff and tampered with the fire sprinklers and exit signs. - 1/07/23 11:45 am FC #4 forced her way "partly into the nurses station ripping down papers on the back of the door . . . attempting to push past staff to enter . . . " - 1/03/23 7:25 pm FC #4 ". .. out of control . . . attempting elopement multiple times throughout the day . . . rushing staff as they tried to enter or exit the unit, packed peer's clothing in a blanket and carried it around the unit, threatened to jump other peers if they did not do what she said, stuck safety paperclip in the lock so staff could not use that exit, took staff radio and called multiple codes across the hospital . . . " During interview on 2/20/23 MHT #2 stated: - The facility's staffing pattern was 3 clients to 1 staff. - There were "lots of staffing issues." - Nurses were counted in the ratio "but most of them stay in the nurses' station" unless needed to provide coverage for an MHT to take a break. - She did not think there were enough MHT's in the facility. During interview on 2/21/23 HS #1 stated: - The unit's staff to client ratio was 1:3. - If a code was called due to client behavior staff responded from other areas of the hospital. During interview on 2/21/23 HS #2 stated: - The number of MHT's on the unit depended on the number of clients present. - The unit's census was presently 12 clients; there were 4 staff with 3 clients to each staff.	V 315		

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V 315	Continued From page 23 - Staff assigned to provide 1:1 supervision were not included in the ratio. - The ratio included nurses, but the nurses were usually in the nurses' station doing paperwork. - The nurses provided coverage for the MHTs to take breaks. During interview on 2/20/23 the Therapist stated: - "I feel like we never have enough staff on the unit; we either have just enough to be in ratio, but not enough to escort patients around the building." - "We have just enough (direct care staff) to be in ratio, but not enough that we can do our jobs. If I need an escort (for a client) I have to page overhead to request assistance and usually wait 30 - 45 minutes, which cuts into sessions" - The Therapists' offices were not close to the residential unit or the school facility. - The Therapists were recently directed to conduct therapy sessions "in the gym, the rec (recreation) room, or a classroom" for safety, but the change "helps with the ratio and staff escorts." During interview on 2/23/23 the Director of Risk Management and Performance Improvement stated: - Information regarding the requirement for 2:6 ratio was posted in the nurses' station. - Multiple memoranda explaining the 2 staff to 6 client ratio were circulated to staff; the 2:6 ratio requirement was included in orientation and staff signed an attestation acknowledging the ratio requirement was 2:6 and not 1:3. - "That's what got us in trouble last year." - "I guess we were counting the nurses in the ratio." - Licensed Practical Nurses/Licensed Vocational Nurses sometimes worked in the role of MHT and	V 315		

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V 315	Continued From page 24 were counted in the ratio. - A "hall monitor" was added to coverage prior to the incident on 1/27/23. - Additional staff were added to the unit coverage on 2/23/23 in order to meet staffing requirements. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.	V 315		

UHS-FINHELP-00009021 [Redacted]

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V 000	INITIAL COMMENTS A complaint survey was completed on May 26, 2023. One complaint was substantiated (intake #NC00201654) and one complaint was unsubstantiated (intake #NC00201680). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 18 and currently has a census of 12. The survey sample consisted of audits of 2 current clients. This survey originally closed on May 23, 2023 but was reopened on May 26, 2023 due to additional information being provided.	V 000		
V 317	27G .1904 Psych. Res. Tx. Fac. - Transfer or Discharge 10A NCAC 27G .1904 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The PRTF shall meet with existing child and family teams and other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and	V 317		

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V 317	Continued From page 1 other representatives involved in the care and treatment of the child or adolescent including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to hold a service planning meeting with the existing child and family team within 5 days of an emergency transfer or discharge affecting 1 former client (FC #2). The findings are: Review on 5/23/23 of FC#2's record revealed: - 15 year old female. - Admitted 1/24/22, discharged 2/01/23. - Diagnoses included Disruptive Mood Dysregulation Disorder, Generalized Anxiety Disorder; Post Traumatic Stress Disorder, unspecified; and Attention Deficit Hyperactivity Disorder.	V 317		

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V 317	Continued From page 2 - "Clinical Progress Note" dated 1/30/23 included ". . . PRTF Therapist was contacted by [the Psychiatrist] . . . stating the patient is being recommended to transition to a higher level of care within the facility and will be transitioning to the . . . Acute Unit due to increase in aggressive behaviors, resistance to de-escalation which resulted in multiple restraints, seclusions and chemical restraints . . . [the Psychiatrist] stated he would meet with the patient on 2/1/23 . . . Discharge date is currently unknown. Discharge will continue to be assessed and discussed in Treatment Team." - "Clinical Progress Note" dated 1/31/23 included ". . . Definitive discharge date is currently not set. discharge will continue to be assessed and discussed in weekly Treatment Team meetings. Definitive Discharge will be determined based upon the patient's progress and Treatment Team's recommendations." - "Clinical Progress Note" dated 2/01/23 included ". . . PRTF Therapist was informed by (the Psychiatrist) and Nursing Manager . . . that the patient [FC#2] would be IVC'd (involuntarily committed) and admitted to Brynn Marr Hospital Acute Unit. [FC #2] is being discharged from Brynn Marr Hospital PRTF for increased aggression, increase in restraint and seclusions due to her escalation and refusal to de-escalate . . . PRTF Therapist met with the [FC #2] to complete her discharge paperwork. PRTF Therapist was informed that [FC #2] will be admitted to the Acute Unit. [FC#2] will be provided with medication management and clinical care/case management in the acute setting . . . PRTF Therapist contacted the patient's social worker via email on 1/30/23 to inform her of the patient being discharged to a higher level of care. PRTF Therapist will contact the patient's social worker via email when the	V 317		

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V 317	Continued From page 3 patient is transitioned to the acute unit . . . Patient discharging due to being IVC'd . . . Patient being discharged into a higher level of care . . . Patient has been IVC'd by MD (Medical Doctor) . . . " - "Discharge Safety Plan" dated 2/01/23 included ". . . Date and Time of Initiation: 2/1/23 1323 (1:25 pm) . . . Were family, friends, or caregivers of the patient invited to participate?' with box "no" checked; ". . . If no - why not Patient discharged due to IVC . . . " - "Aftercare/Discharge Plan" dated 2/01/23 included ". . . Family Involvement Was family meeting held?" with box "no" checked ". . . If no, why not: Patient being IVC'd legal Participants: Guardian notified (DSS (Department of Social Services) . . .). - No documentation of a child and family team (CFT) meeting within 5 days of discharge from the PRTF unit. During interview on 5/23/23 FC#2's DSS Guardian Representative stated: - While on the PRTF FC#2 had 8 assault charges as a result of her physically aggressive behaviors at the facility. - A decision to discharge FC#2 from the PRTF and involuntarily commit her to the Licensee's acute care unit was made with no input from the guardian. - No CFT meeting for discharge planning was held within 5 days of FC#2's discharge from the PRTF unit. During interview on 5/23/23 the Director of Risk Management and Performance Improvement stated: - Discharge planning was discussed in CFT meetings prior to FC#2's involuntary commitment to the Licensee's acute unit. - FC#2 was discharged from the facility into the	V 317		

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	[redacted]	A. BUILDING: _____ B. WING _____	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYNN MARR HOSPITAL	[redacted]

(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
V 317	Continued From page 4 acute unit of the Licensee's hospital facility. - A meeting would have been held on the acute unit after FC#2 was admitted on the involuntary commitment.	V 317		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:	V 367		

PRINTED: 05/26/2023
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRYNN MARR HOSPITAL	[redacted]

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V 367	Continued From page 5 (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRYNN MARR HOSPITAL	[redacted]

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V 367	Continued From page 6 (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) as required. The findings are: Review on 5/23/23 of the North Carolina Incident Response Improvement System (IRIS) revealed no level III incident reports filed submitted by the facility 2/01/23 - 5/22/23. Review on 5/23/23 of client #1's record revealed: - 17 year old female admitted 3/24/22. - Diagnoses included Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, combined presentation; and Post Traumatic Stress Disorder. Review on 5/23/23 of a list of "[Client #1] Incident Reports April 2023" revealed: - "Aggression by Staff towards patient . . . 4/29/23 . . . [client #1] . . . It was reported that the patient [client #1] requested medication from the	V 367		

Division of Health Service Regulation

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BRYNN MARR HOSPITAL	[redacted]

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V 367	Continued From page 7 oncoming nurse and when she was not given the medication pt (patient) pushed her way into nurses station and was demanding medication. Staff blocking to get the patient out of the nurses station and to get the door closed. The patient then had a phone call with her father . . . the dad got on the phone with the supervisor and stated that the nurse on the unit had closed his daughter's foot in the door . . . notified the House Supervisor of patient and parent concern. Patient has no injury to her foot as assessed by the RN (Registered Nurse) . . . completed camera review of timeframe 1950 - 2020 (7:50 pm - 8:20 pm). [Client #1] is seen in the doorway of the nurse's station but her foot does not get shut in the door. Her foot is not close to the door when shut. RN is seated at the nurses station and an MHT (Mental Health Technician) provides her with the phone. [Client #1] walks down the hallway with her 1:1 staff member on the phone then returns it to the MHT. Allegations of abuse by staff towards patient are unsubstantiated." During interview on 5/23/23 client #1 stated: - She asked the Nurse for a medication and the nurse told her "to come back in a few minutes." - She went back to the nurses' station and knocked on the door and the Nurse asked her "What?" - She was standing with her foot inside the doorway and the Nurse tried to close the door on her foot; she slammed the door open and it hit a chair inside the nurses' station. - She called her father and told him what happened; "he said he would take care of it." - Her foot was not injured. During interview on 5/26/23 client #1's Father/Guardian stated client #1 called him and told him that Registered Nurse #1 (RN	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 8 #1)slammed the nurses' station door on her foot; he contacted the Nurse Supervisor and expressed his concern that his daughter was abused by RN #1. During interview on 5/23/23 RN #1 stated: - Client #1 told her father the "I slammed the door on her foot; it did not happen." - An internal investigation was completed. During interview on 5/23/23 the Director of Risk Management and Performance Improvement stated: - A review of the video surveillance recording made at the time of the alleged incident revealed no evidence of client abuse by RN #1. - The allegation of abuse against RN #1 was not reported as a Level III incident because the allegation was not substantiated by the facility. - She was not aware allegations of client abuse by staff were to be reported into IRIS as level III incidents at the time of the allegation, not following the internal investigation.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are	V 500		

Division of Health Service Regulation

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V 500	Continued From page 9 instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);	V 500		

Division of Health Service Regulation

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V 500	Continued From page 10 (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an instance of alleged or suspected abuse to the County Department of Social Services (DSS) as required. The findings are: Review on 5/23/23 of client #1's record revealed: - 17 year old female admitted 3/24/22. - Diagnoses included Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, combined presentation; and Post Traumatic Stress Disorder. Review on 5/23/23 of a list of "[Client #1] Incident Reports April 2023" revealed: - "Aggression by Staff towards patient . . . 4/29/23 . . . [client #1] . . . It was reported that the patient [client #1] requested medication from the oncoming nurse and when she was not given the medication pt (patient) pushed her way into nurses station and was demanding medication. Staff blocking to get the patient out of the nurses station and to get the door closed. The patient then had a phone call with her father . . . the dad got on the phone with the supervisor and stated that the nurse on the unit had closed his daughter's foot in the door . . . notified the House Supervisor of patient and parent concern. Patient has no injury to her foot as assessed by the RN	V 500		

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V 500	Continued From page 11 (Registered Nurse) . . . completed camera review of timeframe 1950 - 2020 (7:50 pm - 8:20 pm). [Client #1] is seen in the doorway of the nurse's station but her foot does not get shut in the door. Her foot is not close to the door when shut. RN is seated at the nurses station and an MHT (Mental Health Technician) provides her with the phone. [Client #1] walks down the hallway with her 1:1 staff member on the phone then returns it to the MHT. Allegations of abuse by staff towards patient are unsubstantiated." Review on 5/23/23 of the North Carolina Incident Response Improvement System (IRIS) revealed no level III incident reports filed submitted by the facility 2/01/23 - 5/22/23. During interview on 5/23/23 client #1 stated: - She asked the Nurse for a medication and the nurse told her "to come back in a few minutes." - She went back to the nurses' station and knocked on the door and the Nurse asked her "What?" - She was standing with her foot inside the doorway and the Nurse tried to close the door on her foot. - She called her father and told him what happened. During interview on 5/26/23 client #1's Father/Guardian stated client #1 called him and told him that Registered Nurse #1 (RN #1)slammed the nurses' station door on her foot.; he contacted the Nurse Supervisor and expressed his concern that his daughter was abused by RN #1. During interview on 5/23/23 the Director of Risk Management and Performance Improvement stated:	V 500		

Division of Health Service Regulation

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V 500	Continued From page 12 - A review of the video surveillance recording made at the time of the alleged incident revealed no evidence of client abuse by RN #1. - The allegation of abuse against RN #1 was not reported to DSS because the allegation was not substantiated by the facility.	V 500		

UHS-FINHELP-00009148 [Redacted]

State of Alabama
Department of Human Resources

S. Gordon Persons Building
50 Ripley Street
P. O. Box 304000
Montgomery, Alabama 36130-4000
(334) 242-1650
www.dhr.alabama.gov

Kay Ivey
Governor

Nancy T. Buckner
Commissioner

November 23, 2020

[redacted] Chief Operating Officer
Alabama Clinical Schools, Inc.
[redacted]
Birmingham, AL [redacted]

RE: Contract No. [redacted]
Site Visit on November 4-6, 2020

Dear Mr. Holmes:

Enclosed please find the site visit report for the visit made to your center **November 4-6, 2020.** Based on the findings, the Department of Human Resources (DHR) was overbilled by a total of **$.00** for the period monitored.

In this report you will find comments, recommendations, and mandatory changes. The comments are for your information. Recommendations include those practices which would upgrade your program but which you are not required to adhere to. Mandatory changes are those changes you must make in order to comply with the terms of your contract. Failure to implement mandatory changes may result in the termination of the contract.

You are required to submit a written response to this report to the Resource Management Division. In your response you must address each recommendation and indicate if you plan to implement it and how. If you choose not to implement it, please indicate why. You must tell us how you will implement each mandatory change. This response is due in our office by **December 28, 2020**. Failure to timely respond will result in your reimbursement being held.

Thank you for your cooperation. If you have any questions, please contact your Program Analyst, [redacted]

Respectfully,

[redacted]
[redacted] Director
Resource Management Division

SS:CM
Enclosure
PC: [redacted]
State Office Staff
[redacted] **Monitoring File**

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

CONTRACTOR: Alabama Clinical Schools

CONTRACT NO: [redacted]

PROGRAM TYPE: Intensive

PROGRAM ANALYST: [redacted]

SITE LOCATION: Birmingham, Alabama

DATE OF VISIT: November 4-6, 2020

PURPOSE OF VISIT: To monitor contract compliance and provide technical assistance.

CONTRACT CAPACITY: **50- Slots (Sexual Reactive)**

LICENSE: Yes X No **If Yes, Name of Agency** State Department of Mental Health

DATE OF EXPIRATION: November 30, 2020

MET WITH: [redacted] Executive Director
[redacted] Chief Operating Officer
[redacted] Director of Clinical Services
[redacted] Human Resource Director

MONTHS (S) REVIEWED	NO. OF RECORDS REVIEWED	TOTAL NO. DHR CLIENTS
September 2020	5 (1 Discharge)	27

FINANCIAL CHARGEBACK: Yes No X **IF Yes, amount:** $.00

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

Client Records			
Yes	**No**	**N/A**	
X			1. Did client records contain a **DHR-OCG-724, Purchase of Service Authorization** and it was completed correctly and timely?
		X	2. When applicable, did client records contain documentation from County DHR worker, indicating a change in service? a. Was documentation done prior to change?
X			3. Were discharge summaries available?
X			a. Were they completed in the required time frame?
		X	b. If frequency was less than the required interval, was there written correspondence from the County DHR approving that frequency?
X			4. Does the facility have a discharge survey file?
X			5. Was there a dated intake evaluation on file?
X			6. Were the children Medicaid eligible?
X			7. Did the client files contain a current ISP/Treatment plan? If so, what were the dates: B. A. – 08/28/20 P. C. – 09/22/20 D. A. – 06/23/20 B. K. – 08/27/20 P. P. – 07/02/20 (Discharged 09/15/20)
		X	8. Were ancillary services authorized by an 1878, **Authorization of Service Form** from the county?
		X	9. Did provider billing for excess services include any core services? If yes, what as the amount? **$.00.**

List of discrepancies: There were no discrepancies or mandatory changes noted during this review period.

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

Client Records			
Yes	No	N/A	
X			1. Are any children presently taking medication? If yes:
X			a. Is the medication maintained in a locked area?
X			b. Do you have written procedures to distribute the medications?

List of client's medication and dosage:

B. A. – Concerta 36 mg. tablet taken daily; Clonidine 0.1 mg. tablet taken daily; Zoloft 75 mg. tablet taken daily

P. C. – Melatonin 3 mg. tablet taken at bedtime; Adderall 15 mg. tablet taken in the morning; Seroquel 50 mg. taken at bedtime

D. A. – Ability 10 mg. tablet taken in the morning; Aripiprazole15mg. tablet taken in the a.m.; Atomoxetine HCL 60 mg. capsule taken in the a.m.; Guanfacine HCL ER 3 mg. tablet taken at noon; Aripiprazole 10 mg. tablet taken at bedtime; Atomoxetine 40 mg. capsule taken at bedtime; Oxcarbazepine 300 mg. tablet taken at bedtime; Trazodone 100 mg. tablet taken at bedtime

B. K. – Adderall 15 mg. tablet taken in the a.m.

P. P. – (Medications at discharge) Prozac 40 mg. tablet taken in the a.m.; Intuniv ER 2 mg. tablet taken in the a.m.; Abilify 2 mg. tablet taken in the a.m.; Cogentin 0.25 mg. tablet taken in the a.m.; Focalin XR 20 mg. tablet taken in the a.m.

List of discrepancies: There were no discrepancies noted during this review period.

CONFIDENTIAL UHS-FINHELP-00009151

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

Personnel (This section only applies to facilities not licensed by DHR)			
Yes	No	N/A	
X			1. Does the facility have a personnel file on each employee?
X			2. Is verification of a valid Alabama driver's license in the personnel record of each employee who transports clients?
	X		3. Is there documentation of a criminal history background check provided on required personnel?
X			4. Does the facility have a policy regarding nondiscrimination that is compliant with state and federal laws and applicable for delivery of services and hiring practices without regard to race, color, sex, national origin, handicap, or age?
X			a. Has staff been notified of this policy?
X			b. Has the policy been publicized in the community?
X			c. Is it posted visibly at the facility?
X			d. Does disseminated information on services include a statement or policy of nondiscrimination?
X			5. Are staff and clients aware of procedures for filing and where to file complaints or grievances?
X			6. Are minority persons employed at the facility?
X			7. Are minority clients served at the facility?
X			8. Is the facility serving handicapped clients?
X			9. Has/is the facility willing to hire handicapped employees?
X			10. Does the facility have a file containing signed immigration status forms on each employee and written policy regarding employee's method of providing citizenship?

CONFIDENTIAL UHS-FINHELP-00009152

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

COMMENTS: A random sample of personnel files (10) of staff employed in the residential facility were selected and reviewed for the monitoring visit. It was noticed that there was not an ABI/FBI clearance on file for Redacted - PII Dietary Director who was hired 03/24/14. Please review the policy in your signed contract which is mentioned below in the mandatory change regarding ABI/FBI criminal history checks.

MANDATORY CHANGE:

#3. Contractors shall conduct DHR child abuse and neglect central registry checks and, pursuant to Alabama ACT No. 2000-775 to the extent said Act is applicable, Alabama and National ABI and FBI criminal history checks, with fingerprints, on all personnel, new and current, including subcontractors, working in direct services positions with individuals or families in which said personnel have unsupervised access to children or vulnerable adults, which for purposes of this Contract shall mean having direct contact with children or vulnerable adults being served. The Contractor shall further comply with the Department's policies and procedures for conducting and evaluating said checks as well as with any work rules for personnel covered by said policies and procedures as directed by the Department (see contract document Sec. E-17, Other Agreements). Also see Revised Minimum Standards for Residential Child Care Facilities August 27, 2019, page 16: Information regarding the character and suitability of the applicant. Fingerprint based criminal record checks of state and national crime information databases and child abuse registry checks are required on any adult working in a facility, which includes child care institutions, group homes, residential treatment centers, shelters, and other congregate care settings. There are no exemptions or exceptions for conducting the checks on any adults who work in such settings, including adults who do not work directly with children. This includes but is not limited to: (1) Results of criminal record checks; (2) Response to Clearance of State Central Registry On Child Abuse/Neglect (DHR-DFC-1598); (3) Documentation of contact with former employers and references; and (4) Other pertinent history. Also see Revised Minimum Standards for Residential Child Care Facilities August 27, 2019, page 14: §38-13-4 provides the following: (a) Every employer, child care facility, adult care facility, the Department of Human Resources, and child placing agency required to obtain a criminal history background information check pursuant to this chapter shall obtain, prior to or upon the date of employment, or issuance of a license or approval or renewal thereof, and maintain in the agency or personnel file, a request with written consent for the criminal history background information check and a statement signed by the applicant, volunteer, or employee indicating whether he or she has ever been convicted of a crime, and if so, fully disclosing all convictions. A copy of the ABI/FBI clearance for the employee, Redacted - PII must be sent along with a response to this report to the Resource Management Division, Office of Contracts.

CONFIDENTIAL UHS-FINHELP-00009153

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

Administrative

The facility is located in Birmingham, AL. There is a main building that houses administrative offices, kitchen area, client's sleeping quarters, activity rooms, a dining hall, group therapy rooms, and classrooms for the children.

The sexual reactive program provides treatment for males between the ages of 9 and 18 years of age. In the sexual reactive program the children are divided into three different groups: Courage, Integrity and Respect Group. The groups are each placed on different wings in the building. There are 10 bedrooms on each hall and each bedroom has two beds in them for a total of 20 beds on each unit. There is both single and double occupancy across the groups. This is usually the case except for the first 90-days when a child is admitted to the program as he will not be assigned a roommate and he will not be assigned a roommate after that time if the circumstances dictate otherwise. The Courage Group serves sexually reactive males between the ages of 9-12 years old. The Integrity Group serves males between the ages of 16-18 years old and the Respect Group serves males between the ages of 13-15 years old.

The sleeping quarters are adequately furnished for the boys. The bedrooms provide sufficient space for both clothing and other personal belongings for each child. The bathrooms/showers were clean and neat. The cleaning supplies were safety stored. There appeared to be adequate heating and cooling for both the living and sleeping areas of the building.

The facility has a game/lounging area on each hall for the boys to use. These rooms are adequately furnished. There is a large television in the activity room for the boys to watch and there are board games and other games for the boys to play with. There is also a basketball court for the boys to use. They have their own basketball teams and play competitively against one another. Adjacent to the basketball court is outdoor space that allows for other physical activities. There is also adequate indoor space and there is an outside courtyard at the facility to allow for visitation between the boys and family members.

The kitchen is clean and well-stocked. Menus are posted and there is a current health inspection posted in the facility. The grounds appeared to be attractive and well kept. There was seemingly sufficient outside space to accommodate the needs of the residents.

CONFIDENTIAL UHS-FINHELP-00009154

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

Administration			
Yes	**No**	**N/A**	
			2. Does the facility have:
X			a. A current fire inspection
X			Is it available? If yes, the date of inspection **10/14/20**
X			b. An evacuation plan available
X			1. If so, is it posted?
X			c. Smoke detectors
X			1. Are they working?
X			d. Fire extinguishers
X			1. Are they working?
X			e. Cleaning supplies are secured an available.
X			f. Areas that are clean and adequately supplied.
X			1. Kitchen and dining area
X			2. Sleeping quarters
X			3. Bathrooms
X			4. Living quarters
X			3. Does the program serve clients noted in the narrative and the definitions contained within the core services?
X			4. Does the program have insurance coverage which includes:
X			a. Vehicle liability insurance **01/01/20 to 01/01/21**
		X	b. Fire and theft for center contents (if state-owned)
X			c. On-premises liability insurance
X			d. Certificate(s) of insurance on file in the Resource Management Division **01/01/2020 to 01/01/2021**
X			5. Are attendance records completed on a daily basis?
X			a. Are they available for review?
X			b. Do all absences appear on the attendance report?
X			c. Does the program specify on the attendance report absences due to a trial visits?
X			d. Is the program following policy regarding trial visits?
X			6. Is there a record of children who have been denied admission to the facility and was a written explanation submitted to the County DHR Resource Management Division?
X			7. Are units of service billed on the **Residential Expenditure Form** consistent with those units appearing on the attendance sheet?
	X		8. Is there a potential financial chargeback? If yes, what is the amount? $.00.

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

Administrative			
Yes	**No**	**N/A**	
X			9. Are program service components provided as described in the narrative?
			10. Children Discharged.
X			a. Were children discharged because they successfully completed treatment plans, and they were ready for a less restrictive placement?
	X		b. Were children discharged because of difficulty with their behaviors or emotional status, and the provider did not feel that they were appropriate for this facility?
		X	c. Was a thirty (30) day state approved notice of permission for discharge on file?
	X		d. Were children discharged because they were admitted to a psychiatric hospital, ran away, or were incarcerated?
			e. What was the total number of discharged children involved in sample? __1__
X			11. Does the facility have a written policy regarding reporting of abuse and neglect?
X			a. Were incidents of abuse and neglect investigated by DHR?
X			b. Were files regarding reports kept locked in file cabinets?
X			12. Does the facility have written policy concerning safeguarding of confidential/HIPPA information?
X			a. Are the files locked?
X			b. Are the consent forms signed by the legal guardian to allow provider's staff to access medical information in case files?
X			13. Does the facility have written policy regarding visitation between children and birth families?
X			a. Are family visits encouraged?
	X		b. Are family visits used as a reward rather than a right?
X			c. Does the provider have allocated space on campus to facilitate family visits?
X			14. Does the facility have written policy about allowances for children?

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF RESOURCE MANAGEMENT
SITE VISIT REPORT FOR RESIDENTIAL SERVICES

Core Services			
Yes	**No**	**N/A**	
X			1. Does the child's record have a certificate of need on file?
X			2. Does the provider provide an ongoing psychiatric, medical psychological, social, and educational assessment?
X			3. Does the provider provide a diagnosis from these ongoing assessments?
X			4. Does the provider provide local transportation to appointments such as physicians, counseling, extra-curricular, family visits, etc.?
X			5. Are the children involved in at least one extra-curricular activity of their choosing, e.g. band, karate, various sports, Boy or Girl Scouts?
X			6. Does the provider provide treatment planning with a treatment team?
X			7. Does the provider provide an active treatment program in a therapeutic milieu?
X			8. Does the provider provide psychiatric services/medication management?
X			9. Does the provider provide clinical therapy services, including family therapy and any behavioral programming?
X			10. Does the provider provide routine medical care?
X			11. Does the provider provide an educational program?
X			11. Does the provider provide vocational and recreational therapies?
X			12. Does the provider provide independent living skills?
X			13. Does the provider provide a minimum of $5-$10 per week allowance?
X			14. Does the provider provide haircuts, feminine hygiene products, oral and body hygiene products, over the-counter medications, gifts for birthdays, Christmas or other special occasions, etc.?
X			16. Does the provider encourage the child's relationship with family, peers and other significant persons, including, but limited to, the supervision of family visitation?
X			17. Does the provider provide supportive services to the family?
X			18. Does the provider provide bi-weekly group therapy sessions for the children?
X			19. If needed, does the provider provide two (2) hours per week of tutoring, by a qualified person, to offer assistance in a certain subject matter?
X			20. Do social workers visit the children and if so, how often? Monthly?

Alabama Clinical Schools

Site Visit Response

Site Visit Date(s): November 4th- 6th, 2020

RE: Contract No. [redacted]

Program Analyst: [redacted]

Mandatory Change: There was no ABI/FBI clearance on file for Redacted - PII Dietary Director, among the sample of personnel files reviewed.

Program Response: ACS completed ABI/FBI paperwork on Redacted - PII following the State DHR site visit. On November 17th, Redacted - PII received a letter from the Office of Criminal History, requesting additional documentation pertaining to a November 2015 arrest before a suitability letter can be issued. ACS has reviewed the requested documentation, which reflects a misdemeanor theft charge. The additional documentation has been submitted to the Office of Criminal History and ACS is awaiting receipt of the suitability letter. ACS will forward the clearance letter to the Resource Management Division, Office of Contracts, as soon as it is received.

[redacted] LBSW, MPA
Chief Operating Officer/Director of Risk & PI

12/28/2020
Date

UHS-FINHELP-00009159 [Redacted]

WV Department of Health & Human Resource, Bureau of Children and Families
Office of Children and Adult Services, Division of Regulatory Management

Licensure Summary of Findings of Non-Compliance and Plan of Correction	Licensing Specialist(s): [redacted]	Date(s) of Inspection: 11/15-11/17/22
NAME OF AGENCY: Alabama Clinical School	STREET ADDRESS, CITY, STATE, ZIP CODE: [redacted] Birmingham, AL [redacted]	

Purpose of Inspection: Child Welfare Residential Licensing Review (Based on West Virginia Legislative Rules for Minimum Licensing Requirements for Group Residential Facilities in West Virginia 78CSR3, July 1, 2021)

REGULATION NUMBER	REGULATION AND SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION	COMPLETION DATE
	1.8 Purpose – These standards are the basis for the licensing and approval of residential child care and treatment facilities in West Virginia. Licenses or certificates of approval are issues if the standards and applicable rules and regulations are met. The purpose is to protect the health, safety and well-being of children receiving care in residential facilities and to regulate the provision of out of home behavioral health treatment for children with behavioral, emotional and/or developmental challenges, placed in congregate treatment settings, through the formulation, application and enforcement of minimum licensing requirements. Nothing in these standards are intended to interfere with any requirements relating to funding streams.		
	8.2. Legal Compliance The organization shall comply with all applicable federal, state and local laws, rules and regulations associated with all aspects of services delivery and operations and shall possess all relevant and appropriate licenses. 4.8 Corrective Action Plan 4.8.1. Within **10 working days after receipt** of the licensing report, the organization shall submit to the Secretary for approval a written plan to correct all areas of non-compliance that are in violation of this rule. The plan shall specify: 4.8.1.a. Any action taken or procedures proposed to correct the areas of non-compliance and prevent their reoccurrence; 4.8.1.b. The date or projected date of completion of each action taken or to be taken; and 4.8.1.c. The signature of the administrator or his or her designee.		
	Findings: Based on a licensure review conducted on 11/15/22-11/17/22, the organization is out of compliance with the rules cited within this report. Organization shall submit a written plan to correct all areas of non-compliance as required above. Please note the new format for corrective action responses. All four areas need identified action for each citation. Agency's Corrective Action Response: • Specifically, what the agency is going to do to correct the area of noncompliance. (*Explanation of how the agency will correct the area of noncompliance).* • How noncompliance will be prevented in the future. (*Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.).* • Who in the agency is responsible for the implementation of the corrective action response. (*Document the individual and/or all those involved in a chain of command within the agency).* • How will the agency document that the corrective action responses are implemented. (*Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom).* Date for Completion:		

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 2 of 9	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

§78-3-10 Management of Human Resources.
10.1 Deployment of Employees
10.2. Personnel Practices

10.2.5. The organization shall submit a request for a criminal history background check and a protective services records check to the WV CARES unit of the Department for each potential employee or independent contractor prior to permitting that employee or independent contractor to work with children.

10.2.8. The organization must demonstrate compliance will all provisions of the WV CARES Act and its Legislative rule, 69CSR10. The organization may not allow employees or independent contractor to work in a group residential child care and treatment facility prior to receiving the results of the check.

Findings: Based on review of personnel records it was found that E1, E2, E3, E4, E5, E6, E9, E11, and E12 did not have WV CARES results back prior to being hired. In addition, it was found for E1, E3, E4, E5, E6, E8, E9, E10, E11, E12 protective service background checks were not received prior to being hired for work.

Agency's Corrective Action Response:

1. Specifically, what the agency is going to do to correct the area of noncompliance. (Explanation of how the agency will correct the area of noncompliance). The Human Resources Dept. at Alabama Clinical Schools is modifying existing processes in order to correct this issue. Going forward, prospective candidates will be required to submit to the background check sooner in the hiring process to ensure all required results are received *prior* to orientation beginning. The background clearances required for work at Alabama Clinical Schools are extensive. They include 1) fingerprints, which are ran through state and federal systems (ABI / FBI) to determine suitability for working with children and/or vulnerable members of the population; 2) Criminal Background Check using the Pre-Check system; 3) Alabama Child Abuse & Neglect (CAN) Registry Clearance.

2. How noncompliance will be prevented in the future. (Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.). The above described process change should ensure future compliance. However, to ensure of this compliance, the HR Dept. has created an HR Clearance Checklist. The HR Generalist will initially complete the checklist and submit to the HR Director. The HR Director will validate the checklist. This will be the final clearance for new hires.

3. Who in the agency is responsible for the implementation of the corrective action response. (Document the individual and/or all those involved in a chain of command within the agency). The two primary individuals responsible for the above actions are 1) [redacted] HR Generalist; and 2) [redacted] HR Director.

4. How will the agency document that the corrective action responses are implemented. (Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom). This corrective action will be reviewed for a minimum of 90 days in monthly meetings involving the CEO, HR Director, and HR Generalist. This will include independently verifying compliance by auditing a sample of new hire files.

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REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

Date for Completion: 12/10/2022

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 4 of 9	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

§78-3-11. Training and Supervision of Employees.

11.1. Orientation of New Employees

11.1.1. The organization shall ensure that each new employee, volunteer, and student receive an orientation within the first 10 business days of employment and shall document that orientation in the individual's personnel record.
11.1.2. The organization shall orient all new employees on the following:
11.1.2.a. An organizational chart that delineates lines of accountability and authority at all levels of the organization;
11.1.2.b. The objectives and process of the organization's continuous quality improvement program;
11.1.2.c. The organization's policies and procedures on confidentiality and disclosure of information on persons served, including penalties for violation of these policies and procedures and an orientation to federal confidentiality requirements as they apply to the organization;
11.1.2.d. The legal rights of persons served;
11.1.2.e. Mandatory reporting procedures for suspected abuse and neglect;
11.1.2.f. Appropriate identification and documentation of incidents;
11.1.2.g. The responsibility to abide by organizational and professional ethics;
11.1.2.h. Fire drills; and
11.1.2.i. Procedures regarding medical and psychiatric emergencies, including necessary notification of guardians and others.

11.2. Employee Training and Content

11.2.1. The organization shall provide training to clinical and direct care employees in the following health related topics within 30 days of employment:
11.2.1.a. Basic medical needs and problems of the population served, including management of sick children and symptoms of common medical problems, such as allergy reactions, diabetes and asthma;
11.2.1.b. Basic first aid (completed according to OSHA- approved pediatric first aid requirements and adult requirements as appropriate) and medication reactions (including desired and undesired effects). This training must be updated every three years.
11.2.1.c. Cardio-Pulmonary Resuscitation (CPR) Adult Training is required every two years and First Aid certification every three years, specific to population served (adult, child and/or infant);
11.2.1.d. Supervision of self-administration of medication as applicable including typical medications prescribed, appropriate dosages and schedules and common side effects. This training shall be updated annually;
11.2.1.e. Basic de-escalation techniques and passive restraints. This training must be updated annually;
11.2.1.f. The organization's protocols for universal disease precautions and providing services to children with contagious and infectious diseases. This training must be updated annually;
11.2.1.g. The organization's procedures regarding the duty to warn others of impending harm due to threats made by a resident of the organizations program. The procedures shall include, at a minimum, the requirement that verbal communication of the treatment to the potential victim occur immediately;
11.2.1.h. Appropriate management of suicidal threats or behaviors;
11.2.1.i. The organization shall inform all employees in writing of its policy defining and prohibiting corporal and degrading punishment.

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 5 of 9	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

11.2.1.j. The organization shall train appropriate employees on procedures for maintaining a safe, hygienic, and sanitary environment. Procedures shall address:
11.2.1.j.1. Steps to retard the spread of infection in bathrooms, bedding and food; and
11.2.1.j.2. Proper storage of cleaning supplies and hazardous materials.

11.2.2. Additionally, program employees with direct care responsibilities shall be trained within 90 days of employment on the following:
11.2.2.a. Sensitivity to differences in cultural norms and values as appropriate;
11.2.2.b. Management of children attempting to escape supervision or who are away from supervision;
11.2.2.c. Sensitivity to sexual identity including lesbian, gay, bisexual, transgender, and questioning youth;
11.2.2.d. Family dynamics, including human growth and development;
11.2.2.e. Proper documentation techniques; and
11.2.2.f. Basic therapeutic or behavior management techniques.
11.2.2.g. Children's trauma stress experiences, to include:
11.2.2.g.1. Impact on development, behavior, and relationships;
11.2.2.g.2. Understanding the types of trauma;
11.2.2.g.3. Understanding the influence of cultural factors;
11.2.2.g.4. Recognizing how on-going stressors impact child traumatic stress;
11.2.2.g.5. Responding to crises with interventions; and
11.2.2.g.6. Strategies and interventions to promote resiliency and health.

11.2.3. Employees shall be trained at the time of admission to serve any child with special needs such as dietary restrictions, use of an epinephrine auto-injector, rescue inhalers, diabetic monitoring mechanisms, etc.

11.2.4. The organization shall document all employee training provided to employees, including a survey by the employee that indicates that he or she feels adequately trained to do their job.

11.2.5. Until the training is completed, the employee may not work unless accompanied at all times by an employee who is experienced and knowledgeable in these areas.

24.4.2. In addition to the requirements for employee training prescribed in Section 11 of this rule, direct care employees shall receive refresher training in emergency safety interventions twice a year, which shall include both didactic and experiential activities.

Findings: Based on review of employee records it was found that E3, E4, E8, E11 did not have all the required trainings. The above employees did have *Handle with care* restraint training. Also, E3, E4, E11 had CPR training. E8 did not have CPR. These were the only trainings located within the employee files. In addition, it was found that training in 24.4.2 (seclusion, physical restraints, chemical restraints, etc. that includes what teaching methods are used and activities/experiments are used) are only given once yearly. Employee trainings are not consistently being completed.
Agency's Corrective Action Response:

1. Specifically, what the agency is going to do to correct the area of noncompliance. (Explanation of how the agency will correct the area of noncompliance). The HR Dept. has completed a full audit of all employee files to fully identify all past due and/or missed training requirements. From these results, staff have been given 30-day deadlines to complete all past due trainings. Any direct care staff member who remains

NAME OF AGENCY:	STREET ADDRESS, CITY, STATE, ZIP CODE: Page 6 of 9		
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

behind on required trainings after February 6th will be suspended from active duty until all required trainings have been brought current.

2. How noncompliance will be prevented in the future. (Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.). The HR Dept. will completely weekly reports detailing the status of outstanding trainings until everyone is at 100% compliance. These reports will be submitted to supervisory staff and department directors. Review of these reports will ensure progress is being made and that staff still behind remain aware of the established 2/6/2023 deadline. Following all staff reaching 100%, the HR Dept. will produce monthly reports moving forward to include future and upcoming expiration dates for trainings. Further, the HR checklist established for new hires, as noted elsewhere in this corrective action plan, will prevent staff from assuming active duty if any required trainings are missed / need to be made up.

3. Who in the agency is responsible for the implementation of the corrective action response. (Document the individual and/or all those involved in a chain of command within the agency). The two primary individuals responsible for the above actions are 1) [redacted] HR Generalist; and 2) [redacted] HR Director.

4. How will the agency document that the corrective action responses are implemented. (Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom). The HR Dept. staff will maintain status reports on training. Any corrective actions, such as active duty suspensions, will also be maintained in HR. Any staff suspended must be independently checked off by HR and their immediate Dept. Director before returning to active duty.

Date for Completion: 2/6/2023

NAME OF AGENCY:	STREET ADDRESS, CITY, STATE, ZIP CODE: Page 7 of 9		
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

§78-3-10 Management of Human Resources.

10.5. Employee, Volunteer, and Student Records

10.5.1.d. Reference verification;

Findings: Based on the review of employee records it was found 7 of the 12 records reviewed had no reference verifications.

Agency's Corrective Action Response:

1. Specifically, what the agency is going to do to correct the area of noncompliance. (Explanation of how the agency will correct the area of noncompliance). 100% of the employee files have been audited by HR to fully determine any employee in need of additional reference verifications. A deadline of February 6th has been established to obtain references for any file identified as missing reference verifications.

2. How noncompliance will be prevented in the future. (Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.). The newly established HR checklist will identify any employee needing additional reference verifications before active duty is assumed. This will allow these issues to be identified and corrected before it becomes a future issue on any employee file.

3. Who in the agency is responsible for the implementation of the corrective action response. (Document the individual and/or all those involved in a chain of command within the agency). The two primary individuals responsible for the above actions are 1) [redacted] HR Generalist; and 2) [redacted] HR Director.

4. How will the agency document that the corrective action responses are implemented. (Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom). HR Dept. Staff will check off files as the missing reference verifications are obtained.

Date for Completion: 2/6/2023

§78.3.4.11. Administrative and Judicial Review.
Any person, corporation, governmental official or child welfare organization, aggrieved by a decision of the Secretary made pursuant to this rule may contest the decision upon making a request for a hearing by the Secretary within 30 days of receipt of notice of the decision. Administrative and judicial review shall be made in accordance with the provisions of W. Va. Code §29a-5-1, *et seq.* Any decision issued by the Secretary may be made effective from the date of issuance. Immediate relief there may be obtained upon a showing of good cause made by a verified petition to the circuit court of Kanawha County or the circuit court of any county where the affected organization of child welfare organization may be located. The pendency of administrative or judicial review shall not prevent the Secretary from obtaining injunctive relief as provided for in 4.10.b. of this rule.

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 8 of 9	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

Agency Representative Signature: [redacted]	Title: Chief Executive Officer	Date: 1/9/23

Send Agency's Corrective Action Plan to: [redacted] licensing specialist, [redacted]
or PO BOX 1268, Weston, WV 26452

Notes:

- **Verification of employee's education and/or credentials not in some employee files.**
- **Some resident bathrooms were dirty and appeared to be unsanitary; areas of some walls had pieces missing.**
- **Some resident mattresses were flimsy that go flat when residents laid on them.**

Employee Files Reviewed:

E1: [redacted] (DOH 01/03/22)
E2: [redacted] (DOH 02/04/20)
E3: [redacted] (DOH 08/29/22)
E4: [redacted] (DOH 04/26/21)
E5: [redacted] (DOH 10/26/06)
E6: [redacted] (DOH 04/11/21)
E7: [redacted] (DOH 12/07/20)
E8: [redacted] (DOH 01/03/22)
E9: [redacted] (DOH 03/26/19)
E10: [redacted] (DOH 01/21/21)
E11 [redacted] (DOH 08/28/22)
E12 [redacted] (DOH 09/23/19)

Residents Interviewed:

R1: [redacted]
R2:
R3:
R4:

Program Strengths:

- **Human resources department was very accommodating and friendly.**
- **Children talked highly about staff and the treatment they are receiving.**
- **Appropriate staff to resident ratios are maintained.**
- **Program has several activities to keep children engaged and interested.**
- **Administrators state they will begin a very large renovation beginning early 2023.**

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 9 of 9	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

WV Department of Health & Human Resource, Bureau of Children and Families
Office of Children and Adult Services, Division of Regulatory Management

Licensure Summary of Findings of Non-Compliance and Plan of Correction	Licensing Specialist(s): [redacted]	Date(s) of Inspection: 11/15-11/17/22
NAME OF AGENCY: Alabama Clinical School	STREET ADDRESS, CITY, STATE, ZIP CODE: [redacted] Birmingham, AL [redacted]	

Purpose of Inspection: Child Welfare Residential Licensing Review (Based on West Virginia Legislative Rules for Minimum Licensing Requirements for Group Residential Facilities in West Virginia 78CSR3, July 1, 2021)

REGULATION NUMBER	REGULATION AND SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION	COMPLETION DATE

1.8 Purpose – These standards are the basis for the licensing and approval of residential child care and treatment facilities in West Virginia. Licenses or certificates of approval are issues if the standards and applicable rules and regulations are met. The purpose is to protect the health, safety and well-being of children receiving care in residential facilities and to regulate the provision of out of home behavioral health treatment for children with behavioral, emotional and/or developmental challenges, placed in congregate treatment settings, through the formulation, application and enforcement of minimum licensing requirements. Nothing in these standards are intended to interfere with any requirements relating to funding streams.

8.2. Legal Compliance
The organization shall comply with all applicable federal, state and local laws, rules and regulations associated with all aspects of services delivery and operations and shall possess all relevant and appropriate licenses.

4.8 Corrective Action Plan
4.8.1. Within 1**0 working days after receipt** of the licensing report, the organization shall submit to the Secretary for approval a written plan to correct all areas of non-compliance that are in violation of this rule. The plan shall specify:
4.8.1.a. Any action taken or procedures proposed to correct the areas of non-compliance and prevent their reoccurrence;
4.8.1.b. The date or projected date of completion of each action taken or to be taken; and
4.8.1.c. The signature of the administrator or his or her designee.

Findings: Based on a licensure review conducted on 11/15/22-11/17/22, the organization is out of compliance with the rules cited within this report. Organization shall submit a written plan to correct all areas of non-compliance as required above. Please note the new format for corrective action responses. All four areas need identified action for each citation.

Agency's Corrective Action Response:

- Specifically, what the agency is going to do to correct the area of noncompliance. (*Explanation of how the agency will correct the area of noncompliance).*
- How noncompliance will be prevented in the future. (*Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.).*
- Who in the agency is responsible for the implementation of the corrective action response. (*Document the individual and/or all those involved in a chain of command within the agency).*
- How will the agency document that the corrective action responses are implemented. (*Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom).*

Date for Completion:

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 2 of 7	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

§78-3-10 Management of Human Resources.
10.1 Deployment of Employees
10.2. Personnel Practices

10.2.5. The organization shall submit a request for a criminal history background check and a protective services records check to the WV CARES unit of the Department for each potential employee or independent contractor prior to permitting that employee or independent contractor to work with children.

10.2.8. The organization must demonstrate compliance will all provisions of the WV CARES Act and its Legislative rule, 69CSR10. The organization may not allow employees or independent contractor to work in a group residential child care and treatment facility prior to receiving the results of the check.

Findings: Based on review of personnel records it was found that E1, E2, E3, E4, E5, E6, E9, E11, and E12 did not have WV CARES results back prior to being hired. In addition, it was found for E1, E3, E4, E5, E6, E8, E9, E10, E11, E12 protective service background checks were not received prior to being hired for work.

Agency's Corrective Action Response:

1. Specifically, what the agency is going to do to correct the area of noncompliance. (Explanation of how the agency will correct the area of noncompliance).

2. How noncompliance will be prevented in the future. (Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.).

3. Who in the agency is responsible for the implementation of the corrective action response. (Document the individual and/or all those involved in a chain of command within the agency).

4. How will the agency document that the corrective action responses are implemented. (Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom).

Date for Completion: 12/10/22

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 3 of 7	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

§78-3-11. Training and Supervision of Employees.

11.1. Orientation of New Employees

11.1.1. The organization shall ensure that each new employee, volunteer, and student receive an orientation within the first 10 business days of employment and shall document that orientation in the individual's personnel record.
11.1.2. The organization shall orient all new employees on the following:
11.1.2.a. An organizational chart that delineates lines of accountability and authority at all levels of the organization;
11.1.2.b. The objectives and process of the organization's continuous quality improvement program;
11.1.2.c. The organization's policies and procedures on confidentiality and disclosure of information on persons served, including penalties for violation of these policies and procedures and an orientation to federal confidentiality requirements as they apply to the organization;
11.1.2.d. The legal rights of persons served;
11.1.2.e. Mandatory reporting procedures for suspected abuse and neglect;
11.1.2.f. Appropriate identification and documentation of incidents;
11.1.2.g. The responsibility to abide by organizational and professional ethics;
11.1.2.h. Fire drills; and
11.1.2.i. Procedures regarding medical and psychiatric emergencies, including necessary notification of guardians and others.

11.2. Employee Training and Content

11.2.1. The organization shall provide training to clinical and direct care employees in the following health related topics within 30 days of employment:
11.2.1.a. Basic medical needs and problems of the population served, including management of sick children and symptoms of common medical problems, such as allergy reactions, diabetes and asthma;
11.2.1.b. Basic first aid (completed according to OSHA- approved pediatric first aid requirements and adult requirements as appropriate) and medication reactions (including desired and undesired effects). This training must be updated every three years.
11.2.1.c. Cardio-Pulmonary Resuscitation (CPR) Adult Training is required every two years and First Aid certification every three years, specific to population served (adult, child and/or infant);
11.2.1.d. Supervision of self-administration of medication as applicable including typical medications prescribed, appropriate dosages and schedules and common side effects. This training shall be updated annually;
11.2.1.e. Basic de-escalation techniques and passive restraints. This training must be updated annually;
11.2.1.f. The organization's protocols for universal disease precautions and providing services to children with contagious and infectious diseases. This training must be updated annually;
11.2.1.g. The organization's procedures regarding the duty to warn others of impending harm due to threats made by a resident of the organizations program. The procedures shall include, at a minimum, the requirement that verbal communication of the treatment to the potential victim occur immediately;
11.2.1.h. Appropriate management of suicidal threats or behaviors;
11.2.1.i. The organization shall inform all employees in writing of its policy defining and prohibiting corporal and degrading punishment.

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE:	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

11.2.1.j. The organization shall train appropriate employees on procedures for maintaining a safe, hygienic, and sanitary environment. Procedures shall address:
11.2.1.j.1. Steps to retard the spread of infection in bathrooms, bedding and food; and
11.2.1.j.2. Proper storage of cleaning supplies and hazardous materials.

11.2.2. Additionally, program employees with direct care responsibilities shall be trained within 90 days of employment on the following:
11.2.2.a. Sensitivity to differences in cultural norms and values as appropriate;
11.2.2.b. Management of children attempting to escape supervision or who are away from supervision;
11.2.2.c. Sensitivity to sexual identity including lesbian, gay, bisexual, transgender, and questioning youth;
11.2.2.d. Family dynamics, including human growth and development;
11.2.2.e. Proper documentation techniques; and
11.2.2.f. Basic therapeutic or behavior management techniques.
11.2.2.g. Children's trauma stress experiences, to include:
11.2.2.g.1. Impact on development, behavior, and relationships;
11.2.2.g.2. Understanding the types of trauma;
11.2.2.g.3. Understanding the influence of cultural factors;
11.2.2.g.4. Recognizing how on-going stressors impact child traumatic stress;
11.2.2.g.5. Responding to crises with interventions; and
11.2.2.g.6. Strategies and interventions to promote resiliency and health.

11.2.3. Employees shall be trained at the time of admission to serve any child with special needs such as dietary restrictions, use of an epinephrine auto-injector, rescue inhalers, diabetic monitoring mechanisms, etc.

11.2.4. The organization shall document all employee training provided to employees, including a survey by the employee that indicates that he or she feels adequately trained to do their job.

11.2.5. Until the training is completed, the employee may not work unless accompanied at all times by an employee who is experienced and knowledgeable in these areas.

24.4.2. In addition to the requirements for employee training prescribed in Section 11 of this rule, direct care employees shall receive refresher training in emergency safety interventions twice a year, which shall include both didactic and experiential activities.

Findings: Based on review of employee records it was found that E3, E4, E8, E11 did not have all the required trainings. The above employees did have *Handle with care* restraint training. Also, E3, E4, E11 had CPR training. E8 did not have CPR. These were the only trainings located within the employee files. In addition, it was found that training in 24.4.2 (seclusion, physical restraints, chemical restraints, etc. that includes what teaching methods are used and activities/experiments are used) are only given once yearly. Employee trainings are not consistently being completed.
Agency's Corrective Action Response:

1. Specifically, what the agency is going to do to correct the area of noncompliance. (Explanation of how the agency will correct the area of noncompliance).

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2. How noncompliance will be prevented in the future. (Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.).

3. Who in the agency is responsible for the implementation of the corrective action response. (Document the individual and/or all those involved in a chain of command within the agency).

4. How will the agency document that the corrective action responses are implemented. (Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom).

Date for Completion: 12/10/22

§78-3-10 Management of Human Resources.

10.5. Employee, Volunteer, and Student Records

10.5.1.d. Reference verification;

Findings: Based on the review of employee records it was found 7 of the 12 records reviewed had no reference verifications.

Agency's Corrective Action Response:

1. Specifically, what the agency is going to do to correct the area of noncompliance. (Explanation of how the agency will correct the area of noncompliance).

2. How noncompliance will be prevented in the future. (Explain systematic changes, utilization of tickler systems, training of current/new employees, form revisions, quality assurance procedures, etc.).

3. Who in the agency is responsible for the implementation of the corrective action response. (Document the individual and/or all those involved in a chain of command within the agency).

4. How will the agency document that the corrective action responses are implemented. (Explanation of how and where all documentation will be maintained how corrective actions will be monitored and by whom).

Date for Completion: 12/10/22

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE: Page 6 of 7	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

§78.3.4.11. Administrative and Judicial Review.
Any person, corporation, governmental official or child welfare organization, aggrieved by a decision of the Secretary made pursuant to this rule may contest the decision upon making a request for a hearing by the Secretary within 30 days of receipt of notice of the decision. Administrative and judicial review shall be made in accordance with the provisions of W. Va. Code §29a-5-1, *et seq*. Any decision issued by the Secretary may be made effective from the date of issuance. Immediate relief there may be obtained upon a showing of good cause made by a verified petition to the circuit court of Kanawha County or the circuit court of any county where the affected organization of child welfare organization may be located. The pendency of administrative or judicial review shall not prevent the Secretary from obtaining injunctive relief as provided for in 4.10.b. of this rule.

Agency Representative Signature:	**Title:**	**Date:**

Send Agency's Corrective Action Plan to: [redacted] licensing specialist [redacted]
or PO BOX 1268, Weston, WV 26452

Notes:

- **Verification of employee's education and/or credentials not in some employee files.**
- **Some resident bathrooms were dirty and appeared to be unsanitary; areas of some walls had pieces missing.**
- **Some resident mattresses were flimsy that go flat when residents laid on them.**

Employee Files Reviewed:

E1: [redacted] (DOH 01/03/22)
E2: (DOH 02/04/20)
E3: (DOH 08/29/22)
E4: (DOH 04/26/21)
E5: (DOH 10/26/06)
E6: (DOH 04/11/21)
E7: (DOH 12/07/20)
E8: (DOH 01/03/22)
E9: (DOH 03/26/19)
E10 (DOH 01/21/21)
E11 (DOH 08/28/22)
E12 (DOH 09/23/19)

Residents Interviewed:

R1:
R2:
R3:
R4:

NAME OF AGENCY:		STREET ADDRESS, CITY, STATE, ZIP CODE:	
REGULATION NUMBER	SUMMARY STATEMENT OF NON-COMPLIANCE	AGENCY'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATION)	COMPLETION DATE

Program Strengths:

- **Human resources department was very accommodating and friendly.**
- **Children talked highly about staff and the treatment they are receiving.**
- **Appropriate staff to resident ratios are maintained.**
- **Program has several activities to keep children engaged and interested.**
- **Administrators state they will begin a very large renovation beginning early 2023.**

UHS-FINHELP-00009190 [Redacted]

The Joint Commission

Final Accreditation Report

Alabama Clinical Schools, Inc
[redacted]
Birmingham, AL [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 12/8/2020 - 12/11/2020

Program Surveyed
Behavioral Health Care and Human Services

Final Report: Posted 12/28/2020

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The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	12/08/2020 - 12/11/2020	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

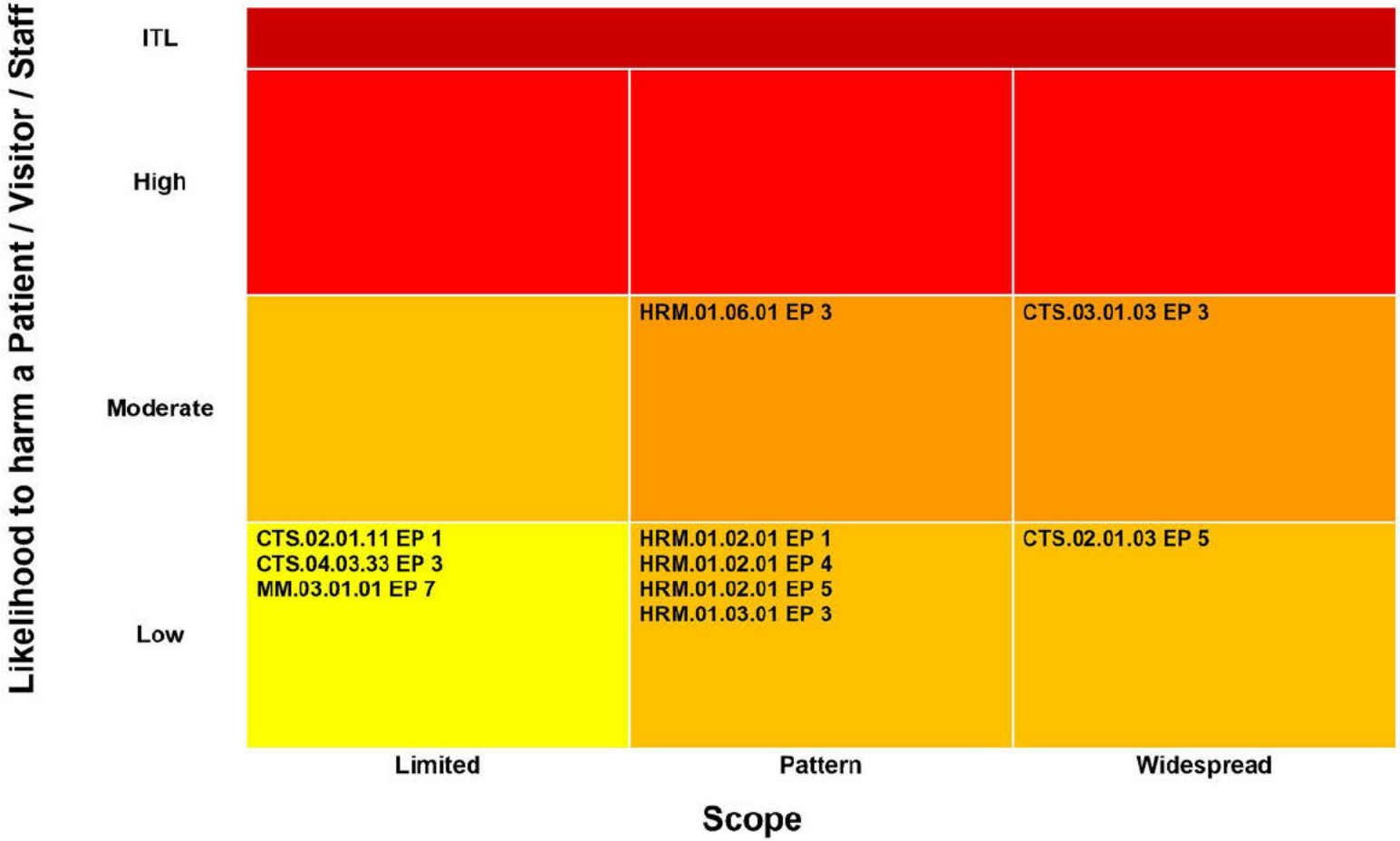
The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.01.03	5	Low / Widespread	✓
CTS.02.01.11	1	Low / Limited	✓
CTS.03.01.03	3	Moderate / Widespread	✓
CTS.04.03.33	3	Low / Limited	✓
HRM.01.02.01	1	Low / Pattern	✓
	4	Low / Pattern	✓
	5	Low / Pattern	✓
HRM.01.03.01	3	Low / Pattern	✓
HRM.01.06.01	3	Moderate / Pattern	✓
MM.03.01.01	7	Low / Limited	✓

The Joint Commission
SAFER™ Matrix

Program: Behavioral Health Care and Human Services



The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.03	5	Low Widespread	When relevant to the individual's current care, treatment, or services, as determined by the organization, the organization gathers clinical/case information from both inpatient and outpatient providers who have treated the individual. When it is not possible to obtain this information, the organization documents the reason why it could not be obtained.	1) Observed in Record Review at Alabama Clinical Schools, Inc. [redacted] Birmingham, AL) site . The HCO was unable to demonstrate that it had documented the reason why historical information on the patient's treatment from other providers was not obtained. This was affirmed by the Chief Operating Officer.
CTS.02.01.11	1	Low Limited	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting	1) Observed in Individual Tracer at Alabama Clinical Schools, Inc. [redacted] Birmingham, AL) site . The HCO was unable to demonstrate it queried for dental problems during the nutritional screening. This was affirmed by the Director of Nursing.
CTS.03.01.03	3	Moderate Widespread	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress	1) Observed in Individual Tracer at Alabama Clinical Schools, Inc. [redacted] Birmingham, AL) site . The HCO was unable to demonstrate that measurable objectives were incorporated into the treatment plan to ascertain patient progress toward identified goals. The was affirmed by the Clinical Director and Lead Therapist.
CTS.04.03.33	3	Low Limited	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.	1) Observed in Building Tour at Alabama Clinical Schools, Inc. [redacted] Birmingham, AL) site . During the main site building tour, the HCO was unable to demonstrate it had securely labeled two (2) stainless steel food pans containing meats and cheeses in the kitchen's main refrigerator. This was affirmed by the CEO and Chief Operation Officer.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
HRM.01.02.01	1	Low Pattern	The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal. Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member's license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care or human services organization, then primary source verification does not need to be completed a second time by the organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.	1) Observed in HR File Review at Alabama Clinical Schools, Inc. ([redacted] Birmingham, AL) site . The HCO was unable to demonstrate that primary source verification was completed at the time of a renewal for a therapist and for a registered dietician. This was affirmed by the Human Resources Director and observed by the surveyor as corrected on site.
HRM.01.02.01	4	Low Pattern	The organization obtains a criminal background check on the job applicant as required by law and regulation or organization policy. Criminal background checks are documented.	1) Observed in HR File Review at Alabama Clinical Schools, Inc. ([redacted] Birmingham, AL) site . The HCO was unable to demonstrate that a criminal background check had been completed In two (2) of four (4) contracted provider personnel files. This was affirmed by the Human Resources Director.
HRM.01.02.01	5	Low Pattern	Staff comply with health screening in accordance with law and regulation or organization policy. Health screening compliance is documented. Note: Organizations should consider the applicability of the Americans with Disabilities Act to their assignment of job duties and responsibilities, and, if applicable, review their policies and procedures. In addition, federal entities are required to comply with the Rehabilitation Act of 1974.	1) Observed in HR File Review at Alabama Clinical Schools, Inc. [redacted] Birmingham, AL) site . The HCO was unable to demonstrate that required health screenings were completed in two (2) of four (4) contracted provider personnel files. This was affirmed by the Human Resources Director.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
HRM.01.03.01	3	Low Pattern	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.	1) Observed in HR File Review at Alabama Clinical Schools, Inc. [redacted] Birmingham, AL) site . The HCO was unable to demonstrate in two (2) of four (4) contracted provider personnel files that written documentation of orientation was present. This was affirmed by the Human Resources Director.
HRM.01.06.01	3	Moderate Pattern	The organization conducts an initial assessment of staff competence. This assessment is documented.	1) Observed in HR File Review at Alabama Clinical Schools, Inc. ([redacted] Birmingham, AL) site . The HCO was unable to demonstrate in two (2) of four (4) contracted provider personnel files that an initial competency evaluation had been completed. This was affirmed by the Human Resources Director.
MM.03.01.01	7	Low Limited	For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. Note: This element of performance is also applicable to sample medications.	1) Observed in Medication Management Tracer at Alabama Clinical Schools, Inc. [redacted] Birmingham, AL) site . The HCO was unable to demonstrate that an opened multi-dose vial of tuberculin PPD had been labeled with a discard date compatible with the manufacturer's recommended instructions for use. This was affirmed by the Director of Nursing.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.01.03	5	The organization performs screenings and assessments as defined by the organization's policy.	When relevant to the individual's current care, treatment, or services, as determined by the organization, the organization gathers clinical/case information from both inpatient and outpatient providers who have treated the individual. When it is not possible to obtain this information, the organization documents the reason why it could not be obtained.
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.03.01.03	3	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress
CTS.04.03.33	3	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
HRM.01.02.01	1	The organization verifies and evaluates staff qualifications.	The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal. Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Standard	EP	Standard Text	EP Text
			Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member's license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care or human services organization, then primary source verification does not need to be completed a second time by the organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.
HRM.01.02.01	4	The organization verifies and evaluates staff qualifications.	The organization obtains a criminal background check on the job applicant as required by law and regulation or organization policy. Criminal background checks are documented.
HRM.01.02.01	5	The organization verifies and evaluates staff qualifications.	Staff comply with health screening in accordance with law and regulation or organization policy. Health screening compliance is documented. Note: Organizations should consider the applicability of the Americans with Disabilities Act to their assignment of job duties and responsibilities, and, if applicable, review their policies and procedures. In addition, federal entities are required to comply with the Rehabilitation Act of 1974.
HRM.01.03.01	3	The organization provides orientation to staff.	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.
HRM.01.06.01	3	Staff are competent to perform their job duties and responsibilities.	The organization conducts an initial assessment of staff competence. This assessment is documented.
MM.03.01.01	7	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. Note: This element of performance is also applicable to sample medications.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Final Accreditation Report

Alabama Clinical Schools, Inc

[redacted]

Birmingham, AL [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 3/3/2021

ESC Programs Reviewed
Behavioral Health Care and Human Services

Final Report: Posted 3/3/2021

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- Standards/Elements of Performance (EP) Language 5

The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	3/3/2021	No Requirements for Improvement	None	None

Appendix 70.

CONFIDENTIAL UHS-FINHELP-00009205

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health Care and Human Services

Standard	Level of Compliance
CTS.02.01.03	Compliant
CTS.02.01.11	Compliant
CTS.03.01.03	Compliant
CTS.04.03.33	Compliant
HRM.01.02.01	Compliant
HRM.01.03.01	Compliant
HRM.01.06.01	Compliant
MM.03.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.01.03	5	The organization performs screenings and assessments as defined by the organization's policy.	When relevant to the individual's current care, treatment, or services, as determined by the organization, the organization gathers clinical/case information from both inpatient and outpatient providers who have treated the individual. When it is not possible to obtain this information, the organization documents the reason why it could not be obtained.
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.03.01.03	3	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress
CTS.04.03.33	3	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
HRM.01.02.01	1	The organization verifies and evaluates staff qualifications.	The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal. Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Standard	EP	Standard Text	EP Text
			Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member's license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care or human services organization, then primary source verification does not need to be completed a second time by the organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.
HRM.01.02.01	4	The organization verifies and evaluates staff qualifications.	The organization obtains a criminal background check on the job applicant as required by law and regulation or organization policy. Criminal background checks are documented.
HRM.01.02.01	5	The organization verifies and evaluates staff qualifications.	Staff comply with health screening in accordance with law and regulation or organization policy. Health screening compliance is documented. Note: Organizations should consider the applicability of the Americans with Disabilities Act to their assignment of job duties and responsibilities, and, if applicable, review their policies and procedures. In addition, federal entities are required to comply with the Rehabilitation Act of 1974.
HRM.01.03.01	3	The organization provides orientation to staff.	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.
HRM.01.06.01	3	Staff are competent to perform their job duties and responsibilities.	The organization conducts an initial assessment of staff competence. This assessment is documented.
MM.03.01.01	7	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. Note: This element of performance is also applicable to sample medications.

Appendix 70.

CONFIDENTIAL UHS-FINHELP-00009208

UHS-FINHELP-00009210 [Redacted]

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, ALABAMA 36130-1410
WWW.MH.ALABAMA.GOV

KAY IVEY
GOVERNOR

KIMBERLY G. BOSWELL
COMMISSIONER

January 27, 2021

Mr. [redacted]
Executive Director
Alabama Clinical Schools, Inc.
[redacted]
Birmingham, Alabama [redacted]

Dear Mr. [redacted]

Enclosed please find the site visit report for Alabama Clinical Schools, Inc. for the community standards certification site visit conducted on January 20-21, 2021, and the certificates of compliance, indicating they meet the Department of Mental Health standards for operation. These certificates must be posted in the respective facilities at all times and are not transferable to any other locations or entities.

I extend my thanks to you and your staff for the services you provide. Should you have any questions concerning the foregoing, please contact the Office of Certification Administration at 334-353-2069.

Sincerely,

[redacted]
Commissioner

[redacted]

Enclosure

cc: [redacted]

Alabama Department of Mental Health

Mental Illness Site Visit Report

1. **Site Visit Scoring Summary.**
2. **Administrative Findings.**
3. **Programmatic Findings.**

Alabama Department of Mental Health

CERTIFICATION SITE VISIT SCORING SUMMARY

DIVISION: **Mental Health and Substance Abuse Division**

TYPE VISIT: ☒ **Regular** ☐ **Follow-up** ☐ **Initial (TOA)** ☐ **Corrected** ☐ **For Cause**

AGENCY: Alabama Clinical School

ADDRESS: [redacted] Birmingham **State:** Alabama **Zip Code:** [redacted]

EXECUTIVE DIRECTOR: [redacted]

SUB-CONTRACT AGENCY: ☐ **Yes** ☐ **No**
Agency Name:
Address: **City:** **State:** **Zip Code:**

SURVEYOR(S): [redacted] and [redacted]

DATE(S) OF SITE VISIT: January 20-21, 2021

Service/Site Name	Certification File #	Date of Review	Score	Recommended Certification	Plan of Action
Administrative Services					
Governing Body	3458	1/20/2021	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Mental Illness Program Staff	3459	1/20/2021	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Quality Assurance	3457	1/21/2021	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Administrative Services	2792	1/20/2021	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Residential					
Alabama Clinical Schools CRF	2057	1/20/2021	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Child and Adolescent Seclusion/Restraint	3456	1/20/2021	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Rehabilitative Intervention Service Enrichment (RISE) CRF	6060	1/21/2021	99%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
RISE CRF Seclusion/Restraint	6198	1/21/2021	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No

SITE VISIT REPORT

This is a summary of the findings reported to the agency Executive Director during the exit interview. **Action plans are required for providers who receive a Provisional or a one (1) year score. A written plan of action should be submitted to the Office of Certification Administration, within 30 days of receipt of this report.**

ADMINISTRATIVE FINDINGS

N/A

PROGRAMMATIC FINDINGS

Certification File Number: 6060

Administrative Code: 580-2-9-.08 (3) General Clinical Practice
Finding(s): Services were not individualized, well planned, based on a comprehensive mental health evaluation and assessment of needed treatment and support, and include treatment designed to enhance the consumer's abilities to recover and function in society as normally as possible. **Note:** A CANS assessment was not completed on each consumer.
Record(s): 2656

UHS-FINHELP-00009216 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: Cumberland Hospital, LLC

Date of Inspection: 06-20-2019
Program Type/Facility Name: Cumberland Hospital

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
300.B.3 - Application - references check	N	B. The records of each employee shall include: 3. Written references or notations of oral references. In review of Employee #1, #2, and #3's personnel record, listed is employment verification. There is no documented evidence of written or notations of oral references within the personnel record.	PR: The facility will obtain at least one written reference and/or confirmation of an oral reference prior to extending on offer of employment. Confirmation of reference checks will be maintained in the permanent employee HR file. The facility's Director of Human resources is the responsible person assigned to this action. Monitoring Plan: The HRD the category "References check" to the tracking system for all new-hire documentation elements. For a minimum of 90 days, the HRD will audit 100% of new employee files to ensure that documentation of reference checks have been included in the employee's permanent file. OLR: Accepted, 8/9/2019	08/01/2019
70 - Compliance with human rights regulations	N	12VAC35-115-230.A-1/2-3 - Provider Requirements for Reporting. which states: A. Providers shall collect, maintain, and report the following information concerning abuse, neglect, and exploitation: 1. The director of a facility operated by the department shall report allegations of abuse and neglect via the department's web-based reporting application in accordance with all applicable operating instructions issued by the commissioner or his designee. 2. The director of a service licensed or funded by the department shall report each allegation of abuse or neglect via the department's web-based reporting application within 24 hours of receipt of the allegation (see 12VAC35-115-175). 3. The investigating authority shall provide a written report of the results of the investigation of abuse or neglect to the director and human rights advocate via the department's web-based reporting application within 10 working days from the date the investigation began unless an extension has been granted (see 12VAC35-115-175) This regulation was not met as evidenced by the following: Incident reports reviewed in the time-frame between 01/2019 thru 06/2019 that was peer to peers and was reported on the Human Right in CHRIS. The following incidents were not reported with-in the time-frame required by the Human Rights regulations.	PR: The facility will enter all reportable incidents into the CHRIS system hereto forward. Senior Human Rights Advocate with DBHDS, will conduct a training with the Cumberland RTC Program Manager, Director of Clinical Services, and the Cumberland Patient Rights Advocate which covers the elements of regulation 12VAC35-115-230.A1/2-3, including incident reporting via the CHRIS system. The facility will complete a retrospective review of on all (24) missing incidents noted in the survey report with scheduled training session. The Residential Program Manager will forward all copies of completed CHRIS reports as well as copies of the facility's investigation to the Cumberland Patient Advocate for compliance monitoring. The Director of Clinical Services will audit 100% of CHRIS investigations to include all elements of Residential Human Rights reporting for a minimum of 90 days to ensure that the process is completed timely and according to the regulations. Human Rights reporting tracking will be reported monthly to the facility's PI and Medical Executive committees. The Director of Clinical Services will be responsible for the actions noted in this section of the corrective action. OLR: Accepted, 8/9/2019	08/07/2019

Appendix 72.

Investigation ID:
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **06-20-2019**
Program Type/Facility Name: **Cumberland Hospital**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		1. Individual #1 -02/23/19 -03/13/19 -05/25/19 2. Individual #2 -02/23/19 -02/26/19 -03/13/19 3. Individual #3 -03/12/19 4. Individual #4 -04/21/19 -04/24/19 -05/10/19 -05/12/19 -05/20/10 -06/09/19 5. Individual #5 -04/24/19 6. Individual #6 -05/20/19 -05/12/19 -06/09/19 -06/16/19 7. Individual #7 -05/25/19 8. Individual #8 -05/13/19 -06/12/19 -05/12/19 9. Individual #9 -04/05/19 10. Individual #10 -06/09/19		
765.H.1.a - Discharge summaries-services provided	N	H. Discharge summaries. 1. No later than 30 days after discharge, a comprehensive	PR: Policy 352.13 on Discharge from Residential Program Item 6.b.#4 was added to include—	06/21/2019

Appendix 72.

Investigation ID:
License #: [redacted]
Organization Name: Cumberland Hospital, LLC

Date of Inspection: 06-20-2019
Program Type/Facility Name: Cumberland Hospital

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: a. Services provided to the resident This regulation was NOT MET as evidenced by: In review of the provider's policies and procedures, the above component is not listed as a requirement when completing the comprehensive discharge summary. The provider will need to update their policy and procedure manual to reflect the above component.	-services provided to the resident. Discharge Summary Template was reviewed by the Director of HIM. Updated template to include: •Section for Services Provided to the Resident All Discharge Summaries will be audited for the next 90 (or until 100% compliant) days to assure new template is being used and all components are present. (July, August, and Sept). Responsible person for this action will be the Director of Health Information Management. The HIM Director conducted training with HIM staff to inform staff of the minor changes to the Residential Program Discharge Summary template. OLR: Accepted, 8/9/2019	
765.H.1.c - Discharge summaries-continuing needs	N	1. No later than 30 days after discharge, a comprehensive discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: c. The resident's continuing needs and recommendations, if any, for further services and care. This regulation was NOT MET as evidenced by: In review of the provider's policies and procedures, the above component is not listed as a requirement when completing the comprehensive discharge summary. The provider will need to update their policy and procedures manual to reflect the above component.	PR: Policy 352.13 on Discharge from Residential Program Item 6.b.#6 was added to include— The resident's continuing needs and recommendations, if any, for further services and care. Discharge Summary Template was reviewed by the Director of HIM. Updated template to include: •A Category under the "Continuing Needs and Recommendations Section" for "Other Services/Care" All Discharge Summaries will be audited for the next 90 (or until 100% compliant) days to assure new template is being used and all components are present. (July, August, and Sept). Responsible person for this action will be the Director of Health Information Management. The HIM Director conducted training with HIM staff to inform staff of the minor changes to the Residential Program Discharge Summary template. OLR: Accepted, 8/9/2019	07/17/2019
765.H.1.e - Discharge summary: Dates of admission and discharge	N	1. No later than 30 days after discharge, a comprehensive discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: e. Dates of admission and discharge.	PR: Policy 352.13 on Discharge from Residential Program Item 6.b.#7 was added to include— Dates of admission and discharge. Discharge Summary Template was reviewed by the	07/17/2019

Appendix 72.

Investigation ID:
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **06-20-2019**
Program Type/Facility Name: **Cumberland Hospital**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		This regulation was NOT MET as evidenced by: In review of the provider's policies and procedures, the admission date is not listed as a requirement when completing the comprehensive discharge summary. The provider will need to update their policy and procedures manual to reflect the above component.	both Admission and Discharge dates of the resident. All Discharge Summaries will be audited for the next 90 (or until 100% compliant) days to assure new template is being used and all components are present. (July, August, and Sept). Responsible person for this action will be the Director of Health Information Management. The HIM Director conducted training with HIM staff to inform staff of the minor changes to the Residential Program Discharge Summary template. OLR: Accepted, 8/9/2019	
765.H.1.f - Discharge summaries-date and signature	N	1. No later than 30 days after discharge, a comprehensive discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: f. Date the discharge summary was prepared and the signature of the person preparing it. This regulation was NOT MET as evidenced by: In review of the provider's policies and procedures, the above component is not listed as a requirement when completing the discharge summary. The provider will need to update their policy and procedures manual to reflect the above component.	PR: Policy 352.13 on Discharge from Residential Program Item 6.b.#8 was added to include— Date the discharge summary was prepared and the signature of the person preparing it. Discharge Summary Template was reviewed by the Director of HIM. Confirmed template includes section for the date the summary was prepared and the signature of the person preparing it. All Discharge Summaries will be audited for the next 90 (or until 100% compliant) days to assure new template is being used and all components are present. (July, August, and Sept). Responsible person for this action will be the Director of Health Information Management. The HIM Director conducted training with HIM staff to inform staff of the minor changes to the Residential Program Discharge Summary template. OLR: Accepted, 8/9/2019	07/17/2019

Appendix 72.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #[redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **06-20-2019**
Program Type/Facility Name: **Cumberland Hospital**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

[redacted] Specialist

email to: [redacted]

(Signature of Organization Representative)

Date

Due Date: 08-06-2019

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

Appendix 72.

UHS-FINHELP-00009223 [Redacted]

Investigation ID:4
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **10-22-2020**
Program Type/Facility Name: **RTC Cumberland Unit 9**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
1070.A - Any serious incident reported w/in 24 hours to placing agency and guardian	N	A. Any serious incident, accident, or injury to the resident; any overnight absence from the facility without permission; any runaway; and any other unexplained absence shall be reported within 24 hours (i) to the placing agency; (ii) to either the parent or legal guardian, or both as appropriate; and (iii) noted in the resident's record. This regulation was NOT MET as evidenced by: In review of the serious incident reports for Individual #1, the provider failed to notify the department via web-based reporting service of serious incidents for the following dates: May 18, 2020; August 18, 2020; September 22, 2020.	The facility's Director of Risk Management is the responsible person for entering serious incidents in the department's web-based reporting service. The facility's former Director of Risk Management, effective 11/25/2020, failed to enter the noted incidents from 5/18, 8/18 and 9/22/2020 in the system upon identification of the deficiency by the agency's reviewers prior to his departure from employment at the facility. The facility's Director of Quality reviewed the identified incident reports for Individual #1 internally and determined that they are reportable via the web-based incident reporting system. The facility will correct the deficiency for Individual #1 on dates: 5/18, 8/18 and 9/22/2020 by entering/completing the reports in the department's web-based reporting application by 12/12/2020. The facility's newly-hired Director of Risk Management (11/30/2020) is the responsible person for this action. The Director has requested expedited access to the system, but as of this writing has not yet received the ability to complete the reports. Access is expected to be granted this week and the Director of Risk will work with the agency to complete/update the reports as required. Ongoing reporting via the CHRIS system will be completed as required by 12VAC35-115-230 A.2: Provider Requirements for Reporting, by the facility's Director of Risk Management. To ensure sustained compliance with the regulation, the Director of Risk will report internally, on a daily basis, during morning flash meeting, the detail of the previous day's incident reports for all DBHDS licensed patients via an electronic report produced directly from the facility's internal incident reporting system. The report shall contain all incidents recorded for DBHDS licensed patients from the previous day. During or immediately following flash meeting, the Director of Risk will identify those incidents requiring reporting via the CHRIS system and will adhere to the requirement that those incidents be entered by the end of the business day. The facility further agrees with the recommendation noted at the end of the report that the provider would benefit from attending a CHRIS training hosted by the OHR in order to improve a better understanding of the reporting	12/12/2020

Appendix 73.

Investigation ID:4
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **10-22-2020**
Program Type/Facility Name: **RTC Cumberland Unit 9**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			requirements. The provider agrees to schedule this training with OHR at its earliest convenience.	
680.B - Serious incident reports sent Interstate Compact	NS	B. Documentation that the provider has sent copies of all serious incident reports regarding any child placed through the Interstate Compact to the administrator of the Virginia Interstate Compact on the Placement of Children shall be kept in the resident's record. This regulation was NON COMPLIANT SYSTEMIC as evidenced by: There is no documentation in Individual #1's records to indicate that the provider sent copies of all serious incident reports, specifically abuse reports, to the administrator of the Virginia Interstate Compact on the Placement of Children. This is a repeated citation. The provider was cited in January 2020 and the provider did not follow their CAP which was approved on 3/10/20. The approved CAP states: "A new policy, HP 399.00, was written to address the procedure for serious incident reporting requirements associated with Interstate Compact Agreements. A copy of the new policy is provided." "Educational training was completed on 2/19/2020 for the RTC Case Manager, Program Director, the Admission Coordinator and all hospital case management staff members regarding submission of serious incident reporting requirements to the VICPC Administrator and the need to maintain documentation of said submissions in the resident's chart." "To ensure sustained compliance with the elements of the new facility policy, records of out-of-state residents will be audited for a minimum of 90 days of sustained 100% compliance with the elements of the policy to include that copies of all serious incident reports, if any, have been sent to the administrator of the Virginia Interstate Compact on the Placement of Children."	The Director of Case Management is identified as the responsible person for the items identified in this corrective action and ongoing compliance with regulation 680.B As corrective action for the noted immediate finding, the provider sent, via e-mail, copies of Individual #1's serious incident reports to the administrator of the Virginia Interstate Compact on the Placement of Children on 12/4/2020. To further address the systemic issue of repeated non-compliance with the requirement to notify the administrator of the Virginia Interstate Compact on the Placement of Children, the facility's Directors of Quality, Case Management and Risk met on 12/4/2020 to discuss and develop a robust process for identification and communication of incidents which require reporting to the VICPC to facility case managers as specified by facility policy #399.00. Specifically, the Director of Risk will provide to the Director of Case Management, on a daily basis, during morning flash meeting, the detail of the previous day's incident reports for all DBHDS licensed patients via an electronic report produced directly from the facility's internal incident reporting system. The report shall contain all incidents recorded for DBHDS licensed patients from the previous day. During or immediately following flash meeting, the Director of Risk and the Director of Case Management will highlight those incidents requiring reporting to the administrator of VICPC. The Director of Case Management will then forward the reports and information directly to the case manager(s) responsible for the patient(s) involved in the incidents so that timely reporting to VICPC can be completed by the end of the business day. The facility will begin this process on 12/7/2020 and it will become a permanent process. To ensure sustained compliance with reporting of incidents to VICPC, the Director of Case Management shall require that case managers provide a copy, on a weekly basis, of all incidents reported to the administrator VICPC for an	12/4/2020 12/7/2020

Appendix 73.

Investigation ID:4
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **10-22-2020**
Program Type/Facility Name: **RTC Cumberland Unit 9**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		"The responsible person for the corrective action is the facility's Director of Admissions and Case Management."	audit against the Risk list of incidents originally identified as "reportable." The Director shall continue to audit compliance with incident reporting to VICPC for a minimum of 180 days of sustained 100% compliance. Instances of noncompliance identified, if any, will be corrected by an immediate reporting of the incident to the administrator, VICPC and corrective action, up to and including termination for repeated noncompliance, with the responsible facility case manager.	
70 - Compliance with human rights regulations	N	12VAC35-115-230 A.2: Provider Requirements for Reporting which states: "The director of a service licensed or funded by the department shall report each allegation of abuse or neglect via the department's web-based reporting application within 24 hours of receipt of the allegation." This regulation was NOT MET as evidenced by the following: The director is required to report each allegation of abuse or neglect via CHRIS within 24 hours of receipt of the allegation. As of 11/2/2020, the listed allegations had not been entered into CHRIS. 1. A-20200011: Date of Incident: 2/24/2020. 2. A-20200012: Date of Incident: 3/21/2020. 3. A-20200006: Date of Incident: 5/18/2020. 4. A-20200008: Date of Incident: 8/11/2020. 5. A-20200007: Date of Incident: 8/18/2020.	The facility's Director of Risk Management is the responsible person for entering allegations of abuse or neglect in DBHDS's web-based reporting application. The facility's former Director of Risk Management, effective 11/25/2020, failed to enter the noted incidents in the system upon identification of the deficiency by the agency's reviewers prior to his departure from employment at the facility. Of note, the following identified deficient reports are believed to be not applicable to the agency's web-based reporting system: A-20200011 – 2/24/2020: Patient was admitted to Cumberland's Hospital Program at the time of this incident. CHRIS report is not applicable for VDH Hospital Program patients. Incident Report should be deleted from the CHRIS system. A-20200012 – 3/21/2020: Patient was admitted to Cumberland's Hospital Program at the time of this incident. CHRIS report is not applicable for VDH Hospital Program patients. Incident Report should be deleted from the CHRIS system. The facility's Director of Quality reviewed the remaining identified incident reports internally and determined that they are reportable via the CHRIS system. The facility will correct the deficiency for reports A-20200006, A-20200008, and A-20200007 by entering/completing the reports in the department's web-based reporting application by 12/12/2020. The facility's newly-hired Director of Risk Management (11/30/2020) is the responsible person for this action. The Director has requested expedited access to the system, but as of this	12/12/2020

Appendix 73.

Investigation ID:4
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **10-22-2020**
Program Type/Facility Name: **RTC Cumberland Unit 9**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			writing has not yet received the ability to complete the reports. Access is expected to be granted this week and the Director of Risk will work with the agency to complete/update the reports as required. Ongoing reporting via the CHRIS system will be completed as required by 12VAC35-115-230 A.2: Provider Requirements for Reporting, by the facility's Director of Risk Management. To ensure sustained compliance with the regulation, the Director of Risk will report internally, on a daily basis, during morning flash meeting, the detail of the previous day's incident reports for all DBHDS licensed patients via an electronic report produced directly from the facility's internal incident reporting system. The report shall contain all incidents recorded for DBHDS licensed patients from the previous day. During or immediately following flash meeting, the Director of Risk will identify those incidents requiring reporting via the CHRIS system and will adhere to the requirement that those incidents be entered by the end of the business day.	
750.B.3 - ISP describes goals,objectives, strategies	N	B. Individualized service plans shall describe in measurable terms the: 3. Goals, objectives, and strategies established for the resident. This regulation was NOT MET as evidenced by: Review of Individual #1's current ISP was not revised to include relevant goals, objectives and strategies to meet their individualized needs. Based on an interview with the individual, Individual #1 was placed on Sexual Aggression Precaution (SAP), but the current ISP was not revised to reflect this plan or a change in supervision.	The Director of Case Management is identified as the responsible person for the items identified in this corrective action and ongoing compliance with regulation 750.B.3 Individual #1's case manager is the responsible person for revising the patient's individualized service plan to reflect the patient's change in precautions status. The Director of Quality reviewed the patient's service plan and determined that individual #1 was placed on Sexual Aggression Precautions on 9/14/2020 via an order from her attending physician; however the precaution status was not updated on the patient's 9/15 or 10/13/2020 service plans. As corrective action for the noted finding, the Director of Quality re-educated the Residential Program case manager on the requirement to update a resident's service plan to include any change in precautions status or level of observation during the previous review period. The education was completed on 12/4/2020. The case manager was provided copies of Individual #1's deficient service plans for reference and she demonstrated understanding of how and where to document precautions or supervision changes on the service plan document.	12/4/2020

Appendix 73.

Investigation ID:4
License #[redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **10-22-2020**
Program Type/Facility Name: **RTC Cumberland Unit 9**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			To ensure sustained compliance with the requirement to update an individual's change in precaution or observation status, if any, on the individual's service plan, residential service plans for all residents will be audited for a minimum of 90 days of sustained 100% compliance with the requirement that precaution and level of observation status be documented on the service plan.	
870.F.1 - Supervision P&P's based on population, services, qualifications, number of residents	N	F. Supervision policies. 1. The provider shall develop and implement written policies and procedures that address staff supervision of children including contingency plans for resident illnesses, emergencies, off-campus activities, and resident preferences. These policies and procedures shall be based on the: a. Needs of the population served; b. Types of services offered; c. Qualifications of staff on duty; and d. Number of residents served. This regulation was NOT MET as evidenced by: The provider's policies state the following: Every 15 minute (routine) observation is the minimum level of observation for all patients. Staff will observe patient and document on the patient observation record every 15 minutes. Assigned staff should observe for the rise and fall of the patient's chest to ensure he/she is breathing without difficulty. Staff will be vigilant for potential risk factors identified for specific patient's (levels of precautions). Assigned staff will observe patient's on bed rest or when sleeping. In discussion with Staff #1 and review of the security video, the provider failed to comply with their own policy and procedures. The staff assigned to this shift failed to comply with the 15 minute observation. In addition, according to Staff #3, the Unit is separate by gender. Either gender is not permitted to enter the opposite side of the Unit. As evidence by the review of the security video, Individual #1 entered the Boys side of the Unit to engage with Individual #1. Staff #3 was viewed at the Nurses Station, which Individual #1 needed to bypass in order to enter the Boys side of the Unit.	The Chief Nursing Officer is identified as the responsible person for the actions concerning this finding and the ongoing compliance with regulation 870.F.1 To correct the finding that the provider failed to provide adequate supervision of the individuals assigned to this Unit, the facility will provide re-education for all direct care staff assigned to the Residential Unit on the facility's policy #392, "Policy on Levels of Observation." The training will be conducted by the facility's Assistant Director of Nursing. The redacted details of the patient incident on 9/22/2020 will be provided as reference material to provide staff a deeper understanding of the necessity for adherence to all elements of the policy. Staff training for all regular staff is expected to be completed by 12/12/2020 and for PRN staff prior to the start of their next scheduled shift. To ensure ongoing compliance with the requirements of policy #392, the facility's senior leadership team will continue to conduct random, daily rounds to assess staff's compliance with documentation of every 15 minute patient status checks. The facility's Director of Risk Management will further perform random, monthly security camera review of the Residential Unit to assess that staff is complying with every 15 minute patient observation rounds. As additional corrective action and to provide a physical deterrent from female patients being able to enter the male patients side of the building and vice versa, the Director of Plant Operations installed a half door at the nursing station to provide a physical separation from one side of the unit to the other. The barrier was installed on 11/30/2020.	12/12/2020 11/30/2020

Appendix 73.

Investigation ID:4
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **10-22-2020**
Program Type/Facility Name: **RTC Cumberland Unit 9**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		The provider failed to provide adequate supervision of the individuals assigned to this Unit.		

Appendix 73.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:4
License #: [redacted]
Organization Name: **Cumberland Hospital, LLC**

Date of Inspection: **10-22-2020**
Program Type/Facility Name: **RTC Cumberland Unit 9**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
OHR Recommendation:

1. Upon review of the following CHRIS entries entered by the, it appears that the provider would benefit from attending a CHRIS training hosted by the OHR in order to improve a better understanding of the reporting requirements.

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

[redacted] Specialist

(Signature of Organization Representative)

Date

email to: [redacted]

Due Date: 12-07-2020

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

Appendix 73.

UHS-FINHELP-00009230 [Redacted]

CONFIDENTIAL

John Kasich,
Governor

Tracy Plouck,
Director

Ohio Department of Mental Health and Addiction Services

Ohio MHAS
Promoting wellness and recovery

CERTIFICATE TO OPERATE AN ALCOHOL AND DRUG ADDICTION PROGRAM ISSUED TO:

Provider - 10672

Keystone Richland Center

[redacted]
Mansfield, OH [redacted]
Richland County

Owner

Keystone Richland Center LLC

[redacted]
Atlanta, GA [redacted]
Out of State County

PROGRAM	Effective Date	Expiration Date
Outpatient	6/1/2017	10/25/2018

[redacted]
Director

CERTIFICATION WAS ISSUED BASED, IN PART,ON THE SURVEY REPORT OF A DEPARTMENT RECOGNIZED ACCREDITING ORGANIZATION

In accordance with section 3793.06 of the Ohio Revised Code and section 3793 of the Ohio Administrative Code, this certificate is not assignable or transferable to any Owner or Provider other than those listed herein

UHS-FINHELP-00009230

Promoting wellness and recovery

John R. Kasich, Governor • Mark Hurst, M.D., Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

November 7, 2018

[redacted] CEO
Keystone Richland Center Dba Foundations for Living
[redacted]
Mansfield, OH [redacted]

Re: Certification #[redacted]

Dear Ms. [redacted]:

The purpose of this letter is to provide you with documentation regarding the status of **Keystone Richland Center Dba Foundations for Living**, Ohio Mental Health and Addiction Services certification. Please be advised that the Provider's OhioMHAS certification remains current and valid pending the renewal certification according to the provisions of Administrative Rule 5122-25-04. Please feel free to share this letter as needed to verify the current and valid certification of **Foundations for Living**, including all applicable service locations.

If you have any questions regarding this subject, please contact me at [redacted] or at [redacted]@mha.ohio.gov.

Sincerely,

[redacted]
Behavioral Health Standards Surveyor
Bureau of Licensure and Certification

pc: [redacted] Chief, Bureau of Licensure and Certification, OhioMHAS
[redacted] Executive Director, Mental Health & Recovery Services Board of Richland County
[redacted] JD, MSN, RN, Supervisor, Bureau of Licensure and Certification, OhioMHAS
[redacted] Foundations For Living
Certification File

Promoting wellness and recovery

John R. Kasich, Governor • Mark Hurst, M.D., Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

November 26, 2018

[redacted] CEO
Keystone Richland Center dba Foundations for Living
[redacted]
Mansfield, OH [redacted]

Dear Ms. [redacted]

This letter is a follow-up to the Department's on-site survey on November 1, 2018, which was conducted in response to your agency's request for certification of **Mental Health Day Treatment** in accordance with 5122-29-06 of the Ohio Administrative Code (OAC).

This correspondence outlines the Department's findings during the survey and summarizes corrective actions that are required to comply with Ohio Department of Mental Health and Addiction Services (OhioMHAS) certification standards.

5122-27-03 Treatment Planning

(B) The development of the ITP is a collaborative process between the client and service provider based on a diagnostic assessment, a continuing assessment of needs, and the identification of interventions and services appropriate to the individual's diagnosis and other related needs. An AoD case management plan of care may be based upon the diagnostic assessment or a separate case management assessment.

(C) The ITP shall document, at a minimum, the following:

(1) A description of the specific mental health or addiction services and supports needs of the client, including the AoD level of care if applicable

(2) Anticipated treatment goals and objectives based upon the needs identified in this rule. Such goals shall be mutually agreed upon by the provider and the client. If these goals are not mutually agreed upon, the reason needs to be fully documented in the ICR;

(3) Name or description of all services being provided;

(4) Frequency and duration of treatment services;

(D) An initial ITP may be developed within seven days of completion of the assessment or at the time of the first face-to-face contact following assessment, whichever is later. An initial ITP is one which documents the immediate clinical needs of the client, and includes the items required of an ITP in paragraphs (C)(1) and (C)(3) of this rule to meet those immediate needs.

(G) The ITP shall be periodically reviewed at the client's request; when clinically indicated; when there is a change in the level of care; or when a recommended service is added, terminated, denied, or no longer available to the client.

Findings: During the review of client records, the Mental Health Day Treatment program is not being supported by the client's ITP. Throughout documentation, it was determined that the ITP's are being developed prior to the completion of the assessment. In addition, there were no ITP updates to reflect the need for Mental Health Day Treatment services which would include the treatment goals and objectives specific to Mental Health Day Treatment and the frequency and duration Mental Health Day Treatment is to be provided.

Note: The provider is also providing CPST, however, this service is not documented in clients ITP as a treatment recommendation.

Corrective Action: The provider shall provide a proposal that ensures development of the ITP is based upon a diagnostic assessment and a continuing assessment of the client's needs. The provider shall provide a plan that ensures a review of the ITP is completed when there is a recommendation to add a service such as Mental Health Day Treatment which includes the treatment goals and objectives specific to the service being added and includes the frequency and duration of the service.

5122-27-04 Progress Notes

(D) Service level progress noted shall include, at a minimum, the following:

(3) The location of the service contact;

(4) A description of the service rendered;

(5) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;

Findings: During the review of client records, the location of the service was not consistently documented on the group notes. Progress notations do not contain a description of the Mental Health Day Treatment service rendered and did not include an assessment of the client's progress or lack of progress, and a brief description of progress made, if any. Also, the progress notation did not support that Mental Health Day Treatment is being provided in accordance with the rule requirements. Progress notes for QMHS Day Treatment included: educating on proper hygiene, cleaning up bathrooms, and using deodorant, which are activities that are provided as part of the daily residential milieu. Also, there were Mental Health Day Treatment notes for helping residential staff conduct community meetings to discuss resident concerns and doing exercise as part of the day treatment program, however none of these activities were identified as goals or objectives on the youths ITP nor do they meet the criteria of structured intensive activities under

Mental Health Day Treatment services. Additionally, in reviewing day treatment progress notation, specifically group notes, it was also identified that the agency is providing relapse prevention, AA/NA groups, substance abuse group therapy, even though the youth did not have a substance use diagnosis.

Corrective Action: The provider shall provide a proposal that ensures how future client records will consistently document the location of the service on the progress notes. The provider shall provide a proposal that ensures how future client records will contain a description of the Mental Health Day Treatment service rendered and include an assessment of the client's progress or lack of progress, and a brief description of progress made, if any. Additionally, the provider shall provide a proposal that ensures progress notations support the need for provisions of services being provided to clients.

5122-29-03 General Services

(C) Assessment activities:

(1) An assessment:

(b) Determines diagnosis, treatment needs, and establishes a treatment plan to address the person's mental illness or substance use disorder.

(2) When the assessment is to be provided to a client it should start prior to the initiation of other services, except for emergency situations.

(D) Counseling and therapy

(3) Group counseling and therapy encounters may not exceed a 1-to-12 behavioral health professional to patient ratio.

Findings: During the review of client records, the diagnostic assessments are not being updated to include Mental Health Day Treatment services as a treatment recommendation. The initial ITP's are being developed prior to completion of the assessment. The behavioral health professional to patient ratio is not consistently documented on group notes.

Corrective Action: The provider shall provide a proposal that ensures assessments are utilized to determine a client's treatment needs and establish a treatment plan based on treatment needs and recommendations. Also, the provider shall provide a proposal that ensures assessments are being developed prior to the initiation of other services.

5122-29-06 Mental Health Day Treatment

(A) Mental health day treatment services are clinically indicated by assessment with clear admission and discharge criteria. The environment at this level of treatment is highly structured, and there should be an appropriate staff-to-client ratio in order to guarantee sufficient therapeutic services and professional monitoring, control, and protection.

(C) Mental health day treatment must be an intense treatment service that consists of high levels of face-to-face mental health interventions that address the individualized mental health needs of the individual as identified in their individualized treatment plan (ITP).

(E) For purposes of this rule, a mental health day treatment program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities that may include, but are not limited to, the following:

(1) Determination of needed mental health interventions;

(2) Skills development

(a) Interpersonal and social competency as age, developmentally, and clinically appropriate, such as:

(i) Functional relationships with adults;

(ii) Functional relationship with peers;

(iii) Functional relationship with the community/schools;

(iv) Functional relations with employer/family; and

(v) Functional relations with authority figures.

(b) Problem solving, conflict resolution, and emotions/behavior management.

(c) Developing positive coping mechanisms;

(3) Managing mental health and behavioral symptoms to enhance vocational/school opportunities and/or independent living; and

(4) Psycho-educational interventions including individualized instruction and training of persons served in order to increase their knowledge and understanding of their psychiatric diagnosis(es), prognosis(es), treatment, and rehabilitation in order to enhance their acceptance of these psychiatric disabilities, increase their cooperation and collaboration with treatment and rehabilitation, improve their coping skills, and favorably affect their outcomes. Such education shall be consistent with the individual's ITP and be provided with the knowledge and support of the interdisciplinary/intersystem team providing treatment in coordination with the ITP.

(F) Providers of mental health day treatment services shall have a staff development plan based upon identified individual needs of mental health day treatment program staff. Evidence that the plan is being followed shall be maintained.

Findings: During the review of client records, the assessments do not clinically indicate the need for Mental Health Day Treatment services. Documentation does not support that the treatment is highly structured. Clients are participating in services/activities such as arts, crafts, playing board games, exercising, coordinated recreation, martial arts, free time and assigned lunch activities. These services/activities do not meet the criteria of intensive, goal oriented, distinct and identifiable treatment interventions for Mental Health Day Treatment. Again, the need for Mental Health Day Treatment services was not identified on any of the client ITP's. Additionally, there was no documentation to determine the staff-to-client ratio to guarantee sufficient therapeutic services and professional monitoring, control, and protection.

During the review of personnel records, providers of Mental Health Day Treatment services did not have a staff development plan in their file. Therefore, we were unable to determine if there were any identified individual needs of these individuals.

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Corrective Action: The provider shall submit a proposal that ensures assessments indicate the need for Mental Health Day Treatment services. The provider shall revise and submit for review the admission and discharge criteria for its Mental Health Day Treatment program which clearly identifies how the Mental Health Day Treatment service is distinct from the residential admission and discharge criteria and should specify the appropriate staff to client ratios to guarantee sufficient therapeutic services and professional monitoring, control and protection. Additionally, it shall identify how Mental Health Day Treatment will help stabilize, increase or sustain the highest level of functioning for the individual to develop the capacity to continue to work towards an improved quality of life and promote movement to the least restrictive level of care.

The provider shall submit a proposal that ensures providers of Mental Health Day Treatment services have a staff development plan that is based upon identified individual needs and shall document the plan is being followed.

5122-29-30 Eligible providers and supervisors
(C) Qualified behavioral health specialist

> **(1)** Qualified behavioral health specialist (QBHS) means an individual who has received training for or education in either mental health or substance use disorder competencies; and who has demonstrated, prior to or within ninety days of hire the minimum competencies in basic mental health or substance use disorder and recovery skills listed in this rule. The individual shall not otherwise be required to perform duties covered under the scope of practice according to Ohio professional licensure.
>
> **(2)** Basis competencies for each QBHS shall include, at a minimum, an understanding of:
>
> > **(b)** The community behavioral health system, social service systems, the criminal justice system, and other healthcare systems;
> >
> > **(c)** Psychiatric and substance use disorder symptoms and their impact on functioning and behavior

Findings: During the review of personnel records, three of six QBHS staff that are providing Mental Health Day Treatment services did not have the required training or education in either mental health or substance use disorder competencies as noted above.

Corrective action: The provider shall submit a proposal that ensures QMHS staff receive training and education in either mental health or substance use disorder competencies to include (2)(b) and (c) as noted above.

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Please forward your agency's corrective actions to the Department by December 12, 2018. Your response must detail the agency's plan to address each of the identified areas of needed improvement. Please contact me at [redacted] or email at [redacted]@mha.ohio.gov if you have any questions or require additional clarification.

Sincerely,

[redacted]
Behavioral Health Standards Surveyor
Bureau of Licensure and Certification

pc: [redacted] Chief, Bureau of Licensure and Certification, OhioMHAS
[redacted] JD, MSN, RN, Program Administrator/Supervisor, Licensure and Certification, OhioMHAS
[redacted] surveyor, Licensure and Certification, OhioMHAS
[redacted] Executive Director, Mental Health & Recovery Services Board of Richland County
[redacted] Director of Risk Management & PI, Foundations for Living
Certification File

FOUNDATIONS FOR LIVING
a treatment center for youth

December 11, 2018

[redacted] B.S.N.
Behavioral Health Standards Surveyor
Ohio Department of Mental Health and Addiction Services

Dear Kelly,

Please see the below plan of correction for your site visit on 11/1/2018. Foundations For Living has reduced our Day Treatment services to only the Journey's program at this time. Please review the below plan and provide feedback as needed. We appreciate your willingness to assist us in meeting all requirements.

Foundations For Living
Plan of Correction for Day Treatment Certification

5122-27-03 Treatment Planning
(B) The development of the ITP is a collaborative process between the client and service provider based on a diagnostic assessment, a continuing assessment of needs, and the identification of interventions and services appropriate to the individual's diagnosis and other related needs. An AoD case management plan of care may be based upon the diagnostic assessment or a separate case management assessment.
(C) The ITP shall document, at a minimum, the following:
(1) A description of the specific mental health or addiction services and supports needs of the client, including the AoD level of care if applicable
(2) Anticipated treatment goals and objectives based upon the needs identified in this rule. Such goals shall be mutually agreed upon by the provider and the client. If these goals are not mutually agreed upon, the reason needs to be fully documented in the ICR;
(3) Name or description of all services being provided;
(D) An initial ITP may be developed within seven days of completion of the assessment or at the time of the first face-to-face contact following assessment, whichever is later. An initial ITP is one which documents the immediate clinical needs of the client, and includes the items required of an ITP in paragraphs (C)(1) and (C)(3) of this rule to meet those immediate needs.
(G) The ITP shall be periodically reviewed at the client's request; when clinically indicated; when there is a change in the level of care; or when a recommended service is added, terminated, denied, or no longer available to the client.

Findings: During the review of client records, the Mental Health Day Treatment program is not being supported by the client's ITP. Throughout documentation, it was determined that the ITP's are being developed prior to the completion of the assessment. In addition, there were no ITP updates to reflect the need for Mental Health Day Treatment services which would include the treatment goals and objectives specific to Mental Health Day Treatment and the frequency and duration Mental Health Day Treatment is to be provided.
Note: The provider is also providing CPST, however, this service is not documented in clients ITP as a treatment recommendation.

Corrective Action: The provider shall provide a proposal that ensures development of the ITP is based upon a diagnostic assessment and a continuing assessment of the client's needs. The provider shall provide a plan that ensures a review of the ITP is completed when there is a recommendation to add a service such as Mental Health Day Treatment which includes the treatment goals and objectives specific to the service being added and includes the frequency and duration of the service.

Facility Proposal:

Training will be provided on the importance of timely documentation and corrections of documentation to ensure that the assessment is completed and charted prior to the ITP (Completed a Golden Thread training on 11/28/18 and continued on 12/5/18). We updated the treatment plan to reflect day treatment services and to include frequency and duration of services as well as re-evaluation of continuing needs. A transition plan will also be implemented when a client enters or exits the day treatment program (see attached). All will be reviewed in a training on documentation on January 9, 2019. Utilization Review Specialist will send email reminders of when things are due, review the documentation and return for corrections as needed. Timeliness will be tracked by the utilization review specialist. Corrective action will be taken if this is not completed.

5122-27-04 Progress Notes
(D) Service level progress noted shall include, at a minimum, the following:
(3) The location of the service contact;
(4) A description of the service rendered;
(5) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;

Findings: During the review of client records, the location of the service was not consistently documented on the group notes. Progress notations do not contain a description of the Mental Health Day Treatment service rendered and did not include an assessment of the client's progress or lack of progress, and a brief description of progress made, if any. Also, the progress notation did not support that Mental Health Day Treatment is being provided in accordance with the rule requirements. Progress notes for QMHS Day Treatment included: educating on proper hygiene, cleaning up bathrooms, and using deodorant, which are activities that are provided as part of the daily residential milieu. Also, there were Mental Health Day Treatment notes for helping residential staff conduct community meetings to discuss resident concerns and doing exercise as part of the day treatment program, however none of these activities were identified as goals or objectives on the youths ITP nor do they meet the criteria of structured intensive activities under Mental Health Day Treatment services. Additionally, in reviewing day treatment progress notation, specifically group notes, it was also identified that the agency is providing relapse prevention, AA/NA groups, substance abuse group therapy, even though the youth did not have a substance use diagnosis.

Corrective Action: The provider shall provide a proposal that ensures how future client records will consistently document the location of the service on the progress notes. The provider shall provide a proposal that ensures how future client records will contain a description of the Mental Health Day Treatment service rendered and include an assessment of the client's progress or lack of progress, and a brief description of progress made, if any. Additionally, the provider shall provide a proposal that ensures progress notations support the need for provisions of services being provided to clients.

Facility Proposal:
Training will be provided to ensure that group notes include proper date, time, location and number of residents to staff present in the group (this was addressed during clinical meeting on 12/5/18). Training will be provided to ensure that notes are individualized and a notation of progress is made (Completed during clinicals on 12/5/18). Training about the importance of ensuring that group notes

are related to treatment plan goals and objectives will also occur (Completed a training on the Golden Thread on 11/28/18). Clinical director will address this during supervision and will review notes at that time. Corrective action will be issued for continued noncompliance.

5122-29-03 General Services
(C) Assessment activities:
(1) An assessment:
(b) Determines diagnosis, treatment needs, and establishes a treatment plan to address the person's mental illness or substance use disorder.
(2) When the assessment is to be provided to a client it should start prior to the initiation of other services, except for emergency situations.
(D) Counseling and therapy
(3) Group counseling and therapy encounters may not exceed a 1-to-12 behavioral health professional to patient ratio.

Findings: During the review of client records, the diagnostic assessments are not being updated to include Mental Health Day Treatment services as a treatment recommendation. The initial ITP's are being developed prior to completion of the assessment. The behavioral health professional to patient ratio is not consistently documented on group notes.

Corrective Action: The provider shall provide a proposal that ensures assessments are utilized to determine a client's treatment needs and establish a treatment plan based on treatment needs and recommendations. Also, the provider shall provide a proposal that ensures assessments are being developed prior to the initiation of other services.

Facility Proposal:

An assessment has been developed to screen for symptoms that would indicate a history of Human Trafficking and severe trauma. Once the assessment is completed, and there are any red flags, the Lead therapist for the Journey's program reviews for the need for admission to the Journey's program. Please see the attached assessment.

5122-29-06 Mental Health Day Treatment
(A) Mental health day treatment services are clinically indicated by assessment with clear admission and discharge criteria. The environment at this level of treatment is highly structured, and there should be an appropriate staff-to-client ratio in order to guarantee sufficient therapeutic services and professional monitoring, control, and protection.
(C) Mental health day treatment must be an intense treatment service that consists of high levels of face-to-face mental health interventions that address the individualized mental health needs of the individual as identified in their individualized treatment plan (ITP).
(E) For purposes of this rule, a mental health day treatment program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities that may include, but are not limited to, the following:
(1) Determination of needed mental health interventions;
(2) Skills development
(a) Interpersonal and social competency as age, developmentally, and clinically appropriate, such as:
(i) Functional relationships with adults;
(ii) Functional relationship with peers;
(iii) Functional relationship with the community/schools;
(iv) Functional relations with employer/family; and
(v) Functional relations with authority figures.
(b) Problem solving, conflict resolution, and emotions/behavior management.

(c) Developing positive coping mechanisms;
(3) Managing mental health and behavioral symptoms to enhance vocational/school opportunities and/or independent living; and
(4) Psycho-educational interventions including individualized instruction and training of persons served in order to increase their knowledge and understanding of their psychiatric diagnosis(es), prognosis(es), treatment, and rehabilitation in order to enhance their acceptance of these psychiatric disabilities, increase their cooperation and collaboration with treatment and rehabilitation, improve their coping skills, and favorably affect their outcomes. Such education shall be consistent with the individual's ITP and be provided with the knowledge and support of the interdisciplinary/intersystem team providing treatment in coordination with the ITP.
(F) Providers of mental health day treatment services shall have a staff development plan based upon identified individual needs of mental health day treatment program staff. Evidence that the plan is being followed shall be maintained.

Findings: During the review of client records, the assessments do not clinically indicate the need for Mental Health Day Treatment services. Documentation does not support that the treatment is highly structured. Clients are participating in services/activities such as arts, crafts, playing board games, exercising, coordinated recreation, martial arts, free time and assigned lunch activities. These services/activities do not meet the criteria of intensive, goal oriented, distinct and identifiable treatment interventions for Mental Health Day Treatment. Again, the need for Mental Health Day Treatment services was not identified on any of the client ITP's. Additionally, there was no documentation to determine the staff-to-client ratio to guarantee sufficient therapeutic services and professional monitoring, control, and protection.

During the review of personnel records, providers of Mental Health Day Treatment services did not have a staff development plan in their file. Therefore, we were unable to determine if there were any identified individual needs of these individuals.

Corrective Action: The provider shall submit a proposal that ensures assessments indicate the need for Mental Health Day Treatment services. The provider shall revise and submit for review the admission and discharge criteria for its Mental Health Day Treatment program which clearly identifies how the Mental Health Day Treatment service is distinct from the residential admission and discharge criteria and should specify the appropriate staff to client ratios to guarantee sufficient therapeutic services and professional monitoring, control and protection. Additionally, it shall identify how Mental Health Day Treatment will help stabilize, increase or sustain the highest level of functioning for the individual to develop the capacity to continue to work towards an improved quality of life and promote movement to the least restrictive level of care.

Facility Proposal:
Attached is an updated admission and discharge criteria and need will be demonstrated by the assessment above. Training will be provided for staff that work the day treatment units, including a training on human trafficking. Staff will attend additional trainings that relate to the population as they become available. Staff will also be re-educated on the importance of proper therapeutic documentation during clincials on January 9th, 2019. Staff will attend trainings related to the day treatment program and these will be maintained in personnel files. Additionally, unit meetings are taking place that will train staff on current issues and concerns of the population (beginning during unit meetings on 12/5/18). Utilization Review Specialist and Clinical Director will follow-up for compliance. Corrective action will be taken if needed.

Corrective Action: The provider shall submit a proposal that ensures providers of Mental Health Day Treatment services have a staff development plan that is based upon identified individual needs and shall document the plan is being followed.

5122-29-30 Eligible providers and supervisors
(C) Qualified behavioral health specialist
(1) Qualified behavioral health specialist (QBHS) means an individual who has received training for or education in either mental health or substance use disorder competencies; and who has demonstrated, prior to or within ninety days of hire the minimum competencies in basic mental health or substance use disorder and recovery skills listed in this rule. The individual shall not otherwise be required to perform duties covered under the scope of practice according to Ohio professional licensure.
(2) Basis competencies for each QBHS shall include, at a minimum, an understanding of:
(b) The community behavioral health system, social service systems, the criminal justice system, and other healthcare systems;
(c) Psychiatric and substance use disorder symptoms and their impact on functioning and behavior

Findings: During the review of personnel records, three of six QBHS staff that are providing Mental Health Day Treatment services did not have the required training or education in either mental health or substance use disorder competencies as noted above.

Corrective action: The provider shall submit a proposal that ensures QMHS staff receive training and education in either mental health or substance use disorder competencies to include (2)(b) and (c) as noted above.

Facility Proposal:

Additional trainings will be sought out and provided for the QMHS staff to help them develop competencies as they become available. The clinical director will provide trainings on psychiatric and substance use disorder symptoms and the impact on functioning (beginning in QMHS meetings in January 2019).

Respectfully,

[redacted], LISW-S

[redacted] LISW-S

CEO

UHS-FINHELP-00009317 [Redacted]

Disability Rights OHIO

Disability Rights Ohio
200 Civic Center Drive, Suite 300
Columbus, Ohio 43215

614-466-7264 or 800-282-9181
FAX 614-644-1888
disabilityrightsohio.org

February 27, 2023

[redacted] CEO
Foundations for Living
[redacted]

Dear Ms [redacted]

Thank you for the hospitality shown to Disability Rights Ohio (DRO) on February 7, 2023, during our monitoring visit. We appreciate the time and effort that you and your staff provided to DRO to make our visit successful. We identified positive themes and received positive feedback about your services and staff, which are outlined below. We have also identified reported concerns for follow-up, including items for individual residents.

Positive Themes and Patient Compliments

- Youth reported that there have been positive changes to how staff react to a crisis, and they felt staff have improved in assisting them with de-escalating rather than placing them immediately into a restraint.
- Most of the youth knew their resident rights and grievance procedure. Several youths reported that their grievances were resolved quickly and were satisfied with the outcome.
- One youth stated, "I like how the higher ups interact with us."
- Most of the youth reported that they enjoy school, and that credit recovery program has allowed them to catch up on school credits.
- Youth reported that they have easy access to coping skills and that staff are aware of what their coping skills are to help them when they need to calm down.
- Youth are participating in trauma informed care training orientation for new staff. Youth interviewed felt that this allowed them to educate staff on their experiences and provide feedback to staff.
- Therapist, Redacted - PII was a standout staff to residents for advocating for youth and being a support to them.
- Redacted - PII on unit 2 West was reported as being patient with youth and assisting with helping them to de-escalate.
- Staff Redacted - PII and Redacted - PII on 2 East were also identified as being helpful and welcoming to youth on the unit.

Environmental Concerns:

- Several youths across different units reported that the bathrooms are often dirty and not cleaned on a regular basis. Some youth felt that the responsibility to clean bathrooms fell directly to them because other peers do not care about the state of the bathroom. Youth reported that there are often bloody tampons and feces in the bathroom areas that do not

get cleaned for several days. There were also reports that there is mold on the bathroom ceiling on unit 2 East.

- *Per OAC 5122-30-15 (D) The facility shall provide for prompt, thorough, routine cleaning of all areas of the facility, including all bathroom fixtures, kitchen appliances, and floors. Dining areas shall be appropriately cleaned after meals and dishes washed and stored. The facility shall provide all necessary and appropriate household cleaning supplies.*
- *Per OAC 5122-30-15(G) Resident responsibilities for assisting in cleaning, and for maintaining an acceptable housekeeping standard, shall be specified in the residential agreement between the operator and the resident. Regardless of the resident agreement, the operator remains solely responsible for assuring a clean facility.*
- *Per OAC 5122-30-15(P) Kitchen and baths shall be clean including floors, counters, sinks, tubs, and commodes.*

- Youth reported that the heat in day room on 2 East does not appear to be working and that it is very cold in the room. There were also reports that is often cold throughout unit 3 East.
  - *Per OAC 5122-30-15(I) The facility shall maintain room temperatures appropriate for the comfort and health of residents but shall not exceed eighty-one degrees Fahrenheit.*
- Youth reported concerns about the sprinkler system that some youth have been "popping off". Youth report that this can cause a lot of chaos on the units and causes youth to feel unsafe when this incident occurs. During interviews, it was also reported that during one of the times the sprinkler had been "popped off", two staff members were not on the unit and that left only one staff member to respond to the incident. The remaining staff member asked for assistance from a couple youth on the unit to prevent their peers from AWOLing.

Resident Rights and Treatment Concerns:

- Youth reported that they would like to have more of a variety of activities and groups. Youth that have been at the facility for a couple months feel that they are just repeating the same activities over again. Youth also report that they feel bored on the units and would like to have more board games or interactive activities to engage in. There was also feedback given that youth would like to have more physical exercise in the gym during winter since they are unable to go outside to get exercise.
- Across different units, youth reported that they often feel that whole unit gets punished for the actions of one peer.

- Please provide a copy of February's activities schedule for each unit.

Conclusion:

Thank you for your thoughtful consideration of the above items. Disability Rights Ohio is requesting a written response from Foundations for Living by March 16, 2023. Please provide written responses for each of the individual client needs and the requests and recommendations. We have also 5 DRO laminated posters to be posted on the units. Thank you for your assistance. If you have any questions or concerns, you may contact me via email at [redacted] or by phone at [redacted]

Sincerely,

/s/ [redacted]
[redacted]
Advocate

/s/ [redacted]
[redacted]
Monitoring Coordinator

/s/ [redacted]
[redacted]
Community Engagement Coordinator

FOUNDATIONS FOR LIVING
a treatment center for youth

March 24, 2023

[redacted]
Advocate
Disability Rights Ohio
[redacted]

Ms. [redacted]

Thank you for your suggestions as a result of your visit on 2/27/2023. The information that you requested is identified below or attached to this communication:

- Sprinkler mitigation is trained in our Orientation classes as well as annually for all employees. This training consists of education on the code to identify a sprinkler tampering as well as where and how to shut the water off in the event of such an event. Staff are educated on how to monitor bathrooms and bedrooms to dissuade this from happening. When there is indication that a resident or unit is planning to pop the sprinklers a "special treatment team" is held with the resident to address issues leading to their desire and to redirect their focus. Unfortunately, due to the age of our building, sprinkler heads are with in arms reach of most residents. This makes it very hard to prevent all together. FFL is also working with the State Fire Inspector to identify other mitigation strategies.
- HIPPA training will be complete with each Youth Care Specialist in Shift meetings the last week of March.
- All units and the school areas will have grievance forms hung in an area accessible to residents. The Grievance officer will monitor that there are forms available in these areas. This will be the responsibility of the Unit Manager. The forms may be submitted into the locked grievance boxes.
- Unit bathrooms are cleaned professionally weekly and showers are cleaned with mold and mildew spray by our Housekeeping department 2x per month. The youth sweep and mop daily as well as wipe down sinks.

Resident Concern follow up:

- Redacted - PII Dental appointment on 3/3/23

- Redacted - PII Dental appointment on 3/1/23. Met with him on 3/13 and discussed the grievance process with him and how to file a grievance. He also received a copy of his rights on 3/13.
- Redacted - PII was seen by Redacted - PII CNP for follow up hand injury on 02/22. Received a copy of rights on 3/13.
- Redacted - PII Received a copy of rights on 3/13.
- Redacted - PII Received a copy of rights. Phone call list is provided by guardian we can not add friends and significant others to the list unless guardian approves.

Please feel free to contact me with any further questions or concerns. I can be reached at 419-589-5511.

Respectfully,

[redacted] CEO

(Handbook and Activity schedule included)

UHS-FINHELP-00009322 [Redacted]

Promoting wellness and recovery

Mike DeWine, Governor • Lori Criss, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Bureau of Licensure and Certification

Survey Report

April 20, 2021

Date of Survey: March 2-3, 2021

Residential Facility: Keystone Richland Center, LLC DBA Foundations for Living

Facility Type: ☒ Class One ☐ Class Two ☐ Class Three

Response due date: May 5, 2021

This correspondence is in reference to the Department's review to determine compliance with all applicable portions of the Ohio Administrative Code (OAC). After completing the review of your agency files, administrative records, and a facility walk-through the following findings of non-compliance with the OAC were identified. Please note, your facility is required to submit a Corrective Action Plan by the due date above identifying how your facility will correct the findings, supporting documentation such as revised forms or staff training sign-in sheets, a date by which each finding will be corrected and a plan to prevent future non-compliance. You may submit your response by e-mail at [redacted] or fax at [redacted] or mail:

Ohio Department of Mental Health and Addiction Services
Bureau of Licensure and Certification
Attn: [redacted]
[redacted]
Columbus, OH [redacted]

Ohio Administrative Rule (OAC)	Area of Non-Compliance	Action Required For EACH FINDING, please provide a written corrective action plan to detail how the agency will correct this finding, a plan to ensure continued compliance with the rule requirement, and a date by which the finding will be corrected. Any additional corrective action requirements will be noted below.	Agency POC Response FOR AGENCY USE ONLY	POC Review / Approval OhioMHAS USE ONLY
OAC 5122-30-31 Background investigations for employment. **(C)** Requirements for residential facilities. **(3)** A residential shall check each of the following databases to determine if the applicant is included. **(b)** The abuser registry established pursuant to section 5123.52 of the Revised Code (available at https://its.prodapps.dodd.ohio.gov/abr_default.aspx); **(c)** The nurse aid registry established pursuant to section 3721.32of the Revised Code (available at https://odhgateway.odh.ohio.gov/nar/nar_registry_search.aspx), and if there is a statement detailing finding by the director of the Ohio department of health that the applicant or employee neglected or abused a resident of a long-term care facility or residential care facility or misappropriated property of such a resident; **(d)** Conduct a search of the United States department of justice national public website (available at https://nsopw.gov); **(e)** The United States general services administration system for award management database (available at https://www.sam.gov/); and,	**Finding:** Staff members Redacted - PII; Redacted - PII; and Redacted - PII Redacted - PII were missing the following database checks: Abuser registry; nurse aid registry; national sex offender; US SAM, and database of incarcerated and supervised offenders. Staff member Redacted - PII was missing the national sex offender database.	**Additional corrective action requirements:** The facility shall develop and submit for review a plan that ensures the facility will check each database and print the results of these database checks, which will be maintained in each employee's personnel files. In addition, the facility will submit database checks to the Department for review.	Upon conducting a file audit to locate missing documentation as noted in the findings, we recognize that Redacted - PII Redacted - PII, Redacted - PII Redacted - PII, and Redacted - PII Redacted - PII did not have the searches indicated within the last four years. These have since been searched and added to their personnel files (see attached results). Our plan of correction includes adding the due dates to HealthStream, our education and tracking/reporting	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____

(f) The database of incarcerated and supervised offenders established pursuant to section 5120.066 of the Revised Code (available at https://appgateway.drc.ohio.gov/OfffenderSearch The residential facility will print the results of these database checks, which will be maintained in each employee's personnel files.			system, to keep track monthly of those employees coming due for the checks. We will complete all checks on employees on hire and also every four years using the reporting function of HealthStream.	
(C) Requirements for residential facilities. **(4)** A child or adolescent serving residential facility will conduct for itself or request from the Ohio department of job and family services an alleged perpetrator of abuse and neglect report from the Ohio statewide automated child welfare information system (SACWIS). The process can be found at: http:// jfs.ohio.gov/ocf/childprotectivesevices.stm. If the applicant does not present proof that they have lived in Ohio for the prior five years, the residential facility will also request a check of the child abuse and neglect registry of any other state a prospective employee has resided during the prior five years immediately prior to the date of application for employment. The process can be found at: http://centerforchildwelfare.fmhi.usf.edu/ChildProtective/AdamWalsh.pdf.	Staff members Redacted - PII, Redacted - PII and Redacted - PII Redacted - PII were missing the SACWIS database report.	The facility shall develop and submit for review a plan that ensures the facility will check the alleged perpetrator of abuse and neglect report from the Ohio statewide automated child welfare information system (SACWIS) and print the results of this database check, which will be maintained in each employee's personnel files. In addition, the facility will submit database reports to the Department for review.	The SACWIS database had been completed for Redacted - PII (9/2/2020) and for Redacted - PII (9/11/2020), but results were not obtained for Heather Davis as she works only PRN/as needed. This database search has now been conducted. Results dated 3/12/2021 are also attached. We will continue to conduct the SACWIS database checks on hire and every four years utilizing HealthStream reporting to notify when employees are due for review.	
(C) Requirements for residential facilities. **(9)** A residential facility shall, at a frequency of no less than once every four years, check the databases	Staff member Redacted - PII did not have an updated FBI criminal records check. The	The facility shall develop and submit for review a plan that ensures the facility will at a	Redacted - PII completed FBI fingerprinting on May 3, 2021 with the	

specified in paragraph (C)(3) of this rule, obtain an alleged perpetrator report specified in paragraph (C)(4) of this rule, and request the bureau of criminal investigation, or any other state or federal agency designated by the director, to conduct a criminal records check for each employee, owner, operator, manager, or non-resident occupant. The residential facility will request that the reporting agency obtain information from the federal bureau of investigation as part of the criminal records check.	FBI records check in the employee file was dated December 10, 2015.	frequency of no less than every four years, request that the reporting agency obtain information from the federal bureau of investigation as part of the criminal records check. In addition, the facility shall submit Redacted - PII FBI criminal records check for review.	Richland County Sheriff's office. Results are pending. We have reviewed employee files and will be documenting in HealthStream the due dates for FBI checks to be conducted every four years for all employees.	
5122-26-16 **Seclusion, restraint and time-out** **(E) General requirements** **(2)** The following shall not be used under any circumstances: **(g)** A medication that is used as a restraint to control behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's medical or psychiatric condition or that reduces the individual's ability to effectively or appropriately interact with the world around the individual… **(H)** Documentation. **(1)** The presence of advance directives or client preferences addressing the use of seclusion or restraint shall be determined and considered, and documented in the ICR. If the provider will be unable to utilize seclusion or restraint in a manner in accordance with the person's directives or preferences, the provider shall notify the individual, including the rationale, and document such in the ICR.	Finding: During the review of facility's restraint forms, there is an area on the restraint form that identifies medication as a less restrictive intervention for restraints. Medication is a form of chemical restraint, which is prohibited. During the review of resident records for Redacted - PII, Redacted - PII Redacted - PII and Redacted - PII there was no documentation indicating their restraint preferences in their ICRs.	**Additional corrective action requirements:** The facility shall develop and submit for review a plan that ensures the facility is not utilizing chemical restraints. In addition, the facility shall submit the facility's restraint form that no longer identifies medication as a less restrictive intervention for restraints. The facility shall develop and submit for review a plan that ensures the facility is documenting client preferences addressing the use of seclusion or restraints in the ICR.	Policy 7.5 Proper Use and Monitoring of Physical Restraints – identifies facility does not use chemical (medication) restraints. Restraint form has been updated – "Non-Restraint PRN Medication (med/dose/route/frequency/indication)" has been removed from incident report. The ICP (ITP) has been updated to include restraint preferences of the resident. Additionally, the resident's SAT is attached to each ICP.	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____

(H) Documentation. **(2)** In conjunction with the person's active participation, an individual crisis plan shall be developed at the time of admission and incorporated in the person's ITP for each child or adolescent resident of a department licensed residential facility, for each client known to have experienced seclusion or restraint, for an individual who is at risk of harming themselves, and when otherwise clinically indicated. The plan shall be based on the initial alcohol and other drug (AoD) or mental health assessment, and shall include and be implemented, as feasible, in the following order: **(a)** Identification of the methods or tools to be used by the client to de-escalate and manage his or her own aggressive behavior; **(b)** Identification of techniques and strategies for staff in assisting the person to maintain control of his or her own behavior; and **(c)** Identification, in order of least restrictive to most restrictive, of the methods or tools to be used by staff to de-escalate and manage the client's aggressive behavior. **(H)** Documentation.	During the review of Redacted - PII; Redacted - PII and Redacted - PII resident records, the crisis plans were not incorporated into the ITP. In addition, the crisis plans were not based on the diagnostic assessment. [redacted] crisis plans dated November 7, 2020 and November 8, 2020 were completed prior to the diagnostic assessment dated November 11, 2020. During the review of resident records, the facility utilizes a generic crisis plan which is not client specific. It was noted that some crisis plans were left blank and others were not completed in their entirety. For those plans, that were started, they did not comply with (H)(2)(a)(b)(c) of the rule requirement. They did not identify techniques for staff to assist the resident in maintaining control of their behavior. They did not identify least to most restrictive methods/tools to be used by staff to de-escalate and manage the client's behavior. In addition, crisis plans are not completed at the time of admission.	The facility shall develop and submit for review a plan that ensures the crisis plan, which is to be developed at time of admission is based on the initial alcohol and other drug (AoD) or mental health assessment, is incorporated into the person's ITP. The provider also needs to ensure that they are properly identifying the methods or tools to be used by the client to de-escalate and manage his or her own aggressive behavior; techniques and strategies for staff in assisting the person to maintain control of his or her own behavior; and identification, in order of least restrictive to most restrictive, of the methods or tools to be used by staff to de-escalate and manage the client's aggressive behavior.	All clinical staff will be informed to create the resident's crisis plans during the diagnostic assessment and to incorporate this into the ITP. The diagnostic assessment will be completed within 72 hours of admission. The crisis plan will be completed with the resident present and reviewed with the resident at each ITP review. Crisis plans will be reviewed by the clinical director to ensure that mental health symptoms and diagnoses, as well as, substance use are included as contraindicators. Staff interventions will be identified on each crisis plan.	

(3) The provider shall conduct an initial or comprehensive assessment for each child or adolescent resident of a department licensed residential facility, for each client known to have experienced seclusion or restraint, for an individual who is at risk of harming him/herself, and when otherwise clinically indicated for the following which may place the person at greater risk of physical or psychological injury as a result of the use of seclusion or restraint: **(f)** Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug or alcohol use	During the review of Redacted - PII and Redacted - PII resident records, these residents have a diagnosis of Cannabis Use Disorder, which was not identified in their crisis plans nor taken into consideration as a contraindication.	The facility shall develop and submit for a review a plan that ensures the facility identifies medical and other conditions that might compromise physical well-being when conducting an initial or comprehensive assessment. This information needs to be identified in their crisis plans and taken into consideration as a contraindicator.	Staff completing crisis plans will be instructed to include all substance use and medical factors into the crisis plan. These will be listed as contraindicators and addressed appropriately. The clinical director will review all crisis plans to ensure this is complete.	
(J) Performance Improvement. **(1)** The provider shall collect data on all instances of the use of seclusion or restraint and integrate the data into performance improvement activities. **(2)** Data shall be aggregated and reviewed at least semi-annually by providers and at least quarterly by department licensed residential facilities or certified AoD residential providers. The minimum data to be collected for each episode shall include: **(c)** Date, time and shift each method was initiated; **(f)** Client age, race gender and ethnicity; **(g)** Client and staff injuries	Time of restraints were not accurately documented. **Resident** Redacted - PII Reviewed restraint log. Date of restraint 02/13/2021 Time of restraint was from 19:18-7:35, nearly 12 hour restraint. Facility reported the timing of the restraint was entered incorrectly. **Resident** Redacted - PII 02/22/2021- Restraint submitted to the Department indicated the restraint duration was from 19:32-20:42. Review restraint documentation and interview with leadership, revealed the restraint was from 20:32-20:42. There was no documentation the agency collected the following data and integrated it into performance improvement	The facility shall develop and submit for review a plan that ensures staff is documenting the correct time for restraints. In addition, the facility shall develop and submit for review a plan that ensures the provider is collecting the required minimum data for each episode as required by rule requirements.	Shift supervisors will conduct camera review of each restraint occurring on their shift in order to verify duration of restraint. Facility Risk Manager will review restraint logs to ensure documentation is consistent through all reports. Resident's ethnicity has been added to admissions information, and will be documented on census. Incident quality tracking sheets have been updated to include the following: race,	

	activities: Race, ethnicity, and staff injuries.		ethnicity, and gender. Facility Risk Manager will collect data and review monthly in Quality Council and Restraint Reduction Meetings. Injuries sustained by staff is tracked by Director of Human Resources and is reviewed monthly in Quality Council and Restraint Reduction Meetings.	
OAC 5122-30-16.2 Physical restraint **(D)** Documentation of each episode of the use of physical restraint shall be made in the clinical record and shall include: **(6)** Explanation to the person for the reason for implementation of physical restraint and the required behaviors of the person which would indicate sufficient behavioral control so that the physical restraint could be discontinued.	**Finding:** Reviewed the following resident restraints: Redacted - PII October 13, 2020. Redacted - PII February 13, 2021. Redacted - PII February 22, 2021. During the review of the restraint records, there was no documentation that facility staff explained the reason for the physical restraint nor the required behaviors which would indicate sufficient behavioral control so that the physical restraint could be discontinued for each of these residents.	**Additional corrective action requirements:** The facility shall develop and submit for review a plan that ensures facility staff gives an explanation to the person for the reason for implementation of physical restraint and the required behaviors of the person which would indicate sufficient behavioral control so that the physical restraint could be discontinued.	Release criteria is documented and tracked on page 1 of restraint incident report. Resident and staff debriefing have been updated in the restraint incident report to include explanation to patient for the reason restraint was initiated, and explanation of behavior expectations for restraint termination.	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____

Promoting wellness and recovery

Mike DeWine, Governor • Lori Criss, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

April 20, 2021

Keystone Richland Center, LLC DBA Foundations for Living
[redacted] CEO
[redacted]
Mansfield, OH [redacted]

Re: Keystone Richland Center, LLC DBA Foundations for Living, License # [redacted]

Dear Ms. [redacted]

This correspondence is in response to the Department's investigation of Foundations for Living related to a complaint received by the Department on February 16, 2021 alleging physical harm/abuse. The complaint has been unsubstantiated.

During the investigation process, the Department had identified areas of non-compliance with portions of the Ohio Administrative Code (OAC). These findings are based on the for-cause unannounced survey that was conducted on March 2-3, 2021. The findings are outlined on the attached document.

Please submit a written Plan of Correction response by May 5, 2021 that identifies how you will correct (or have corrected) each finding, and a date by which each correction will be made. You may also submit any supporting documentation such as revised forms, training outlines or training verification, etc. You may submit your response by e-mail at [redacted] fax at [redacted] or mail:

Ohio Department of Mental Health and Addiction Services
Bureau of Licensure and Certification
Attn: [redacted]
[redacted]
Columbus, Ohio [redacted]

If you have any questions or require additional information related to certification, please contact me at [redacted] or the email above.

Sincerely,

[redacted]

Behavioral Health Standards Surveyor
Bureau of Licensure and Certification

pc: [redacted] JD, MSN, RN, Interim Chief, Bureau of Licensure and Certification
[redacted] Executive Director, Mental Health & Recovery Services Board of Richland County
[redacted] Office of the State Long-Term Care Ombudsman
Licensure File

UHS-FINHELP-00009366 [Redacted]

The Joint Commission

May 14, 2021

[redacted] MSW, LCSW, LSCSW
CEO
Great Plains Hospital, Inc.
[redacted]
Nevada, MO [redacted]

Joint Commission ID #: [redacted]
Program: Behavioral Health Care and Human Services
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 5/13/2021

Dear Mrs. [redacted]

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Behavioral Health Care and Human Services

This accreditation cycle is effective beginning February 25, 2021 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

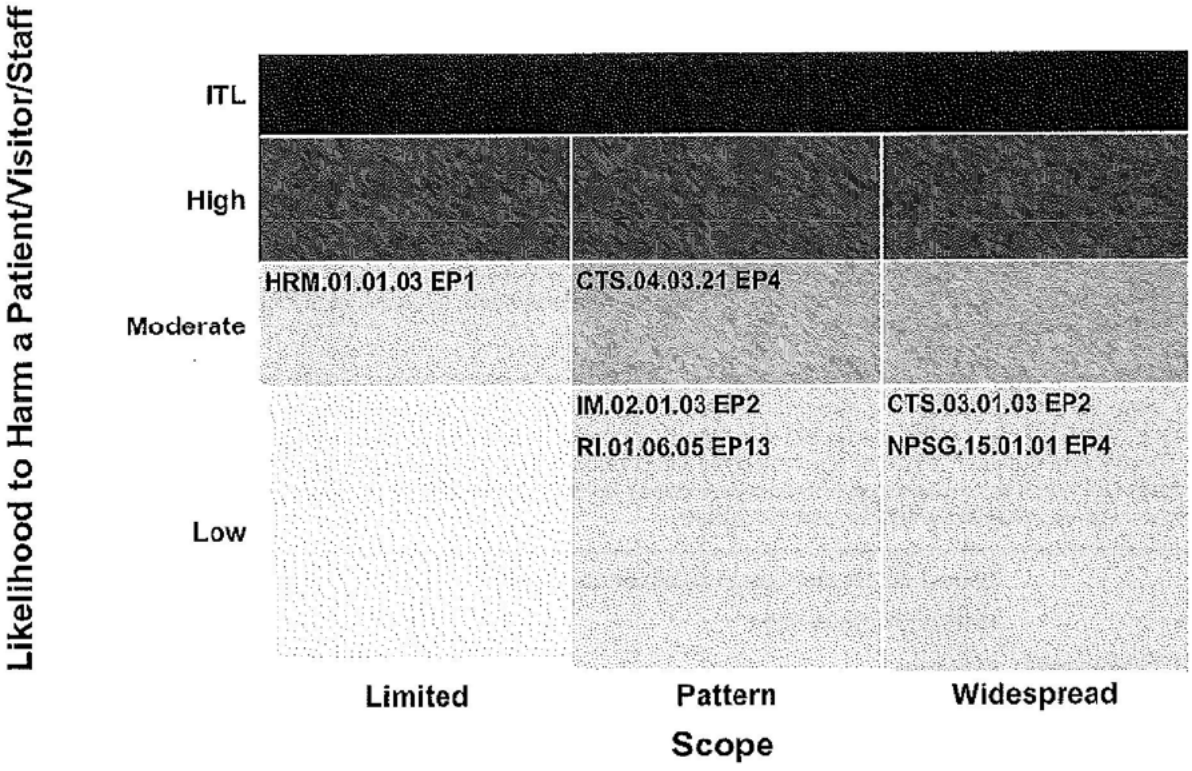
Congratulations on your achievement.

Sincerely,

[redacted] RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

Unannounced Full Event
02/22/2021 - 02/25/2021

HCO Name: Great Plains Hospital, Inc.
Program: Behavioral Health Care and Human Services



Findings Text

Program: Behavioral Health Care and Human Services

Standard/EP: CTS.03.01.03 EP EP2

Likelihood to Cause Harm: Low

Scope: WideSpread

Observed in Individual Tracer at Great Plains Hospital, Inc. [redacted]Nevada, MO) site. The goals observed in the residential program treatment plans were written as clinical formulations and did not reflect the words and ideas of the resident served.

Unannounced Full Event
02/22/2021 - 02/25/2021

HCO Name: Great Plains Hospital, Inc.
Program: Behavioral Health Care and Human Services

Program: Behavioral Health Care and Human Services
Standard/EP: CTS.04.03.21 EP EP4
Likelihood to Cause Harm: Moderate
Scope: Pattern

Observed in Document Review at Great Plains Hospital, Inc. [redacted] Nevada, MO) site. During review of the documentation for the support animals it was observed that the HCO has up to date vaccinations and comprehensive health records for the horses used in equine therapy. Individual tracers reviewed included documentation of an assessment of each resident for appropriateness of participating in this service. Guidelines for establishing and assessing temperament of the horses was not present. The Equine therapists verbalized use of an informal process to assess temperament, but clear guidelines have not been set. This was confirmed by the CEO.

Observed in Document Review at Great Plains Hospital, Inc. [redacted] Nevada, MO) site. During review of the documentation for the support animals it was observed that two of the three support dogs did not have an assessment of temperament completed and most recent rabies vaccination documented. The documentation noted that one had been vaccinated with a three year dose good through 2023 but the other two had been vaccinated with one year doses on 9/5/19 and 12/3/19 respectively and were due for their next vaccines on 9/4/2020 and 12/3/2020.

Program: Behavioral Health Care and Human Services
Standard/EP: HRM.01.01.03 EP EP1
Likelihood to Cause Harm: Moderate
Scope: Limited

Observed in HR File Review at Great Plains Hospital, Inc. [redacted] Nevada, MO) site. In one of five residential staff HR files reviewed, the required CPR re-certification was overdue. The certification had last been documented 12/2017.

Program: Behavioral Health Care and Human Services
Standard/EP: IM.02.01.03 EP EP2
Likelihood to Cause Harm: Low
Scope: Pattern

Observed in Individual Tracer at Great Plains Hospital, Inc. [redacted] Nevada, MO) site. The treatment plans observed in three of four residential tracers reviewed had multiple strike throughs of revised target dates without documented initials of the editor of the record.

Program: Behavioral Health Care and Human Services
Standard/EP: NPSG.15.01.01 EP EP4
Likelihood to Cause Harm: Low
Scope: WideSpread

Observed in Individual Tracer at Great Plains Hospital, Inc. [redacted] Nevada, MO) site. The suicide risk level observed in the residential program tracers was determined as: lower, similar, or higher in risk than a patient who is safely treated on the inpatient unit, and did not identify risk levels for the residential level of care. The HCO policy titled SUICIDE RISK ASSESSMENT AND MANAGEMENT last revised 7/2020 similarly noted risk formulation was to be compared to the general patient population on the inpatient unit and did not differentiate for the residential level of care. In one tracer a client who had a suicide attempt a week before admission was rated as "lower" and in the other tracer a client with multiple attempts prior to admission and who was admitted directly from an acute stay was rated "similarly". In both tracers, clear documentation of mitigation of the identified risk was not present. The HCO has implemented a ligature resistant environment in the residential programs.

Unannounced Full Event
02/22/2021 - 02/25/2021

HCO Name: Great Plains Hospital, Inc.
Program: Behavioral Health Care and Human Services

Program:	Behavioral Health Care and Human Services
Standard/EP:	RI.01.06.05 EP EP13
Likelihood to Cause Harm:	Low
Scope:	Pattern

Observed in Building Tour at Great Plains Hospital, Inc. [redacted] Nevada, MO) site.
The many of the resident bedrooms had bare walls with no personalization from the residents. Some of the rooms had pictures taped up on the walls or windows but equipment to support and encourage personalization was not present.

Final Accreditation Report

Great Plains Hospital, Inc.
[redacted]
Nevada, MO [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 5/13/2021

ESC Programs Reviewed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 5/14/2021

The Joint Commission
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• Requirements for Improvement (RFI) Summary	5
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The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health Care and Human Services

Standard	Level of Compliance
CTS.03.01.03	Compliant
CTS.04.03.21	Compliant
HRM.01.01.03	Compliant
IM.02.01.03	Compliant
NPSG.15.01.01	Compliant
RI.01.06.05	Compliant

The Joint Commission

May 12, 2023

[redacted] MSW, LCSW, LSCSW
CEO
Great Plains Hospital, Inc.
[redacted]
Nevada, MO [redacted]

Joint Commission ID #: [redacted]
Program: Behavioral Health Care and Human Services
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 5/12/2023

Dear Mrs. [redacted]

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Behavioral Health Care and Human Services

This accreditation cycle is effective beginning March 9, 2023 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.
Please note, if your survey was conducted off-site (virtually): Your organization may be required to undergo an on-site survey once The Joint Commission has determined that conditions are appropriate to conduct on-site survey activity.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

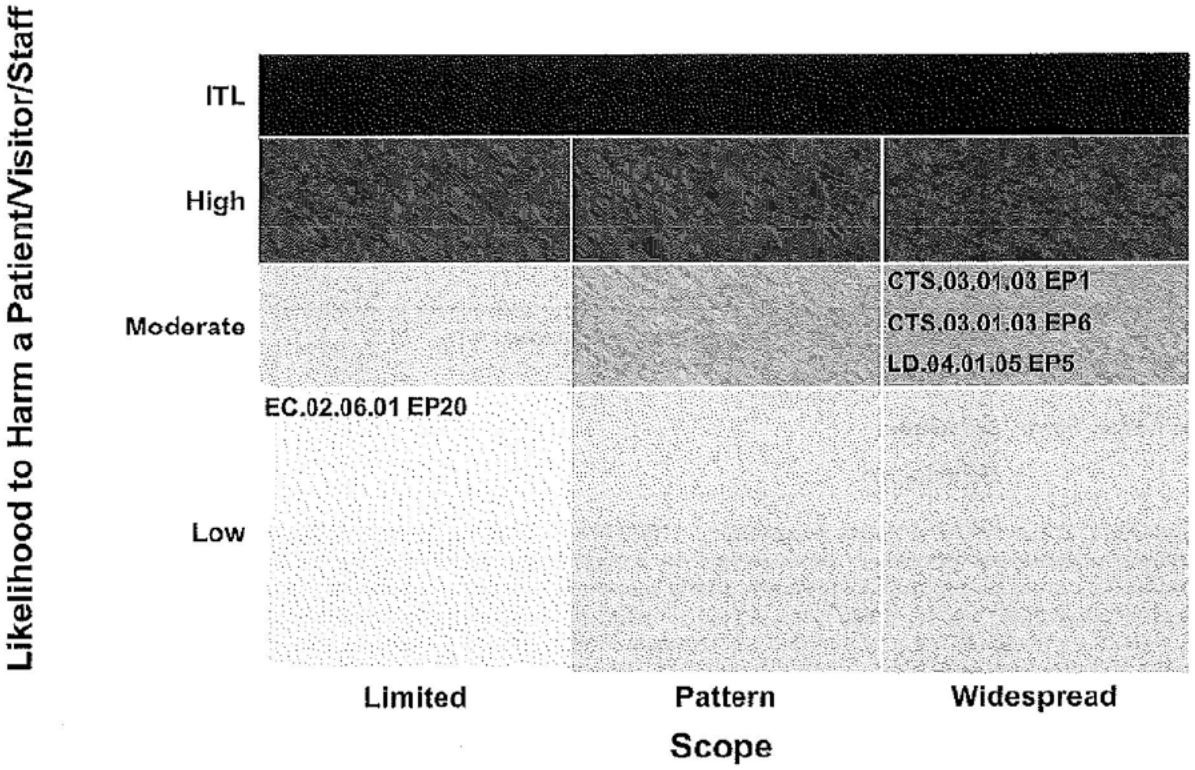
Congratulations on your achievement.

Sincerely,

[redacted]
[redacted] MS, RN
Executive Vice President
Division of Accreditation and Certification Operations

Unannounced Full Event
03/07/2023 - 03/09/2023

HCO Name: Great Plains Hospital, Inc.
Program: Behavioral Health Care and Human Services



Findings Text

Program: Behavioral Health Care and Human Services
Standard/EP: CTS.03.01.03 EP EP1
Likelihood to Cause Harm: Moderate
Scope: WideSpread

Observed in Individual Tracer at Great Plains Hospital, Inc. [redacted] Nevada, MO) site.
In 8 out of 10 patient records reviewed, Evidence of an assessed appropriate goal to guide care, treatment, and or services was not demonstrated. Evidenced by active individual(s) record(s) reviewed with an admission year of 2023, master treatment plan(s) did not demonstrate the assessed needs (substance(s) use, Legal, aggression, etc.) to guide care, treatment, and or services

Program: Behavioral Health Care and Human Services
Standard/EP: CTS.03.01.03 EP EP6
Likelihood to Cause Harm: Moderate
Scope: WideSpread

Observed in Individual Tracer at Great Plains Hospital, Inc. [redacted] Nevada, MO) site.
In 6 out of 10 individual(s) record(s) reviewed, Evidence of treatment plan goal progress was not demonstrated. Evidenced by active individual(s) record(s) reviewed with an admission year(s) of 2022 and 2023, record(s) did not demonstrate documented treatment progress (suicidality, effective communication, family education) to guide care, treatment, and or services.

Unannounced Full Event
03/07/2023 - 03/09/2023

HCO Name: Great Plains Hospital, Inc.
Program: Behavioral Health Care and Human Services

Program:	Behavioral Health Care and Human Services
Standard/EP:	EC.02.06.01 EP EP20
Likelihood to Cause Harm:	Low
Scope:	Limited

Observed in Individual Tracer at Great Plains Hospital, Inc. [redacted] Nevada, MO) site. Evidence of a clean and comfortable environment was not demonstrated. Evidenced by an interior bedroom window(s) on the unit (Two Central) contained discolored debris that could produce a physical reaction. The Chief Executive Officer (CEO) acknowledged the need to clean the window (requiring the removal of the entire pane) for comfort and safety.

Program:	Behavioral Health Care and Human Services
Standard/EP:	LD.04.01.05 EP EP5
Likelihood to Cause Harm:	Moderate
Scope:	WideSpread

Observed in Individual Tracer at Great Plains Hospital, Inc. [redacted] Nevada, MO) site. Evidence of internal program coordination of services was not demonstrated. Evidenced by, active individual (s) record(s) reviewed demonstrated nutritional needs during screening, without a consistent assessment process to determine treatment needs. Specifically, an individual(s) record(s) demonstrated an eating disorder goal, without a clinical rational and or medical diagnosis. Followed by the Dietary Consult form demonstrated the following verbiage "Dietary consult deferred, BM greater than 30, less than 40." The organization policy indicated the discretion of the provider to determine the need for a consult." The Chief Executive Officer (CEO) acknowledged the inconsistency in the policy and practices of nutritional assessment and treatment needs.

Final Accreditation Report

Great Plains Hospital, Inc.
[redacted]
Nevada, MO [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 5/12/2023

ESC Programs Reviewed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 5/12/2023

CONFIDENTIAL

The Joint Commission
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- Requirements for Improvement (RFI) Summary 5

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UHS-FINHELP-0000938

Appendix 77.

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health Care and Human Services

Standard	Level of Compliance
CTS.03.01.03	Compliant
EC.02.06.01	Compliant
LD.04.01.05	Compliant

UHS-FINHELP-00009384 [Redacted]

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, ALABAMA 36130-1410
WWW.MH.ALABAMA.GOV

KAY IVEY
GOVERNOR

LYNN T. BESHEAR
COMMISSIONER

July 25, 2019

Ms. [redacted]
Interim Executive Director
Hill Crest Behavioral Health Services
[redacted]
Birmingham, Alabama [redacted]

Dear Ms. [redacted]

The Office of Certification Administration received your plan of action on July 23, 2019, for Hill Crest Behavioral Health Services. Based on the recommendation of the Associate Commissioner for the Division of Mental Health and Substance Abuse Services, I am accepting your plan of action on the deficits listed in the site visit report conducted May 22-23, 2019.

Thank you for your response. Should you have any questions concerning the foregoing, please contact the Office of Certification Administration at [redacted]

Sincerely,

[redacted]

[redacted]
Commissioner

[redacted]

cc: [redacted]

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, ALABAMA 36130-1410
WWW.MH.ALABAMA.GOV

KAY IVEY
GOVERNOR

LYNN T. BESHEAR
COMMISSIONER

July 1, 2019

Ms. [redacted]
Interim Executive Director
Hill Crest Behavioral Health Services
[redacted]
Birmingham, Alabama [redacted]

Dear Ms. [redacted]

Enclosed please find the site visit report for the community standards certification site visit at Hill Crest Behavioral Health Services conducted May 22-23, 2019, by representatives of the Department of Mental Health. Based on the findings during the site visit, you must submit a **Plan of Action** to the Office of Certification Administration within thirty (30) days from receipt of this letter.

To allow for implementation of the plan of action your Mental Illness Program Staff is being granted certification until June 30, 2020. However, failure to provide an acceptable **Plan of Action** within the thirty (30) day period specified above may result in immediate decertification of these programs. All of your other programs are being granted certification for a period of two years. The certificates of compliance for these programs, indicating they meet the Department of Mental Health standards for operation are enclosed. These certificates, which will expire June 30, 2021, must be posted in the respective facilities at all times and are not transferable to any other locations or entities.

Should you have any questions concerning the foregoing, please contact the Office of Certification Administration at [redacted]

Sincerely,

[redacted]

Commissioner

[redacted]

Enclosure

cc: [redacted]

Alabama Department of Mental Health

Mental Illness Site Visit Report

1. **Site Visit Scoring Summary.**
2. **Administrative Findings.**
3. **Programmatic Findings.**

Alabama Department of Mental Health

CERTIFICATION SITE VISIT SCORING SUMMARY

DIVISION: **Mental Health and Substance Abuse Division**

TYPE VISIT: ☐ **Regular** ☐ **Follow-up** ☐ **Initial (TOA)** ☐ **Corrected** ☐ **For Cause**

AGENCY: Hill Crest Behavioral Health Services

ADDRESS: [redacted] **City:** Birmingham **State:** Alabama **Zip Code:** [redacted]

EXECUTIVE DIRECTOR: [redacted] Interim Executive Director

SUB-CONTRACT AGENCY: ☐ **Yes** ☐ **No**
Agency Name:
Address: **City:** **State:** **Zip Code:**

SURVEYOR(S): [redacted]

DATE(S) OF SITE VISIT: May 22-23, 2019

Service/Site Name	Certification File #	Date of Review	Score	Recommended Certification	Plan of Action
Administrative Services					
Administrative Services	3998	05/23/2019	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Governing Body	4001	05/22/2019	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Mental Illness Program Staff	4000	05/23/2019	80%	☒ 1yr ☐ 2yr ☐ Provisional	☒ Yes ☐ No
Quality Assurance	3999	05/22/2019	100%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Residential Services					
Child & Adolescent CRF	3997	05/22/2019	96%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Rehab Intervention Service Enrichment (RISE) CRF	6059	05/23/2019	99%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No
Child & Adolescent Restraint/Seclusion Center Wide	4931	05/23/2019	91%	☐ 1yr ☒ 2yr ☐ Provisional	☐ Yes ☒ No

SITE VISIT REPORT

This is a summary of the findings reported to the agency Executive Director during the exit interview. **Action plans are required for providers who receive a Provisional or a one (1) year score. A written plan of action should be submitted to the Office of Certification Administration, within 30 days of receipt of this report.**

ADMINISTRATIVE FINDINGS

Certification File Number: 4000

Administrative Code: 580-2-20 Personnel
Finding(s): There was no full-time executive director who has overall responsibility for the operation of the agency. **Note:** The agency had presented a plan to ADMH to have an interim executive director for this agency and have an interim executive director at another agency owned by the parent company UHC, Inc. so that both locations would have a full-time executive director as required. Agency was to submit all required applications for approval. However, they did not implement the plan as presented to ADMH.

PROGRAMMATIC FINDINGS

Certification File Number: 3997

Administrative Code: 580-2-9-.06 (7) Consumer Records
Finding(s): All entries and forms completed by the service provider in the consumer record were not made in ink . **Note:** There were several photocopied group therapy documents in the consumer record.
Record(s): 3001046

Administrative Code: 580-2-9-.06 (9) Consumer Records
Finding(s): There was no evidence to support the Child and Adolescent Community Residential Facility obtained from the recipient a written authorization for disclosure(s) covering each instance in which information concerning the identity of, diagnosis, prognosis, treatment, or case management of the consumer is disclosed. **Note:** There was no written authorization obtained from the recipient permitting the disclosures made to the recipient's father.
Record(s): 3001046

Administrative Code: 580-2-9-.18 (1) Child and Adolescent Residential Program
Finding(s): There was no documentation in the recipients record to support the Child and Adolescent Community Residential Facility provided at least one (1) hour of individual therapy and one (1) hour of group therapy each week to the recipient(s). **Note:** Record # 3001035, as of 05/22/2019 the last documented individual therapy was on 04/03/2019. Record # 3001046 contained photocopied group therapy progress notes.
Record(s): 3001035, 3001046

Administrative Code: 580-2-9-.18 (1) Child and Adolescent Residential Program
Finding(s): The program descriptions written for the Child and Adolescent Community Residential Facility did not address the following:

- The number of beds
- Staff qualifications consistent with requirements set forth in sections 580-2-9- .18(28) through 580-2-9-.18(38) for each type of residential program certified.
- Discharge/transfer criteria and procedures.
- Exclusionary criteria which indicates principal diagnosis of alcoholism or drug dependence.
- The following services are provided in-house or arranged for by the residential staff, depending upon the needs of the individual consumer:
    - Assistance in applying for benefits and vocational services.
- The procedure for referral to the appropriate resource (DHR, Probate Court, etc.) for those consumers who may need a legal guardian while residing in the program.

Record(s): 3001035, 3001046

Certification File Number: 6059

Administrative Code: 580-2-9-.18 (1) Child and Adolescent Residential Program
Finding(s): The program descriptions written for the Rehab Intervention Service Enrichment (RISE) Program Community Residential Facility did not address the following:

- The number of beds.
- The expected length of stay.
- Staff qualifications consistent with requirements set forth in section 580-2-9- .18(37).
- Discharge/transfer criteria and procedures.
- Exclusionary criteria principal diagnosis of alcoholism or drug dependence.
- The following services are provided in-house or arranged for by the residential staff, depending upon the needs of the individual consumer:
    - Assistance in applying for benefits.
    - Assistance in improving social and communication skills.
    - Assistance with medication management.
    - Vocational services.
    - Community orientation.
    - Recreation and activities.
    - A description of how the child/adolescent shall continue to receive appropriate education while in the program.
    - The procedure(s) for referral to the appropriate resource (DHR, Probate Court, etc.) for those consumers who may need a legal guardian while residing in the program.

Record(s): 39740, 38241

Certification File Number: 4931

Administrative Code: 580-2-9-.23 (31) Child and Adolescent Seclusion and Restraint
Finding(s): The restraint episode(s) documented in the recipients' record did not include notification of the recipient's family/legal guardian consistent with organizational policy and the agreement with the family/legal guardian.
Record(s): 33607, 39740, 38241

Administrative Code: 580-2-9-.23 (26) Child and Adolescent Seclusion and Restraint
Finding(s): There was no documentation to support staff authorized to physically apply restraint or seclusion was required to demonstrate competency every six (6) months in the safe use of restraint, including physical holding techniques.
Record(s): 33607, 39740, 38241

UHS-FINHELP-00009396 [Redacted]

Site Monitored: Child and Adolescent CRF Physical [redacted] Birmingham, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:30 ☒AM☐ PM Departure Time:11:50 ☒AM☐ PM
TO: [redacted] **FROM: [redacted]**
Contracting Agency Director **Advocate**

Number of Consumers Present: 22 Number of Staff Present: 4
Names/Positions of Staff Spoken to: Redacted - PII

Section I. Visiting with Individuals

	Observed	Comments
A. Comments from Individuals	Yes	One consumer indicated that another consumer attempted to assault her, which made her feel unsafe. However, she indicated that the consumer did not make physical contact with her because the staff intervened and redirected the other person. Another consumer indicated that she was content in her environment and had no concerns other than her broken foot. She presented with having a brace on her right foot and stated that she did not like wearing the brace. Advocate encouraged consumer to continue wearing the brace until her foot healed.
B. Staff/Consumer Interaction	Yes	Staff and consumer interaction was positive and encouraging. Staff provided feedback and encouragement to consumer when discussing wearing her foot brace.
C. Describe Activities	Yes	During visit consumers were engaged in socialization in common area and one person was eating lunch. Per conversation with consumer, she has opportunities for preferred activities, such as going out to eat at preferred restaurants, volleyball, basketball at PE class.
D. Appearance	Yes	Advocate observed that the physical appearance of consumers in setting was appropriate. Their clothing was in good condition with a neat and clean appearance.
E. Restrictions	Yes	This was a locked unit.
F. Other (specify)	Yes	A thermometer was observed and utilized, along with temperature logs upon entry to setting. Also, consumers were provided with appropriate PPE provided.

Section II. AREAS OBSERVED

Areas Observed	Observed	Concerns
A. Living room	Yes	There were no concerns in common living areas at this time.

Site Monitored: Child and Adolescent CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:30 ☒AM☐ PM Departure Time:11:50 ☒AM☐ PM

Areas Observed	Observed	Concerns
B. Bedrooms	**Yes**	A broken tile was observed in room 804 that presented a piece with a sharp edge, which is a potential safety hazard. This issue was reported to [redacted] COO, at the time of the visit. [redacted] contacted maintenance and requested it be repaired on this day.
C. Bathrooms	**Yes**	
D. Laundry Area	**Yes**	
E. Clothing Storage	**Yes**	
F. Kitchen/Dining Area	**No**	Advocate did not observe a specific dining area.
G. Food Supply	**No**	The food supply was not observed.
H. Classrooms	**Yes**	
I. Outside Area	**Yes**	
J. Advocacy # Posted	**Yes**	Based upon observation, the Advocacy number was not posted in the Boys unit. Advocate spoke with [redacted] COO, stated that the Advocacy number would be posted as soon as possible.
K. Medications Secured	**Yes**	
L. Other (Specify)	**Not Applicable**	

Section III. DIRECTOR'S MONITORING RESPONSE

Director, please notice that Section III is designed to have you write/type in your response and return it to the Advocate at the mailing or email address listed on the last page of this form.

Site Monitored: Child and Adolescent CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:30 ☒AM☐ PM Departure Time:11:50 ☒AM☐ PM

Advocate's Recommendations	Potential Rights Issue	Contracting Agency Director's Response	Director's Targeted Completion Date
Repair or replace tile in room 804.	Safe and Humane Environment	The floor tile in room 804 was replaced by the Director of Plant Operations on 2/11/22.	**Completed 2/11/22**
Ensure access to Advocacy Number on Boys Unit.		Advocacy numbers were reprinted and placed on the unit.	**Completed 2/11/22**

[redacted]

2/21/22

Director's Signature **Date**

__X__ The Contracting Agency is expected to provide information to the advocate regarding concerns/recommendations cited within **30 days.** Responses should be sent to the Advocate who conducted the monitoring.

Service Area Address: **DMH Community Advocacy Office**
Service Area: II East
Address: [redacted]
Birmingham, AL [redacted]
Telephone: [redacted]
Email: [redacted]**mh.alabama.gov**

Site Monitored: Child and Adolescent CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:30 ☒AM☐ PM Departure Time:11:50 ☒AM☐ PM
Advocate: [redacted] **Date: 2/18/22**

cc: DMH Advocacy Director
Other Address:

If response is requested cc: **MH/SA, Beth Bergeron**

Site Monitored: Competency Restoration Program #1 CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 12:15 ☐AM☒ PM Departure Time:12:45 ☐AM☒ PM
TO: [redacted] **FROM:** [redacted]
Contracting Agency Director **Advocate**

Number of Consumers Present: 15 Number of Staff Present: 3
Names/Positions of Staff Spoken to: Redacted - PII

Section I. Visiting with Individuals

	Observed	Comments
A. Comments from Individuals	Yes	Consumers that Advocate interacted with indicated that they were pleased with their experience at the facility, were treated well by staff, and have been provided with good food to eat. One person indicated that they were trying to get back home. Advocate encouraged consumer to continue to follow their treatment plan and work with their treatment team so that they could progress.
B. Staff/Consumer Interaction	Yes	The interaction that was observed between staff and consumers was positive. Staff was courteous, encouraging, and helpful to consumers.
C. Describe Activities	Yes	Consumers were observed to be engaging in preferred activities, such as watching T.V., socializing/recreating outside, and engaging in pool and foosball.
D. Appearance	Yes	Based upon observation, the appearance of consumers in setting was appropriate. Consumers' clothing was in good condition, and they appeared to use proper hygiene.
E. Restrictions	Yes	This is a locked unit.
F. Other (specify)	Yes	It was observed that a thermometer was used to take temperatures upon entry to facility. Also, a temperature log is maintained at setting and adequate soap/sanitizer and PPE is provided to consumers and staff.

Section II. AREAS OBSERVED

Areas Observed	Observed	Concerns
A. Living room	Yes	
B. Bedrooms	Yes	
C. Bathrooms	Yes	

Site Monitored: Competency Restoration Program #1 CRF Physical Address: [redacted] Birmingham, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 12:15 ☐AM☒ PM Departure Time:12:45 ☐AM☒ PM

Areas Observed	Observed	Concerns
D. Laundry Area	**Yes**	
E. Clothing Storage	**Yes**	
F. Kitchen/Dining Area	**No**	The kitchen/dining area was not observed.
G. Food Supply	**No**	The food supply was not observed during visit.
H. Classrooms	**Not Applicable**	
I. Outside Area	**Yes**	
J. Advocacy # Posted	**Yes**	
K. Medications Secured	**Yes**	
L. Other (Specify)	**Not Applicable**	

Section III. DIRECTOR'S MONITORING RESPONSE

Director, please notice that Section III is designed to have you write/type in your response and return it to the Advocate at the mailing or email address listed on the last page of this form.

Advocate's Recommendations	Potential Rights Issue	Contracting Agency Director's Response	Director's Targeted Completion Date

Site Monitored: Competency Restoration Program #1 CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 12:15 ☐AM☒ PM Departure Time:12:45 ☐AM☒ PM

Advocate's Recommendations	Potential Rights Issue	Contracting Agency Director's Response	Director's Targeted Completion Date

[redacted]

2/21/22

Director's Signature **Date**

__X__ There is no response required.

Service Area Address: **DMH Community Advocacy Office**
Service Area: II East
Address: [redacted]
Birmingham, AL [redacted]
Telephone: [redacted]
Email: [redacted]**mh.alabama.gov**

Advocate: [redacted] **Date: 2/18/22**

cc: DMH Advocacy Director
Other Address:

If response is requested cc: **MH/SA, Beth Bergeron**

ADV 500C **Previous Revision 09/10/2007; 4/1/2012; 12/11/15**

Appendix 79.

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Site Monitored: Competency Restoration Program #2 CRF Physical Address [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:50 ☒AM☐ PM Departure Time:12:15 ☐AM☒ PM
TO: [redacted] **FROM:** [redacted]
Contracting Agency Director **Advocate**

Number of Consumers Present: 15 Number of Staff Present: 3
Names/Positions of Staff Spoken to: **Redacted - PII**

Section I. Visiting with Individuals

	Observed	Comments
A. Comments from Individuals	**Yes**	Consumer expressed that he has made much progress since he has been receiving services at facility and is in a much better place. He indicated that he has no concerns and is treated well and that the food provided is adequate. Consumer demonstrated his ability in playing the guitar for Advocate and facility staff during the conversation.
B. Staff/Consumer Interaction	**Yes**	Advocate observed that the interaction between staff and consumers was appropriate. Staff encouraged consumer and provided positive feedback regarding his progress at the facility and encouraged him in his efforts to learn to play guitar.
C. Describe Activities	**Yes**	It was observed that consumers were relaxing in common area socializing. As previously noted, one consumer was engaged in playing guitar. Several men were playing cards and some were working out with weights. Consumers indicated that they have access to a game room with pool table, T.V., and foosball for recreation, along with a gym for basketball.
D. Appearance	**Yes**	The appearance of consumers was appropriate. Clothes were clean, in good condition and properly fitting. There were no issues identified regarding hygiene.
E. Restrictions	**Yes**	This is a locked unit.
F. Other (specify)	**Yes**	It was observed that a thermometer was observed and utilized, along with temperature logs upon entry to setting. Also, consumers were provided with appropriate PPE and soap/sanitizer provided.

Section II. AREAS OBSERVED

Site Monitored: Competency Restoration Program #2 CRF Physical Address: [redacted] Birmingham, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:50 ☒AM☐ PM Departure Time:12:15 ☐AM☒ PM

Areas Observed	Observed	Concerns
A. Living room	Yes	
B. Bedrooms	Yes	
C. Bathrooms	Yes	
D. Laundry Area	Yes	
E. Clothing Storage	Yes	
F. Kitchen/Dining Area	No	The kitchen/dining area was not observed during visit.
G. Food Supply	No	The food supply was not observed during visit.
H. Classrooms	No	
I. Outside Area	Yes	
J. Advocacy # Posted	Yes	
K. Medications Secured	Yes	
L. Other (Specify)	Not Applicable	

Section III. DIRECTOR'S MONITORING RESPONSE
Director, please notice that Section III is designed to have you write/type in your response and return it to the Advocate at the mailing or email address listed on the last page of this form.

Site Monitored: Competency Restoration Program #2 CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:50 ☒AM☐ PM Departure Time:12:15 ☐AM☒ PM

Advocate's Recommendations	Potential Rights Issue	Contracting Agency Director's Response	Director's Targeted Completion Date

[redacted]

Director's Signature 2/21/22 **Date**

__X__ There is no response required.

Service Area Address: **DMH Community Advocacy Office**
Service Area: II East
Address: [redacted]
Birmingham, AL [redacted]
Telephone: [redacted]
Email: [redacted]**mh.alabama.gov**

Advocate: [redacted] **Date: 2/18/22**

cc: DMH Advocacy Director
Other Address:

If response is requested cc: **MH/SA, Beth Bergeron**

ADV 500C **Previous Revision 09/10/2007; 4/1/2012; 12/11/15**

Appendix 79.

CONFIDENTIAL

Site Monitored: JBS Hill Crest Competency Restoration Program CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 10:45 ☒AM☐ PM Departure Time:11:15 ☒AM☐ PM
TO: [redacted] **FROM:** [redacted]
Contracting Agency Director **Advocate**

Number of Consumers Present: 10 Number of Staff Present: 2
Names/Positions of Staff Spoken to: Redacted - PII

Section I. Visiting with Individuals

	Observed	Comments
A. Comments from Individuals	Yes	Although most consumers were in class during the time of the visit, those who the Advocate spoke with at facility indicated that they have no concerns regarding their services, their rights, or treatment by staff at this time.
B. Staff/Consumer Interaction	Yes	Interactions observed between staff and consumers was helpful. Staff answered questions of one consumer regarding the schedule and having the opportunity to return to their bedroom to obtain an item.
C. Describe Activities	Yes	Consumers were observed relaxing in their bedroom and socializing with others and staff. It was indicated by consumers that they are provided opportunities for recreation including going outside, engaging in preferred games, and preferred dining.
D. Appearance	Yes	Based upon observations, consumers' appearance was acceptable. Clothing and shoes of consumers was in adequate condition, there were no observed issues regarding hygiene.
E. Restrictions	Yes	This is a locked facility.
F. Other (specify)	Yes	Advocate observed that a thermometer was used to take temperatures upon entry to facility. Also, a temperature log is maintained at setting and adequate soap/sanitizer and PPE is provided to consumers and staff.

Section II. AREAS OBSERVED

Areas Observed	Observed	Concerns
A. Living room	Yes	
B. Bedrooms	Yes	

Site Monitored: JBS Hill Crest Competency Restoration Program CRF Physical Address: [redacted] Birmingham, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 10:45 ☒AM☐ PM Departure Time:11:15 ☒AM☐ PM

Areas Observed	Observed	Concerns
C. Bathrooms	Yes	
D. Laundry Area	Yes	
E. Clothing Storage	Yes	
F. Kitchen/Dining Area	No	The kitchen/dining area was not observed during visit.
G. Food Supply	No	Advocate did not observe food supply during visit.
H. Classrooms	Yes	
I. Outside Area	Yes	
J. Advocacy # Posted	Yes	
K. Medications Secured	Yes	
L. Other (Specify)	Not Applicable	

Section III. DIRECTOR'S MONITORING RESPONSE

Director, please notice that Section III is designed to have you write/type in your response and return it to the Advocate at the mailing or email address listed on the last page of this form.

Advocate's Recommendations	Potential Rights Issue	Contracting Agency Director's Response	Director's Targeted Completion Date

Site Monitored: JBS Hill Crest Competency Restoration Program CRF Physical Address: [redacted] Birmingham, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 10:45 ☒AM☐ PM Departure Time:11:15 ☒AM☐ PM

Advocate's Recommendations	Potential Rights Issue	Contracting Agency Director's Response	Director's Targeted Completion Date

[redacted]

2/21/22

Director's Signature **Date**

__X__ There is no response required.

Service Area Address: **DMH Community Advocacy Office**
Service Area: II East
Address: [redacted]
Birmingham, AL [redacted]
Telephone: [redacted]
Email: [redacted] mh.alabama.gov

Advocate: [redacted] **Date: 2/18/22**

cc: DMH Advocacy Director
Other Address:

If response is requested cc: **MH/SA, Beth Bergeron**

Site Monitored: Rehab Intervention Services Enrichment (RISE) CRF Physical Address: [redacted] Birmingham, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:15 ☒AM☐ PM Departure Time:11:30 ☒AM☐ PM
TO: [redacted] **FROM: [redacted]**
Contracting Agency Director **Advocate**

Number of Consumers Present: 12 Number of Staff Present: 4
Names/Positions of Staff Spoken to: Redacted - PII

Section I. Visiting with Individuals

	Observed	Comments
A. Comments from Individuals	**Yes**	Consumer indicated that she had been having thoughts about harming herself. However, she said that she did not want anyone to know about this. Advocate stated to consumer that if she was having thoughts about harming herself, then it would have to be disclosed to staff at the facility. Consumer then retracted her previous statement and said that she was not really thinking about harming herself. Advocate observed red marks on the left arm of consumer and consumer indicated that she had harmed herself within the past month. Consumer also stated that she is treated well by staff and that if there are any issues with other consumers, the staff intervenes to resolve the situation. Advocates spoke with COO, [redacted] regarding concerns related to consumer indicating that they had been having thoughts of harming themselves. [redacted] stated that facility therapist was aware of the issue and had already had one conversation with consumer, and she has since calmed down. He also stated that the therapist would have a follow-up conversation with the consumer regarding this concern.
B. Staff/Consumer Interaction	**Yes**	Staff interaction with consumers was acceptable, based upon observation. Staff asked the person if they would like to speak with Advocates and provided them with a choice and also provided a private space to have a conversation for confidentiality.
C. Describe Activities	**Yes**	Most consumers were in class at the time of the visit. However, the consumers available were either relaxing in their bedrooms or common areas. It was indicated that consumers have opportunities to engage in going out to eat, socialization, recreating outside, and engaging in board games and puzzles.
D. Appearance	**Yes**	Consumer was observed to be wearing appropriate clothing and shoes and exhibited adequate hygiene.

Site Monitored: Rehab Intervention Services Enrichment (RISE) CRF Physical Address: [redacted] Birmingnam, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:15 ☒AM☐ PM Departure Time:11:30 ☒AM☐ PM

E. Restrictions	**Yes**	This is a locked unit.
F. Other (specify)	**Yes**	Advocate observed that a thermometer was used to take temperatures upon entry to facility. Also, a temperature log is maintained at setting and adequate soap/sanitizer and PPE is provided to consumers and staff.

Section II. AREAS OBSERVED

Areas Observed	Observed	Concerns
A. Living room	**Yes**	
B. Bedrooms	**Yes**	
C. Bathrooms	**Yes**	
D. Laundry Area	**Yes**	
E. Clothing Storage	**Yes**	
F. Kitchen/Dining Area	**No**	The kitchen/dining area was not observed during visit.
G. Food Supply	**No**	The food supply was not observed at the setting.
H. Classrooms	**Yes**	
I. Outside Area	**Yes**	
J. Advocacy #	**Yes**	

Site Monitored: Rehab Intervention Services Enrichment (RISE) CRF Physical Address: [redacted] **Birmingham, AL** [redacted]
Facility Number: [redacted] **Type Program: MICRF**
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] **Birmingham, AL** [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:15 ☒AM☐ PM Departure Time:11:30 ☒AM☐ PM

Areas Observed	Observed	Concerns
Posted		
K. Medications Secured	**Yes**	
L. Other (Specify)	**Not Applicable**	

Section III. DIRECTOR'S MONITORING RESPONSE

Director, please notice that Section III is designed to have you write/type in your response and return it to the Advocate at the mailing or email address listed on the last page of this form.

Advocate's Recommendations	Potential Rights Issue	Contracting Agency Director's Response	Director's Targeted Completion Date

[redacted]

2/21/22

Director's Signature **Date**

Site Monitored: Rehab Intervention Services Enrichment (RISE) CRF Physical Address: [redacted] Birmingham, AL [redacted]
Facility Number: [redacted] Type Program: MICRF
Contracting Agency Name: Hill Crest Behavioral Health Services
Mailing Address: [redacted] Birmingham, AL [redacted]
Sub- Contracting Agency: N/A

DMH RIGHTS PROTECTION AND ADVOCACY
Monitoring Report

Arrival Date: February 11, 2022 Time: 11:15 ☒AM☐ PM Departure Time:11:30 ☒AM☐ PM
____X___There is no response required.

Service Area Address: DMH Community Advocacy Office
Service Area: II East
Address: [redacted]
Birmingham, AL [redacted]
Telephone: [redacted]
Email: [redacted] mh.alabama.gov

Advocate: [redacted] Date: 2/18/22

cc: DMH Advocacy Director
Other Address:

If response is requested cc: **MH/SA, Beth Bergeron**

[redacted]

Previous Revision 09/10/2007; 4/1/2012; 12/11/15

Appendix 79.

UHS-FINHELP-00009444 [Redacted]

Department of Human Resources

Congregate Care Review

Hill Crest Behavioral Health Services
(Higdon Hill, Rise, and RTC)

November 27, 2021 - December 10, 2021

Office of Quality Assurance

Hill Crest

CONFIDENTIAL

Hill Crest Behavioral Health Services Review

November 27, 2021 - December 10, 2021

INTRODUCTION

This report describes the findings of a Congregate Care Review of Hill Crest Behavioral Health Services completed by the State Department of Human Resources, Office of Quality Assurance, Congregate Care Unit. The on-site review was conducted on December 7, 2021. The on-site review was initiated to serve the following purposes:

- Assess the quality of services delivered by Hill Crest Behavioral Services, County Departments of Human Resources, and State Department of Human Resources, Resource Management Division, to the children and families being served.
- Identify strengths and needs for the purpose of improving the quality of services provided and outcomes for families.
- Evaluate the status of service delivery by Hill Crest Behavioral Services relative to identified core services for intensive programs and to existing contracts.

REVIEW METHOD

The process used in the review of Hill Crest Behavioral Services integrated the following components:

- Review of contracts and core services for intensive programs.
- Review of facility data (incident reports, data tracking, corrective action plans, site visit reports, ejection request, etc.).
- On-site stakeholder interviews including interviews with children, parents, foster parents, GALs, teachers, service providers, and Department caseworkers.
- Record reviews of 2 or more children being served by Hill Crest Behavioral Health Services and completion of the Congregate Review Instrument to assess the safety, permanency, and well-being of the reviewed children. The completed Congregate Review Instruments are attached within this document. See **Appendix A.**

Congregate Care Review Completed by: [redacted]

1. Facility Organizational Structure

☒ **Strength** ☐ **Area Needing Improvement**

Basis:

Identified Strengths:

- Hillcrest has several management staff housed at their facility.
- Each group of employees has a person in charge of their respective program area (i.e., Nurse Manager, Activities Director, Therapy Coordinator, etc.).
- Hillcrest reports they have been able to maintain their child to staff ratios, despite staffing shortages. They further reported they have utilized management at times to ensure ratios are maintained. Child to staff ratios are 1:8 during the day and 1:10 during the night. The nurse to child ratio is 1:15.

Identified Needs:

- No identified needs noted.

2. Reports of Maltreatment

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Staff at Hillcrest reported a structure of reporting within the facility, and staff knew how to make a report to their management.
- Staff understands they are mandated reporters, and they aware of the requirements of making reports to DHR.

Identified Needs:

- Incident reports need to be completed timely and sent to SDHR within the timeframes outlined in the contract.
- All staff need to be trained on how to appropriately complete incident reports.
- Incident reports need to be detailed and include a summary of the incident, all staff involved, and witnesses.
- Reviews of incident reports determined that 'NA" was listed for staff involved in several restraints.
- There is no uniformity among staff about who is supposed to complete in-house incident forms.
- Stakeholder interviews determined that the completion of incident forms typically appears to be passed to a nurse, who may not have been present during the incident, to complete.
- It was also noted that not all reports that rise to the level of a CAN or prevention were being reported to DHR timely.

3. Risk and Safety Management

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Hillcrest has a database that can access incidents and/or staff involved, if given at the time of the report.
- A "Handle with Care" training is being implemented to deter staff from regular use of restraints. The training appears to have been established approximately one month prior to the review.

Identified Needs:

- Onsite camera footage needs to be kept longer than 2 weeks. The Congregate Care Team requested to view 3 separate incidents prior to the onsite visit, and 2 of the requested videos were not available at the time of the visit.
- Hillcrest needs to report all incidents in a timely manner so that DHR will be able to request camera footage of the incidents before it is deleted.
- Hillcrest needs a faster way of obtaining serious incident footage stored at their Corporate Management Company, as it can take several weeks to receive upon request.
- Decrease the use of restraints by using verbal de-escalation and other non-violent de-escalation practices.
- Provide regular, on-going training to staff to decrease the use of restraints.

4. Ejection Request and Reasons / Placement Stability

☒ **Strength** ☐ **Area Needing Improvement**

Basis:

Identified Strengths:

- Hillcrest does not request removal for many things and will allow additional chances for children in their programs.
- Hillcrest has regular treatment plan meetings and will discuss ejection requests as a team before making a recommendation and allow all parties to brainstorm ideas.
- Hillcrest seeks other treatment options before requesting removal.

Identified Needs:

- Children remain at Hillcrest longer than necessary.
- DHR is not working to discharge children when treatment goals have been met.

5. Social Development of the Child (Extra-curricular Activities)

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Hillcrest management and staff realize this area is something that is lacking during COVID and have made efforts to have more on-campus activities and events recently.

Identified Needs:

- Stakeholder interviews determined that there are no true extracurricular activities being offered for the children at this time, and it is being based upon COVID restrictions.
- Hillcrest mentioned beginning a volleyball team that would play other city schools; however, this would be in violation of the treatment needs of the children in an intensive facility.
- Hillcrest need to find a way to provide the children with more options for activities and outdoor time.
- The review team was not made aware of a designated outdoor space for the children.
- Hillcrest needs to have a virtual option for children who wish to attend and participate in a religious service in a denomination of the child's choosing.

6. Support of Permanency Goal of the Child

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Staff attend ISP meetings and update their treatment plans to reflect the permanency goals of the children.
- Staff are implementing some ILP skills for children to include cooking, cleaning, budgeting, and preparing for life on their own.

Identified Needs:

- Family counseling need to occur consistently for all children with family, relatives, or foster parents working toward reunification.
- Family members/caregivers need to be more involved in the treatment planning process to be better prepared for the child's discharge.
- Visits are not occurring unless seen as a Therapeutic Leave of Absence and the child has a set discharge date within the next month. The visits are not able to be day visits or slowly increased.
- Children need phone access to their GALs outside of their 3 calls per week.
- Children should be allowed to attend court without being made to quarantine for 5 days. Children see this as a punishment and often choose not to attend court because of it.

7. Visiting with Parents and Siblings

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Hillcrest has set up Zoom calls once per week for the children following their family counseling sessions.

- Hillcrest has increased phone calls to 3 times per week.
- Hillcrest is aware the children need more face to face interaction with family and are currently brainstorming ways to accomplish this safely while ensuring COVID restrictions are followed.

Identified Needs:

- The facility has not allowed visitation since COVID began.
- The children at Hillcrest need more than 3 calls per week that can only last up to 10 minutes each. This does not appear sufficient as this is the only true contact these children are having with family.
- Hillcrest staff did not seem to know how a child would maintain connections with parents, siblings in another placement, and a grandparent all within a week unless they used 1 call per person or waited until the next week to call one of them.
- The Zoom calls with family are only for a few minutes and occur after therapy sessions and may not always be positive after processing hard topics in family counseling.
- Hillcrest doesn't appear to be prioritizing connections with siblings as phone calls and Zooms were only noted for parents.
- Visitation may be used as a form of punishment at times due to stakeholders reporting that they gave certain individuals visits to "reward" their behavior or to provide an incentive for behavior.

8. Preserving Connections

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- The facility recognized this was an area of need and reported working on ways to make this happen in the near future.

Identified Needs:

- Hillcrest needs to keep the children involved within their community and other important connections.
- It has been determined that the children have not been attending religious events or had family and friends and others outside of DHR come to the facility for activities or events.
- There are no off-campus visits or outings occurring currently.
- The children aren't able to be involved in anything outside of the facility due to COVID restrictions.
- It was learned during stakeholder interviews that children were previously taken to the movies, Walmart trips, parks, or other community events; but this has stopped in the past two years.
- Stakeholders also reported not feeling they had access to the children unless they were employed by DHR.

9. Parents / Caregiver Involvement in Activities Other than Visits

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Parents are given the option to attend treatment plan meetings and IEPs virtually.

Identified Needs:

- Parents and caregivers are not able to be involved in the children's lives at the facility or off campus without special permission and the child being made to quarantine upon their return.
- All potential caregivers, not just parents, should be included in treatment planning.
- Parents and caregivers should be informed and given the opportunity to go to regular doctor visits, ER visits, graduations, or other important educational activities such as extracurricular activities, etc. when they are able.

10. Core Services to Children

☐ **Strength** ☒ **Area Needing Improvement**

Basis:
Identified Strengths:

- There is consistent group and individual therapy occurring weekly, and therapists are available each day of the week if needed by a child in emergency situations.
- Allowances are provided weekly, and the children can buy things they may want or need from the local commissary.
- Transportation to local dental and medical appointments is being provided by staff.
- Vocational training is being provided daily in school, and the children appear to enjoy this class.

Identified Needs:

- More basic and independent living skills are needed at the group home level as it appears they are mostly learning how to clean.
- There were noted concerns of limited outdoor extra-curricular and recreational activities that the child is interested in doing.
- The children enjoy going to My Father's House; however, since COVID they have not been able to go out, and they have not received those life skills.
- Fresh water needs to be readily provided to the children and there are concerns around the cleanliness of the water that is available via paper cups and igloo coolers.
- It was learned during stakeholder interviews that it may be difficult to access adequate amounts of cold water at any time a child may want or need it.
- Children at Hillcrest do not have access to tutoring after regular school hours or know how to access it.

11. Treatment Planning

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Treatment team meetings are occurring on a frequent and consistent basis.
- Children are attending treatment team meetings and they feel they can provide input and have a voice during these meetings.
- Treatment plans include a discharge date and a list of prescribed medications.

Identified Needs:

- Treatment plans need to include more educational information other than only listing child's current grade level.
- Treatment plans need to include a child's educational progress, grades, and summary of Initial and Post-Educational testing identifying needs/strengths.
- Appropriate educational staff need to be included in treatment plan meetings.
- Medication logs are no longer being put into the treatment plan; and therefore, are not being given to DHR or custodians without specifically being requested.
- Medication tracking should be completed and provided to the custodians.
- Behavioral techs who work directly with the children on the floor are not able to attend treatment team meetings due to a shortage of staff.

12. Child and Family Involvement in Treatment Planning

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Children are attending treatment team meetings, and they feel they are able to provide input and have a voice during these meetings.
- Hillcrest has recently implemented a way for parents/caregivers to attend treatment plan meetings virtually. This has not been consistently used for all families.

Identified Needs:

- DHR needs to be informed of the treatment team meetings in advance.
- Treatment plans need to be consistently sent to DHR each month.
- Children need to be informed and educated on the side effects of their prescribed medications listed in their treatment plan.
- Efforts to include family in the treatment planning process need to occur more, (i.e., dates/times) and should be made as convenient for the family as possible
- Virtual options need to be readily available for parents, caregivers, and DHR to attend treatment plan meetings whenever needed by the families.

13. Caseworker Visits with Child

☒ **Strength** ☐ **Area Needing Improvement**

Basis:

Identified Strengths:

- DHR caseworker visits are occurring with children at Hillcrest.
- DHR workers are able to go into the child's room to observe the child.
- DHR workers are able to have private interviews with the child.
- DHR workers are welcomed into the educational department and encouraged to visit by educational staff.

Identified Needs:

- DHR workers need to visit children more than once per month and need to make more meaningful visits instead of drop-ins.
- DHR needs to communicate the progress/barriers and efforts as it relates to the transition of being placed in a less restrictive setting or with family.
- DHR workers need to visit the school at Hillcrest more often and be more involved with educational aspects of these children.

14. Educational Needs of Children

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- The School at Hillcrest is accredited and offers 2 diploma options to give children more opportunity for success.
- The children enjoy attending school and they really enjoy their vocational teacher, as this has helped them to identity different career paths.
- Each classroom has a behavioral tech at all times.
- Entrance and exit educational testing is being provided.
- Access to technology and tablets are available in the classroom, and it is monitored.
- The principal of the school is knowledgeable and attends conferences each year to stay up to date on the latest educational advancements and has applied for and received several grants for the school.

Identified Needs:

- Interviews determined that children are aware they can receive help during class time, but they are not aware of tutoring services being provided after school hours or during school.
- Hillcrest staff did not appear to know about individual tutoring services available.
- It was learned through stakeholder interviews that some children feel they are not on target and need an IEP, but nothing has been done to assist them.
- One child interviewed expressed concerns of not receiving any individualized tutoring services to address below average grades of D's that were received in several subjects.
- Stakeholders reported concerns about the children's transition to public school and not feeling the children will not be on target upon discharge from Hillcrest.
- Concerns were raised of schoolwork not being challenging enough or either schoolwork being too difficult, so there may be a lack of consistency.
- All educational testing results from pre/post-tests need to be provided to DHR.
- Educational staff at Hillcrest need to be invited and made an active part of the ISP.
- DHR needs to provide school transcripts to Hillcrest upon child's admission.

15. Physical Health of Children

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- A nurse practitioner is available daily.
- Nurses are available 24/7 to the children.
- A pediatrician is onsite once per week.
- Hillcrest and DHR partner to transport child to off campus doctor appointments.

Identified Needs:

- Hillcrest needs to provide timely COVID vaccines upon approval of the ISP team.
- Children should be seen by an outside doctor if experiencing medical issues prior to the onsite pediatrician's weekly visit.
- Children should receive timely second opinions by outside doctors if medical issues continue after being evaluated/receiving treatment by the onsite pediatrician and nurses.
- Hillcrest needs to make accommodations for children to receive other treatments, such as braces.

16. Mental/Behavioral Health of Children

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Therapists are available daily, and Hillcrest is fully staffed in this department.
- Interns are assigned to fully licensed therapists and are available to children as additional mental health staff.
- Individual counseling and group therapies are being provided consistently.
- Interns are providing additional therapy sessions but cannot count as the main weekly individual counseling session for the child.

Identified Needs:

- Hillcrest has high turnover rates lately in their mental health staff, and staffing needs to be more consistent to ensure rapport with the children.
- Hillcrest needs to readily provide MAR (medication review tool used in-house) to county staff if this is no longer a part of the treatment plan.
- Hillcrest needs to implement in-person family therapy as it is only occurring via Zoom and doesn't appear consistent across the board for all patients or available to all caregivers.
- Hillcrest needs to implement a behavioral management plan for all children at intake and not be reactionary in planning.

17. Outcome Tracking

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Hillcrest has recently begun active surveying through electronic means to try and get a better sample of children's feelings during their stay.
- The recent changes made to include the utilization of electronic discharge surveys allows children more privacy when completing and a better completion rate.
- Education outcome tracking/testing is being completed at intake and discharge.

Identified Needs:

- Satisfaction surveys weren't occurring until recently.
- Hillcrest needs to share information more readily with DHR instead of depending on DHR staff to ask for certain documents which many staff may not know exist.

18. Daily Care Staff -Training – Clearances

☐ **Strength** ☒ **Area Needing Improvement**

Basis:

Identified Strengths:

- Hillcrest staff receive ongoing training and shadowing upon being hired for at least 2 weeks.
- Hillcrest utilizes a color-coded ID badge system for staff who have pending clearances and are not authorized to be alone with children until they are cleared by their management staff.
- Children have access to staff 24/7 rotating and awake.

Identified Needs:

- Hillcrest needs to implement RPPS training as it is not occurring, and management did not know what it was.
- Hillcrest needs to stabilize staff as they report high turnover rates and a shortage in staffing in almost every department.
- Hillcrest needs to ensure all daily care staff are reviewing charts for the children they are responsible for to gain a better understanding of the child's history/diagnoses/triggers and ways to manage each child individually.
- Hillcrest needs to have more consistent point deduction system for violations instead of leaving to staff discretion. The current system was requested by the review team and unable to be provided or explained.

Overall Indicator Tally

Strengths:	3
Areas Needing Improvement:	15

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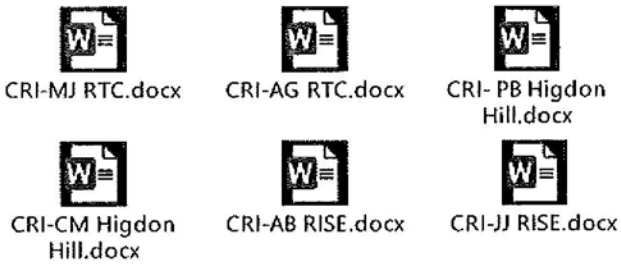
Appendix A
Completed Congregate Review Instruments



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Congregate Care Review
Feedback

Facility:	Hill Crest (Higdon Hill, Rise, and RTC)
Review Dates:	Nov. 27, 2021 – Dec. 10, 2021
Submission Date:	Feb. 11, 2022
Response Dates:	March 14, 2022, May 11, 2022, and Aug. 11, 2022

State DHR, Office of Quality Assurance has established a feedback loop allowing the reviewed facility to provide an update of corrective actions taken to address items found to be an Area Needing Improvement. Please provide a response based upon the needs identified in the Systemic Report.

A response date is provided for each item needing corrective action.

30 days
Response date: 3/14/2022

- Item 6: Support of Permanency Goal of the Child (page 5)
  Response: Click or tap here to enter text.
- Item 7: Visiting with Parents and Siblings (page 5)
  Response: Click or tap here to enter text.
- Item 10: Core Services to Children (page 7)
  Response: Click or tap here to enter text.
- Item 12: Child and Family Involvement in Treatment Planning (page 8)
  Response: Click or tap here to enter text.

3 months
Response date: 5/11/2022

- Item 2: Reports of Maltreatment (page 3)
  Response: Click or tap here to enter text.
- Item 3: Risk and Safety Management (page 3)
  Response: Click or tap here to enter text.
- Item 5: Social Development of the Child (Extra-Curricular Activities) (page 4)
  Response: Click or tap here to enter text.
- Item 8: Preserving Connections (page 6)
  Response: Click or tap here to enter text.

- Item 9: Parents/Caregivers Involvement in Activities other than Visits (page 7)
  Response: Click or tap here to enter text.

- Item 11: Treatment Planning (page 8)
  Response: Click or tap here to enter text.

6 months
Response date: 8/11/2022

- Item 14: Educational Needs of Children (page 9)
  Response: Click or tap here to enter text.

- Item 15: Physical Health of Children (page 10)
  Response: Click or tap here to enter text.

- Item 16: Mental/Behavioral Health of Children (page 10)
  Response: Click or tap here to enter text.

- Item 17: Outcome Tracking (page 11)
  Response: Click or tap here to enter text.

- Item 18: Daily Care Staff – Training / Clearances (page 11)
  Response: Click or tap here to enter text.

Congregate Care Review
Feedback

Facility:	Hill Crest (Higdon Hill, Rise, and RTC)
Review Dates:	Nov. 27, 2021 – Dec. 10, 2021
Submission Date:	Feb. 11, 2022
Response Dates:	March 14, 2022, May 11, 2022, and Aug. 11, 2022

State DHR, Office of Quality Assurance has established a feedback loop allowing the reviewed facility to provide an update of corrective actions taken to address items found to be an Area Needing Improvement. Please provide a response based upon the needs identified in the Systemic Report.

A response date is provided for each item needing corrective action.

30 days
Response date: 3/14/2022

- Item 6: Support of Permanency Goal of the Child (page 5)
  Response: The Director of Clinical Services has instructed the Social Services staff to initiate more frequent family counseling and will provide more detailed documentation on when these sessions occur and/or if the family, relatives, foster parents, or guardians working towards reunification participate/attend the family sessions. Universal facility visitations were suspended due to Covid-19 Safety Protocols. During the Covid-19 Pandemic, patient visitations have been evaluated on a case-by-case basis directly dependent upon the clinical need/benefit to the individual patient; Patients are informed that they may contact their GAL outside the regularly scheduled phone times; Patients were asked to quarantine upon returning from court based on then current CDC/UHS Covid-19 protocols, now that the infection rate has significantly reduced the quarantine requirements are being reduced accordingly. The facility also provides access to court hearings via Zoom.

- Item 7: Visiting with Parents and Siblings (page 5)
  Response: Universal visitations were suspended due to then current CDC/UHS Covid-19 Safety Protocols and the facility being identified as a "high risk" due the proximity of patients to one another. Visitations have been evaluated on a case-by-case basis directly dependent upon the clinical needs/benefit to the individual patient. Due to the dramatic reduction in positivity rates, visitation was re-initiated March 2022. The current unit programs provide a scheduled phone call three (3) times per week. DCS asked the therapists, how they would handle a situation where a resident has more than 3 people to call. The majority of therapists stated they have never faced this issue of more people to call than calls allowed and would seek out assistance from supervisor if had this issue. One therapist noted she has a couple or residents with this issue and has suggested they rotate the calls during the week and offers extra calls when she gets the residents during the week for sessions. DCS has informed all staff to offer calls if they are aware of difficulties reaching family/guardian(s) that is involved. Several therapists noted asking residents if they have difficulty reaching family/caregivers and they assist with allowing calls if this is an issue. DCS asked the therapists when the zoom visits are in relation to the sessions. Most

therapists stated typically at the beginning with a couple stating sometimes at the end. All therapists were agreeable to visits being at the beginning of the session. When asked if siblings are allowed to attend, the majority of staff acknowledged asking if siblings wanted to visit. The procedure will now be to clarify if the siblings need to be in the session after the visit and address appropriately once the session is to begin. DCS clarified that siblings and other family are involved in the zoom visits but they have not been documenting. The attendees will be documented. The patients are afforded supplemental opportunities to communicate with family members/guardians during individual therapy sessions. Phone calls and Zoom calls to family members/guardians are occurring for patients. The Social Services staff notes a session with the patient's family/guardian(s) but does not list the individuals participating in each Zoom call i.e. Mom, Dad, Sister, Brother, etc.. There may also be circumstances in which select additional family members may not be on the approved contact list due to some other clinical reason. All visitations are based upon the clinical need/benefit to the patient and are not used as a punishment or reward. Visitation is a right afforded to all patients. Visitation access was limited/adjusted due to the Covid-19 pandemic CDC/UHS protocols. For clarification, sometimes Temporary Leave of Absence (TLOA) can be confused with visitation. Visitation is not based on levels. TLOA is limited to what is clinically appropriate and is discussed in the treatment team which includes the patient and the family/guardian(s) as part of that team.

- Item 10: Core Services to Children (page 7)
  Response: The Director of Clinical Services is evaluating and updating the program schedule at the group home to include more basic and independent living skills. The visits to My Father's House were suspended due to then current CDC/UHS guidelines related to Covid-19. Patient access to water fountains were suspended due to CDC/UHS safety protocols. However, water is available at all times to patients either via a water pitcher and/or water cooler on each unit. The patients are provided individual cups to obtain the water. The water contained in the cooler is obtained daily (or as often as needed) from the Dietary Department after the water cooler had been cleaned. The facility renewed access to all water fountains on 2/24/22; patients are still provided individual cups to obtain the water. Tutoring services are provided daily during every class period per the school schedule and after school if appropriate to meet the patient's educational needs.

- Item 12: Child and Family Involvement in Treatment Planning (page 8)
  Response: DHR workers are informed via email and phone calls of all treatment team meetings. There are occasions in which a treatment team meeting time may be amended due to unforeseen circumstances. In those rare occasions, a member of the Social Services staff attempts to make contact with the DHR worker at that time to inform him/her of the change. Social Services send both a full Master Treatment Plan and a two (2)-week summary to DHR monthly. If there is any other significant event or information that needs to be communicated with DHR, the Social Services staff member will either call and/or email the DHR worker directly. The RN attending the treatment team meeting will provide continued education to the patient about their medications and any potential side effects. Treatment team meeting dates/times are provided to the guardians in advance of the scheduled meetings. The meeting times are based upon when the physician is available. The facility attempts to maintain the same treatment team schedule from month to month. Hill Crest has offered the option to attend the treatment team meetings via Zoom since 9/2020.

3 months
Response date: 5/11/2022

- Item 2: Reports of Maltreatment (page 3)
  Response: Click or tap here to enter text.

- Item 3: Risk and Safety Management (page 3)
  Response: Click or tap here to enter text.

- Item 5: Social Development of the Child (Extra-Curricular Activities) (page 4)
  Response: Click or tap here to enter text.

- Item 8: Preserving Connections (page 6)
  Response: Click or tap here to enter text.

- Item 9: Parents/Caregivers Involvement in Activities other than Visits (page 7)
  Response: Click or tap here to enter text.

- Item 11: Treatment Planning (page 8)
  Response: Click or tap here to enter text.

6 months
Response date: 8/11/2022

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Jan1 Feb10
Feb11 13th

Congregate Care Review
Feedback

Facility:	Hill Crest (Higdon Hill, Rise, and RTC)
Review Dates:	Nov. 27, 2021 – Dec. 10, 2021
Submission Date:	Feb. 11, 2022
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aware of difficulties reaching family/guardian(s) that is involved. Several therapists noted asking residents if they have difficulty reaching family/caregivers and they assist with allowing calls if this is an issue. DCS asked the therapists when the zoom visits are in relation to the sessions. Most therapists stated typically at the beginning with a couple stating sometimes at the end. All therapists were agreeable to visits being at the beginning of the session. When asked if siblings are allowed to attend, the majority of staff acknowledged asking if siblings wanted to visit. The procedure will now be to clarify if the siblings need to be in the session after the visit and address appropriately once the session is to begin. DCS clarified that siblings and other family are involved in the zoom visits but they have not been documenting. The attendees will be documented. The patients are afforded supplemental opportunities to communicate with family members/guardians during individual therapy sessions. Phone calls and Zoom calls to family members/guardians are occurring for patients. The Social Services staff notes a session with the patient's family/guardian(s) but does not list the individuals participating in each Zoom call i.e. Mom, Dad, Sister, Brother, etc.. There may also be circumstances in which select additional family members may not be on the approved contact list due to some other clinical reason. All visitations are based upon the clinical need/benefit to the patient and are not used as a punishment or reward. Visitation is a right afforded to all patients. Visitation access was limited/adjusted due to the Covid-19 pandemic CDC/UHS protocols. For clarification, sometimes Temporary Leave of Absence (TLOA) can be confused with visitation. Visitation is not based on levels. TLOA is limited to what is clinically appropriate and is discussed in the treatment team which includes the patient and the family/guardian(s) as part of that team.

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  Response: DHR workers are informed via email and phone calls of all treatment team meetings. There are occasions in which a treatment team meeting time may be amended due to unforeseen circumstances. In those rare occasions, a member of the Social Services staff attempts to make contact with the DHR worker at that time to inform him/her of the change. Social Services send both a full Master Treatment Plan and a two (2)-week summary to DHR monthly. If there is any other significant event or information that needs to be communicated with DHR, the Social Services staff member will either call and/or email the DHR worker directly. The RN attending the treatment team meeting will provide continued education to the patient about their medications and any potential side effects. Treatment team meeting dates/times are provided to the guardians in advance of the scheduled meetings. The meeting times are based upon when the physician is available. The facility attempts to maintain the same treatment team schedule from

UHS-FINHELP-00009552 [Redacted]

The Joint Commission

Final Accreditation Report

Hill Crest Behavioral Health Services

[redacted]

Birmingham, AL [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 5/19/2021 - 5/21/2021

Programs Surveyed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 5/26/2021

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	05/19/2021 - 05/21/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date
Behavioral Health Care and Human Services	05/20/2021 - 05/21/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

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What's Next - Follow-up Activity

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.03.01.09	1	Low / Widespread	✓
	2	Low / Widespread	✓
CTS.04.03.33	3	Low / Widespread	✓
EC.02.04.03	3	Low / Limited	✓
LS.02.01.35	5	Low / Limited	✓
MM.03.01.01	2	Low / Limited	✓
	4	Moderate / Pattern	✓
	8	Low / Limited	✓

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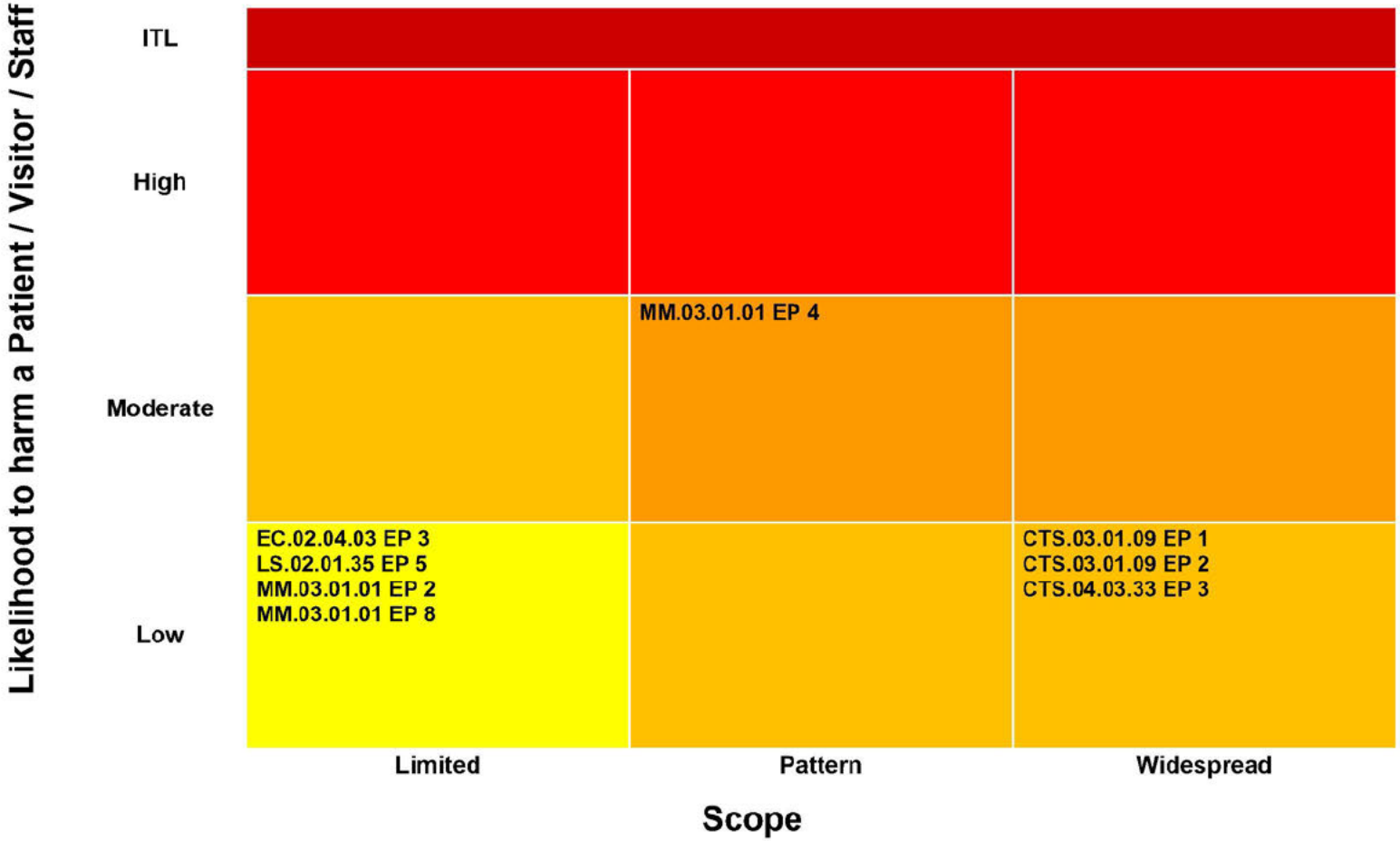
SAFER™ Matrix

Program: Behavioral Health Care and Human Services



The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.03.01.09	1	Low Widespread	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care or other out-of-home care for children and youth).	1) Observed in Record Review at RISE, Phase II ([redacted] Bessemer, AL) site . It was observed that the staff at the group home had not been using the standardized outcome measurement tool selected by the organization's leadership to monitor the client's progress in treatment. This was verified by the Director of Clinical Services.
CTS.03.01.09	2	Low Widespread	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.	1) Observed in Record Review at Higdon Hill Group Home [redacted] Birmingham, AL) site . In 4 out of 4 records reviewed, it was observed that the results of the Child/Adolescent Behavior Assessment (CABA) were not being used to inform the goals and objectives of the treatment plan.
CTS.04.03.33	3	Low Widespread	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.	1) Observed in Building Tour at Higdon Hill Group Home [redacted] Birmingham, AL) site . It was observed that two out of two refrigerators inspected during the building tour of the adolescent group home had dates without recorded temperatures on the temperature logs. The temperature of the refrigerator on the girl's side of the group home had not been completed for 05/19/21. This refrigerator was in need of cleaning as pools of a clear liquid were observed on the middle shelf, and a purple substance was observed on the bottom shelf. In addition, there was a package of opened hotdogs covered in tinfoil without a date that it was opened or a date for it to be discarded. The temperature of the refrigerator on the girl's side of the group home had not been completed for 05/19/21. The temperature of the refrigerator on the boy's side of the group home had not been completed for 05/02/21, 05/03/20, 05/08/20, 05/09/20, 05/10/20, 05/11/20, 05/16/20 and 05/17/20. There was also a half-eaten rotisserie chicken observed in the refridgerator that had a "Best if used by" date of 05/18/21.

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Standard	EP	SAFER™ Placement	EP Text	Observation
EC.02.04.03	3	Low Limited	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.	1) Observed in Building Tour at Higdon Hill Group Home [redacted] Birmingham, AL) site . It was observed the eye flush solution in the staff office had expired in September 2020. This was verified by the Program Manager.
LS.02.01.35	5	Low Limited	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)	1) Observed in Building Tour at RISE, Phase II [redacted] Bessemer, AL) site . It was observed the escutcheon plate in the laundry room and staff office were missing at the group home. This was verified by the Director of Clinical Services. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission
MM.03.01.01	2	Low Limited	For organizations that store medications: The organization stores medications according to the manufacturers' recommendations or a pharmacist's instructions. Note: This element of performance is also applicable to sample medications.	1) Observed in Medication Management Tracer at Higdon Hill Group Home [redacted] Birmingham, AL) site . It was observed that the group home had not been monitoring the temperature of the refrigerator that medications were stored in, therefore, it could not be determined if medications were being stored at the manufacturer's recommended temperature.
MM.03.01.01	4	Moderate Pattern	For organizations that store medications: The organization follows a written policy addressing the control of medication between receipt by staff and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications.	1) Observed in Medication Management Tracer at Higdon Hill Group Home [redacted] Birmingham, AL) site . The organization's policy/process did not include the group home staff monitoring the controlled substances (i.e. counting medications at shift change) to ensure they were not diverted during the course of the patient's care. The process was for the nurse to bring medications from the pharmacy, double lock them in the medication cart, and the adolescent (age 12-17) was responsible for counting their medications as they self-administered them.
				2) Observed in Medication Management Tracer at RISE, Phase II [redacted] Bessemer, AL) site . The organization's policy/process did not include the group home staff monitoring the controlled substances (i.e. counting medications at shift change) to ensure they were not diverted during the course of the patient's care. The process was for the nurse to bring medications from the pharmacy, double lock them in the medication cart, and the adolescent was responsible for counting their medications as they self-administered them.

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Standard	EP	SAFER™ Placement	EP Text	Observation
MM.03.01.01	8	Low Limited	For organizations that store medications: The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. (See also MM.05.01.19, EP 1) Note: This element of performance is also applicable to sample medications.	1) Observed in Medication Management Tracer at Higdon Hill Group Home [redacted] Birmingham, AL) site . It was observed that a bottle of Guaifenesin had expired on 03/17/21 but was still available for use in the medication cart in the staff office of the group room. This was verified by the program manager.

Standard	EP	Standard Text	EP Text
			and time of administration Note 1: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation (See also PC.01.02.03, EP 6; PC.01.03.01, EP 23; PC.03.01.03, EPs 1, 8; PC.06.01.01, EP 1)
RC.02.04.01	3	The patient's medical record contains discharge information.	In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided - The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.03.01.09	1	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care or other out-of-home care for children and youth).
CTS.03.01.09	2	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
CTS.04.03.33	3	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
EC.02.04.03	3	The organization inspects, tests, and maintains medical equipment.	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.
LS.02.01.35	5	The organization provides and maintains systems for extinguishing fires. Note: This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)
MM.03.01.01	2	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization stores medications according to the manufacturers' recommendations or a pharmacist's instructions. Note: This element of performance is also applicable to sample medications.
MM.03.01.01	4	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization follows a written policy addressing the control of medication between receipt by staff and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications.

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Standard	EP	Standard Text	EP Text
MM.03.01.01	8	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. (See also MM.05.01.19, EP 1) Note: This element of performance is also applicable to sample medications.

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Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

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Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

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Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Final Accreditation Report

Hill Crest Behavioral Health Services
[redacted]
Birmingham, AL [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 7/29/2021

ESC Programs Reviewed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 8/5/2021

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Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	7/29/2021	No Requirements for Improvement	None	None
Behavioral Health Care and Human Services	7/29/2021	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health Care and Human Services

Standard	Level of Compliance
CTS.03.01.09	Compliant
CTS.04.03.33	Compliant
EC.02.04.03	Compliant
LS.02.01.35	Compliant
MM.03.01.01	Compliant

[redacted]

The Joint Commission

Standard	EP	Standard Text	EP Text
CTS.03.01.09	1	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care or other out-of-home care for children and youth).
CTS.03.01.09	2	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
CTS.04.03.33	3	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
EC.02.04.03	3	The organization inspects, tests, and maintains medical equipment.	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.
LS.02.01.35	5	The organization provides and maintains systems for extinguishing fires. Note: This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)
MM.03.01.01	2	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization stores medications according to the manufacturers' recommendations or a pharmacist's instructions. Note: This element of performance is also applicable to sample medications.
MM.03.01.01	4	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization follows a written policy addressing the control of medication between receipt by staff and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications.

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The Joint Commission

Standard	EP	Standard Text	EP Text
MM.03.01.01	8	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. (See also MM.05.01.19, EP 1) Note: This element of performance is also applicable to sample medications.

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

UHS-FINHELP-00009579 [Redacted]

The Joint Commission

Final Accreditation Report

Hill Crest Behavioral Health Services
[redacted]
Birmingham, AL [redacted]

Organization Identification Number: [redacted]
ITL Abatement Survey: 1/12/2018 - 1/12/2018

Programs Surveyed
Hospital
Behavioral Health

Final Report: Posted 1/19/2018

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Executive Summary

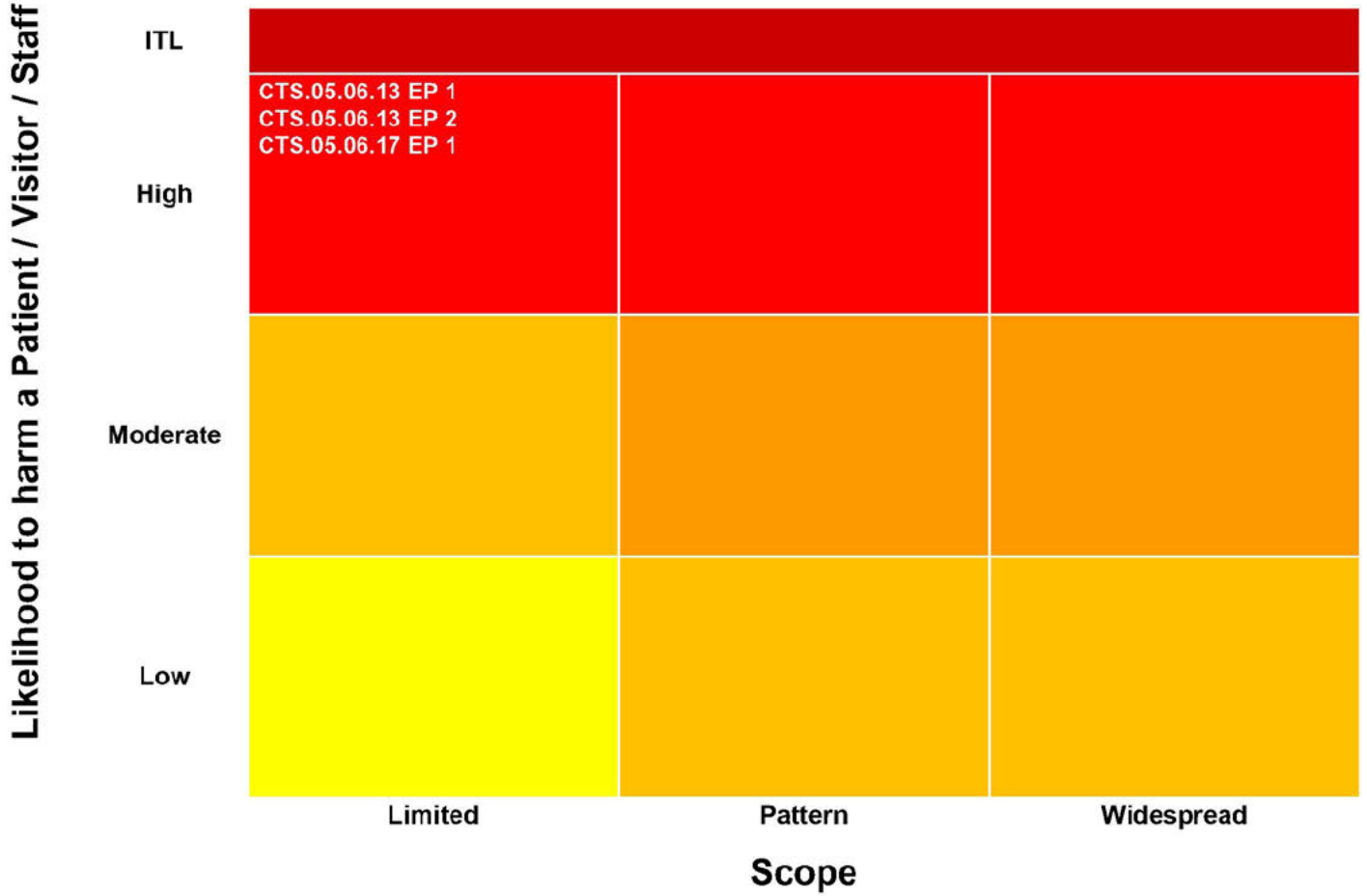
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	01/12/2018 - 01/12/2018	No Requirements for Improvement	None	None
Behavioral Health	01/12/2018 - 01/12/2018	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.05.06.13	1	High / Limited	✓
	2	High / Limited	✓
CTS.05.06.17	1	High / Limited	✓

The Joint Commission
SAFER™ Matrix
Program: Behavioral Health



The Joint Commission
Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.05.06.13	1	High Limited	For organizations that use restraint or seclusion: All restraint and seclusion are applied and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the ongoing care of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner. Note: Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), the organization may authorize qualified, trained staff members who are not licensed independent practitioners to initiate restraint or seclusion before an order is obtained from the licensed independent practitioner. In addition, restraint and seclusion may be ordered by licensed practitioners (for example, registered nurses, licensed social workers) if permitted by state law and by the organization.	1). Observed in Individual Tracer at Hill Crest Behavioral Health Services [redacted] Birmingham, AL) site. An adolescent patient was restrained on 12/31. There was no order until 1/2 and it was unclear in the order that the order was actually for the restraint on 12/31. In addition the Seclusion and Restraint record was not completed until 1/2 when the organization learned about this through the Advocate rounds.
				2). Observed in Individual Tracer

Standard	EP	SAFER™	EP Text	Observation
				at Hill Crest Behavioral Health Services [redacted] Birmingham, AL) site. Another instance was noted in the record of a 13 year old male patient when according to the RN note it appeared as though he had been restrained, but an order for restraint was not obtained. The RN wrote "Patient walked to his room and released." When the Risk Manager and CPI trainer was asked about whether this was a restraint, they agreed to view the video and after agreed that it was a restraint and should have been processed as such. They agreed to continue to educate staff and perhaps revise their policy on "Restraint of a Patient in Residential Services" to include more specific definitions of the types of physical holds they do.
CTS.05.06.13	2	High Limited	For organizations that use restraint or seclusion: As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff do the following: - Notifies and obtains an order (verbal or written) from the licensed independent practitioner - Consults with the licensed independent practitioner about the physical and psychological condition of the individual served	1). Observed in Individual Tracer at Hill Crest Behavioral Health Services [redacted] Birmingham, AL) site. In reviewing the child's record. He had been restrained on 12/31 but the order and physician did not sign off on the record until 1/2. So there is no evidence that the physician was consulted within one hour.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.05.06.17	1	High Limited	For organizations that use restraint or seclusion: The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner, evaluates the individual in restraint or seclusion in person within four hours of the initiation of restraint or seclusion for individuals ages 18 or older, and within two hours of initiation for children and youth ages 17 and under.	1). Observed in Individual Tracer at Hill Crest Behavioral Health Service[redacted] Birmingham, AL) site. In the instance of a 13 year old patient being restrained on 12/31. This was not discovered until 1/2 when the face to note by the RN qualified to do this was completed.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.05.06.13	1	For organizations that use restraint or seclusion: A licensed independent practitioner orders the use of restraint or seclusion. Note: This standard is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to physician assistants and advanced practice nurses to the extent recognized under state law or a state's regulatory mechanism and allowed by the organization.	For organizations that use restraint or seclusion: All restraint and seclusion are applied and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the ongoing care of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner. Note: Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), the organization may authorize qualified, trained staff members who are not licensed independent practitioners to initiate restraint or seclusion before an order is obtained from the licensed independent practitioner. In addition, restraint and seclusion may be ordered by licensed practitioners (for example, registered nurses, licensed social workers) if permitted by state law and by the organization.
CTS.05.06.13	2	For organizations that use restraint or seclusion: A licensed independent practitioner orders the use of restraint or seclusion. Note: This standard is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to physician assistants and advanced practice nurses to the extent recognized under state law or a state's regulatory mechanism and allowed by the organization.	For organizations that use restraint or seclusion: As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff do the following: - Notifies and obtains an order (verbal or written) from the licensed independent practitioner - Consults with the licensed independent practitioner about the physical and psychological condition of the individual served
CTS.05.06.17	1	For organizations that use restraint or seclusion: A licensed independent practitioner sees and evaluates the individual in restraint or seclusion in person.	For organizations that use restraint or seclusion: The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner, evaluates the individual in restraint or seclusion in person within four hours of the initiation of restraint or seclusion for individuals ages 18 or older, and within two hours of initiation for children and youth ages 17 and under.

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The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Final Accreditation Report

Hill Crest Behavioral Health Services
[redacted]
Birmingham, AL [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 5/25/2018

ESC Programs Reviewed
Hospital
Behavioral Health

Final Report: Posted 6/5/2018

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Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	5/25/2018	No Requirements for Improvement	None	None
Behavioral Health	5/25/2018	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.03.01.03	Compliant
EC.02.06.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

[redacted]

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.03.01.03	1	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.
EC.02.06.01	1	The organization establishes and maintains a safe, functional environment.	Interior spaces meet the needs of the individuals served for safety and suitability for the care, treatment, or services provided.

UHS-FINHELP-00009627 [Redacted]

Final Accreditation Report

Brentwood Behavioral Healthcare of Mississippi, LLC

[redacted]

Flowood, MS [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 5/8/2020

ESC Programs Reviewed
Hospital
Behavioral Health

Final Report: Posted 5/26/2020

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Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.01.03	Compliant
CTS.02.02.03	Compliant
EC.02.03.01	Compliant
EC.02.04.03	Compliant
EC.02.06.01	Compliant
NPSG.15.01.01	Compliant
RI.01.01.01	Compliant

The Joint Commission

Redacted

Program: Behavioral Health

The Joint Commission

Standard	EP	Standard Text	EP Text
CTS.02.01.03	2	The organization performs screenings and assessments as defined by the organization's policy.	The organization conducts each individual's assessment within the time frame specified by the needs of the individual served, organization policy, and law and regulation.
CTS.02.02.03	4	A complete and accurate assessment drives the identification and delivery of the care, treatment, or services needed by the individual served.	The organization matches the individual with care, treatment, or services that will meet his or her needs, strengths, preferences, and goals.
EC.02.03.01	1	The organization manages fire risks.	The organization minimizes the potential for harm from fire, smoke, and other products of combustion.
EC.02.04.03	3	The organization inspects, tests, and maintains medical equipment.	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.
EC.02.06.01	26	The organization establishes and maintains a safe, functional environment.	The organization keeps furnishings and equipment safe and in good repair.
NPSG.15.01.01	1	Reduce the risk for suicide.	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).
RI.01.01.01	7	The organization respects the rights of the individual served.	The organization respects the right of the individual served to privacy. (See also IM.02.01.01, EPs 1, 3, and 4) Note: This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, please see EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of health information, please refer to Standard IM.02.01.01.

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

The Joint Commission

Final Accreditation Report

Brentwood Behavioral Healthcare of Mississippi, LLC

[redacted]

Flowood, MS [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 2/24/2020 - 2/26/2020

Programs Surveyed
Hospital
Behavioral Health

Final Report: Posted 3/11/2020

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Executive Summary

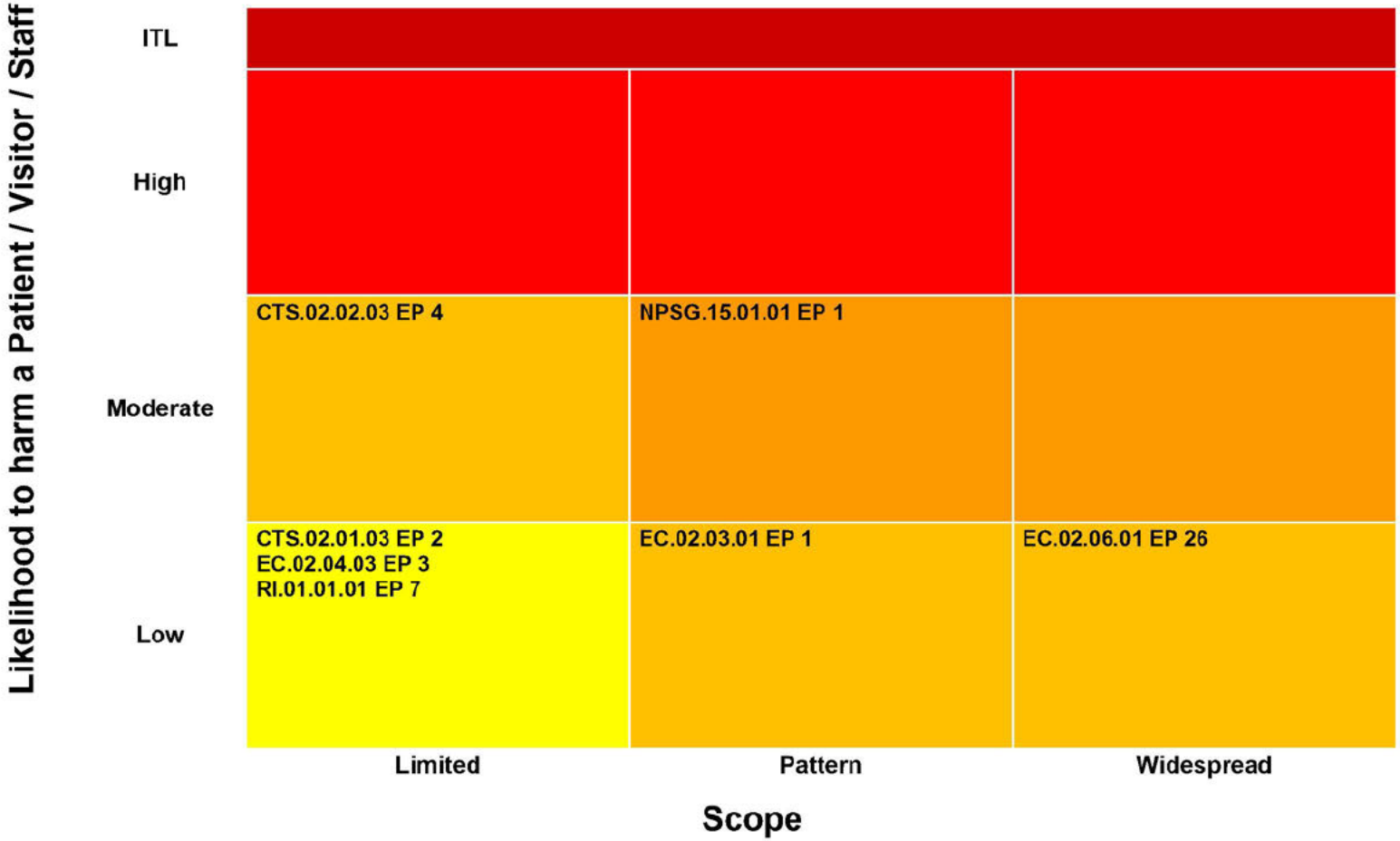
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	02/24/2020 - 02/26/2020	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Unannounced Medicare Deficiency Survey	Survey within 45 Calendar Days from the last day of survey
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date
Behavioral Health	02/25/2020 - 02/25/2020	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.01.03	2	Low / Limited	✓
CTS.02.02.03	4	Moderate / Limited	✓
EC.02.03.01	1	Low / Pattern	✓
EC.02.04.03	3	Low / Limited	✓
EC.02.06.01	26	Low / Widespread	✓
NPSG.15.01.01	1	Moderate / Pattern	✓
RI.01.01.01	7	Low / Limited	✓

The Joint Commission
SAFER™ Matrix
Program: Behavioral Health



The Joint Commission
Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.03	2	Low Limited	The organization conducts each individual's assessment within the time frame specified by the needs of the individual served, organization policy, and law and regulation.	1). Observed in Individual Tracer at Brentwood Acquisitions, Inc [redacted]Jackson, MS) site . Assessments for a residential patient were either not completed or only partially completed within the time frame identified by organizational policy. This was affirmed by the Clinical Director and Program Director.
CTS.02.02.03	4	Moderate Limited	The organization matches the individual with care, treatment, or services that will meet his or her needs, strengths, preferences, and goals.	1). Observed in Individual Tracer at Brentwood Acquisitions, Inc [redacted]Jackson, MS) site . For an adolescent on the residential unit identified at high risk for self-harm, the biopsychosocial assessment section labeled "Interventions for High Risk Residents" did not included specific interventions beyond those provided to all residents (e.g., individual therapy, group therapy). This was affirmed by the Clinical Director and Program Director.
EC.02.03.01	1	Low Pattern	The organization minimizes the potential for harm from fire, smoke, and other products of combustion.	1). Observed in Building Tour at Brentwood Acquisitions, Inc [redacted]Jackson, MS) site . Two dryer lint traps on the residential unit showed large amounts of combustible material. This was affirmed by the Clinical Director and program Director.
EC.02.04.03	3	Low Limited	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.	1). Observed in Building Tour at Brentwood Acquisitions, Inc [redacted]Jackson, MS) site . A "Smart Sink" used for medication wasting showed brown discoloration on the drain protector leading to the liquid wasting portion of the equipment. Nursing staff were not able to speak to the product's cleaning or maintenance.
EC.02.06.01	26	Low Widespread	The organization keeps furnishings and equipment safe and in good repair.	1). Observed in Building Tour at Brentwood Acquisitions, Inc [redacted]Jackson, MS) site . Multiple bedrooms on the residential unit showed wall patching and paint loss. This was affirmed by the Clinical Director and Program Director.
				2). Observed in Building Tour at Brentwood Acquisitions, Inc [redacted]Jackson, MS) site . Multiple bathrooms on the residential unit showed signs of a copper colored substance resembling rust on hand rails and soap dispensers. This was affirmed by the Clinical Director and the Program Director.
NPSG.15.01.01	1	Moderate Pattern	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk	1). Observed in Building Tour at Brentwood Acquisitions, Inc [redacted]Jackson, MS) site . The residential unit building tour identified ligature points in Room 9 including a gap

The Joint Commission

Standard	EP		EP Text	Observation
			(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).	between the desk and the corner of the room walls creating a ligature anchor point if not sealed with pick resistant caulk and a CPAP machine locker that was secured with a pad lock creating a loopable anchor point. These were affirmed by the Facilities/Safety Director. The pad lock was removed and observed as corrected on site. The gap was filled with pick resistant caulk and observed as corrected on site.
RI.01.01.01	7	Low Limited	The organization respects the right of the individual served to privacy. (See also IM.02.01.01, EPs 1, 3, and 4) Note: This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, please see EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of health information, please refer to Standard IM.02.01.01.	1). Observed in Building Tour at Brentwood Acquisitions, Inc [redacted] Jackson, MS) site . During the residential building tour, Room 2 was observed without a privacy curtain between the sleeping area and the bathroom. This was affirmed by the Clinical Director and Program Director.

The Joint Commission

Redacted

Program: Behavioral Health

The Joint Commission

Standard	EP	Standard Text	EP Text
CTS.02.01.03	2	The organization performs screenings and assessments as defined by the organization's policy.	The organization conducts each individual's assessment within the time frame specified by the needs of the individual served, organization policy, and law and regulation.
CTS.02.02.03	4	A complete and accurate assessment drives the identification and delivery of the care, treatment, or services needed by the individual served.	The organization matches the individual with care, treatment, or services that will meet his or her needs, strengths, preferences, and goals.
EC.02.03.01	1	The organization manages fire risks.	The organization minimizes the potential for harm from fire, smoke, and other products of combustion.
EC.02.04.03	3	The organization inspects, tests, and maintains medical equipment.	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.
EC.02.06.01	26	The organization establishes and maintains a safe, functional environment.	The organization keeps furnishings and equipment safe and in good repair.
NPSG.15.01.01	1	Reduce the risk for suicide.	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).
RI.01.01.01	7	The organization respects the rights of the individual served.	The organization respects the right of the individual served to privacy. (See also IM.02.01.01, EPs 1, 3, and 4) Note: This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, please see EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of health information, please refer to Standard IM.02.01.01.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

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Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

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Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

UHS-FINHELP-00009639 [Redacted]

[redacted]

mdcps
Mississippi Department of Child Protection Services

The State of Mississippi
Governor Tate Reeves
Commissioner Andrea A. Sanders
www.mdcps.ms.gov

August 26, 2022

[redacted] CEO
Brentwood Behavioral Healthcare
[redacted]
Flowood, MS [redacted]
Redacted - PII

Dear Ms. Land:

Enclosed you will find the final investigation report of the Mississippi Department of Child Protection Services (MDCPS) Special Investigations Unit (SIU) related to a report of child maltreatment involving a foster child placed with your agency. This report is being provided to you pursuant to Mississippi Code Section 43-21-261(22)(a) so that you may take such corrective action as may be necessary to provide appropriate care to children in the custody of MDCPS.

Under Mississippi Code Section 43-21-261(2), your agency has a legal duty to keep this report and all contents thereof confidential in compliance with the Mississippi Youth Court Act. Any unauthorized disclosure of this information is a misdemeanor punishable by a fine a not to exceed $1,000 and imprisonment not to exceed one (1) year. Miss. Code § 43-21-267(1). Unauthorized disclosure also may be punished by a finding of civil contempt by the relevant youth court judge. Miss. Code § 43-21-267(2). Should you have questions about your obligation to keep this information confidential, you should consult with your agency's legal counsel.

Sincerely,

[redacted]
Chief Legal Counsel

[redacted] Jackson, MS [redacted]

[redacted]

mdcps
Mississippi Department of Child Protection Services

The State of Mississippi
Governor Tate Reeves
Commissioner Andrea A. Sanders
www.mdcps.ms.gov

8.9.22

[redacted] CEO
Brentwood Behavioral Healthcare
[redacted]
Flowood, MS [redacted]
Redacted - PII

RE: Brentwood Behavioral Health: Redacted - PII

Dear Mrs. [redacted] CEO:

This letter is to notify you of the findings of our assessment of your facility. On 7.11.22 the Mississippi Department of Child Protection Services received a report of alleged emotional abuse & neglect on (CIC) Redacted - PII by facility staff Redacted - PII

The assessment finds the allegations to be substantiated for emotional abuse & neglect on Redacted - PII Redacted - PII by facility staff Redacted - PII

At minimum MDCPS recommendations include:

1.Training for staff on behavioral indicators of children with history of trauma exposure
2.Training for staff on mandated reporting and reporting ANE in a timely manner
3.Complaince with MDCPS request for information on children in care at the facility

A licensure investigation may follow this maltreatment in care investigation to further assess any violations of licensure requirements and address any corrective actions as needed. Your assigned Licensure entity may be contacting you regarding the licensure investigation.

Sincerely,

[redacted] Social Service Specialist, II
MDCPS Special Investigations Unit

[redacted] Social Service Manager
MDCPS Special Investigation Unit

[redacted] Jackson, MS [redacted]

7/9/22 Redacted - PII

UHS-FINHELP-00009680 [Redacted]

The Joint Commission

Final Accreditation Report

Texas San Marcos Treatment Center, LP

[redacted]
San Marcos, TX [redacted]

Organization Identification Number [redacted]
Unannounced Full Event: 5/30/2018 - 6/1/2018

Program Surveyed
Behavioral Health

Final Report: Posted 6/4/2018

The Joint Commission
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The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health	05/30/2018 - 06/01/2018	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

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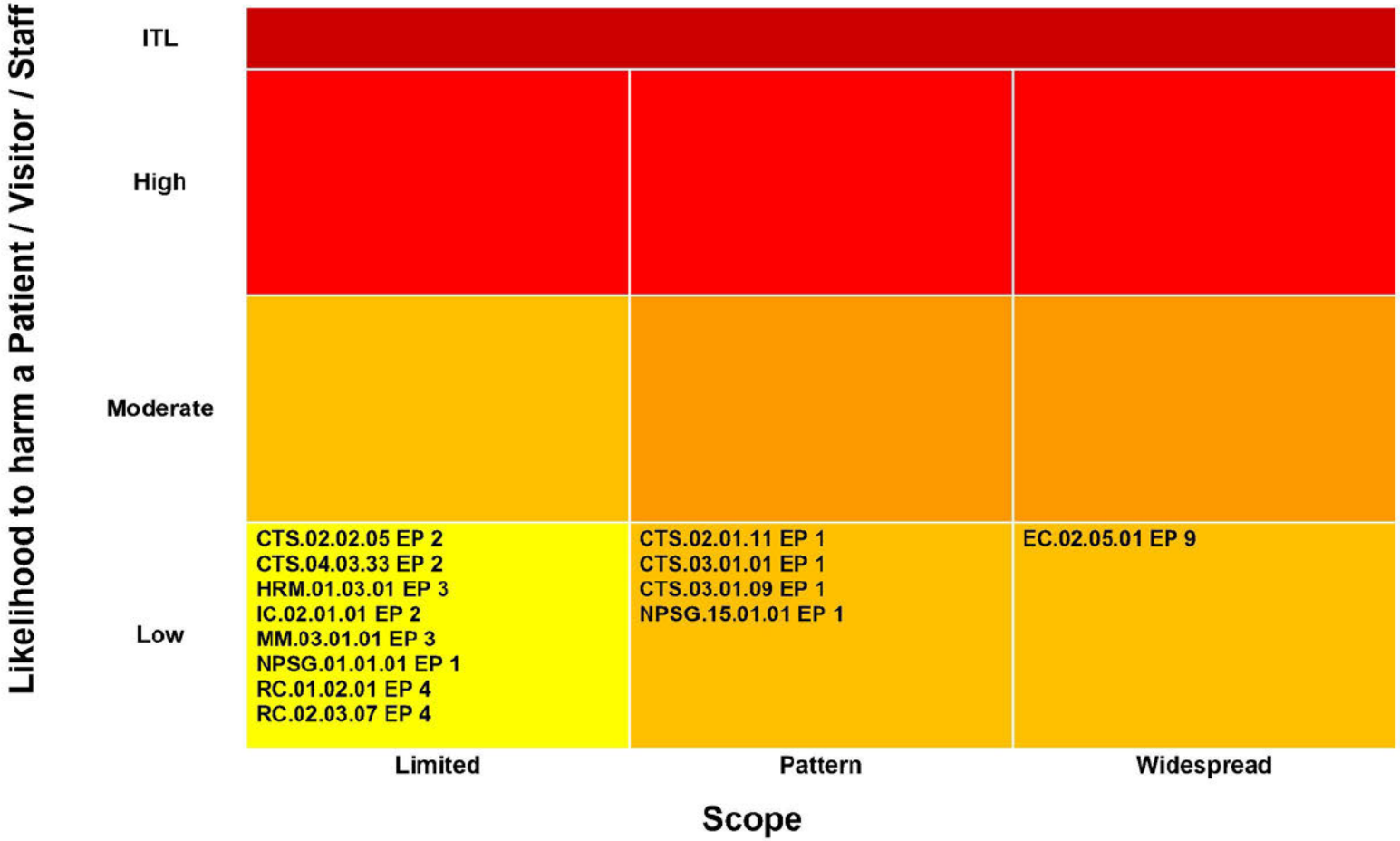
What's Next - Follow-up Activity

Program: Behavioral Health

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.01.11	1	Low / Pattern	✓
CTS.02.02.05	2	Low / Limited	✓
CTS.03.01.01	1	Low / Pattern	✓
CTS.03.01.09	1	Low / Pattern	✓
CTS.04.03.33	2	Low / Limited	✓
EC.02.05.01	9	Low / Widespread	✓
HRM.01.03.01	3	Low / Limited	✓
IC.02.01.01	2	Low / Limited	✓
MM.03.01.01	3	Low / Limited	✓
NPSG.01.01.01	1	Low / Limited	✓
NPSG.15.01.01	1	Low / Pattern	✓
RC.01.02.01	4	Low / Limited	✓
RC.02.03.07	4	Low / Limited	✓

The Joint Commission
SAFER™ Matrix
Program: Behavioral Health



The Joint Commission
Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.11	1	Low Pattern	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of ten pounds or more in the last three months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting	1). Observed in Individual Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . The child had a long standing problem with diabetes that was being treated. The nutrition screen contained an item for diabetes that required a yes or no answer and would trigger a referral for a nutritional assessment. The nurse had left that entire section of the assessment blank.
				2). Observed in Surveyor review but corrected onsite pending acceptable Evidence of Standards Compliance at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . It was noted that the organization's nutrition screen, did not contain questions to inquire about weight loss or gain in the last three months nor to identify if there was a decrease in food intake. While surveyor was onsite, the organization amended the nutrition screening form to include all required questions.
CTS.02.02.05	2	Low Limited	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis.	1). Observed in Individual Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . When reviewing a client's record, it was noted there were no questions to identify if the client had a history of exploitation.
CTS.03.01.01	1	Low Pattern	The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.	1). Observed in Individual Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . In 2 of 3 patient records reviewed, Needs of the individual based on psychological and psychiatric assessments were not identified on the treatment plans.
CTS.03.01.09	1	Low Pattern	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus	1). Observed in Individual Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . In 3 of 4 patient records reviewed, it was noted that standardized tools were scored and documented in client's files, but there were no indication of the tools being utilized to monitor the client's progress or achievement of their goals.

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Standard	EP	SAFER™ Placement	EP Text	Observation
			such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care).	
CTS.04.03.33	2	Low Limited	For organizations providing food services: Food and nutrition products are prepared under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.	1). Observed in Building Tour at Texas San Marcos Treatment Center, LP ([redacted]San Marcos, TX) site . There was a process to ensure that foods requiring refrigeration were stored at the proper temperature. However, it was ineffective. The temperature was recorded several times per day. Within a 30 day period, it had been out of the required range 22 times and there was no documentation that any action had been taken.
EC.02.05.01	9	Low Widespread	The organization labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.	1). Observed in Building Tour at Texas San Marcos Treatment Center, LP ([redacted]San Marcos, TX) site . The water shutoff controls for the buildings were not labeled.
				2). Observed in Surveyor review but corrected onsite pending acceptable Evidence of Standards Compliance at Texas San Marcos Treatment Center, LP [redacted]San Marcos, TX) site . During a building tour of three residential units, it was noted that those units shared a main water, gas, and electric shutoff. The shutoffs were not labeled. This was corrected onsite.
HRM.01.03.01	3	Low Limited	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the	1). Observed in Competency Session at Texas San Marcos Treatment Center, LP[redacted]San Marcos, TX) site . It was noted that a staff member who transitioned to a new job within the organization did not have documentation of his orientation to his new position.

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Standard	EP	SAFER™ Placement	EP Text	Observation
			organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.	
IC.02.01.01	2	Low Limited	The organization uses standard precautions, * including the use of personal protective equipment (such as gloves and face shields), to reduce the risk of infection. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).	1). Observed in Medication Management Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . A nurse did not use personal protective equipment (such as gloves) when removing a bag contaminated whit blood.
MM.03.01.01	3	Low Limited	For organizations that store medications: The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation. Note: This element of performance is also applicable to sample medications.	1). Observed in Building Tour at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . The organization process to ensure the safe storage of controlled medications and prevent diversion required that, at change of shift, both nurses count the controlled medications and sign that the count was accurate. It was observed that, after the completion of the change of shift process, as the nurse who had been on duty was leaving, when a question was asked about this process, it became clear that it had not been followed. The nurse who was leaving then returned, signed the form verifying that it had been done and the nurses proceed to count the medications.
				2). Observed in Building Tour at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . During a tour of the medication rooms of Gateway East and New Heights with nursing staff, it was noted that there were expired medications. Gateway East has Triple Antibiotic Ointment that expired in February 2018; New Heights had SteriStips that expired in 2017.
NPSG.01.01.01	1	Low Limited	Use at least two identifiers of the individual served when administering medications or collecting specimens for clinical testing. The room number or physical location of the individual served is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11)	1). Observed in Medication Management Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . The organization policy required that the individual administering medications verify the name and birth date of the child receiving the medications. While passing medications, the nurse did not ask either for three children. Although the nurse may have been familiar with the children because of their long stays in the program, the Director of Nursing verified that this was not in compliance with their policy.
NPSG.15.01.01	1	Low Pattern	Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase	1). Observed in Individual Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . The

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
			or decrease the risk for suicide.	suicide risk assessment process had a very limited set of risk, factors that increase the risk of suicide, and protective factors, factors that decrease the risk of suicide, The factors that increased the risk of suicide were limited to items screened for in the suicide risk screen.
RC.01.02.01	4	Low Limited	Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.	1). Observed in Individual Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . The weekly report by the case manager for a four week period was completed, However, the signature line was blank. It had not been signed by the author..
RC.02.03.07	4	Low Limited	Verbal orders are authenticated within the time frame specified by law and regulation.	1). Observed in Record Review at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . The verbal telephone order written by the nurse and implemented was not signed by the physician who had given the order for 34 days. The organization policy is that all verbal orders must be signed within 48 hours.
				2). Observed in Individual Tracer at Texas San Marcos Treatment Center, LP [redacted] San Marcos, TX) site . A telephone order was given verbally on 3/13/18 and signed on 3/19/2018, which was outside of the organization's policy to have telephone orders signed within 48 hours.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of ten pounds or more in the last three months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.02.02.05	2	The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis.
CTS.03.01.01	1	The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served. Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.	The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.
CTS.03.01.09	1	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress,

The Joint Commission

Standard	EP	Standard Text	EP Text
			functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care).
CTS.04.03.33	2	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are prepared under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
EC.02.05.01	9	The organization manages risks associated with its utility systems.	The organization labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.
HRM.01.03.01	3	The organization provides orientation to staff.	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.
IC.02.01.01	2	The organization implements its infection prevention and control plan.	The organization uses standard precautions, * including the use of personal protective equipment (such as gloves and face shields), to reduce the risk of infection. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
MM.03.01.01	3	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation. Note: This element of performance is also applicable to sample medications.

The Joint Commission

Standard	EP	Standard Text	EP Text
NPSG.01.01.01	1	Use at least two identifiers when providing care, treatment, or services. Note: Treatments covered by this goal include high-risk interventions and certain high risk medications (for example, methadone). In some settings, use of visual recognition as an identifier is acceptable. Such settings include those that regularly serve an individual (for example, therapy) or serve only a few individuals (for example, a group home). These are settings in which the individual stays for an extended period of time, staff and populations served are stable, and individuals receiving care are well-known to staff.	Use at least two identifiers of the individual served when administering medications or collecting specimens for clinical testing. The room number or physical location of the individual served is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11)
NPSG.15.01.01	1	Identify individuals at risk for suicide.	Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.
RC.01.02.01	4	Entries in the clinical/case record are authenticated.	Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.
RC.02.03.07	4	Qualified staff receive and record verbal orders. Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.	Verbal orders are authenticated within the time frame specified by law and regulation.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Final Accreditation Report

Texas San Marcos Treatment Center, LP
[redacted]
San Marcos, TX [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 8/29/2018

ESC Programs Reviewed
Behavioral Health

Final Report: Posted 8/30/2018

The Joint Commission
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- Requirements for Improvement (RFI) Summary 4

Appendix 5

- Standards/Elements of Performance (EP) Language 5

The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health	8/29/2018	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.01.11	Compliant
CTS.02.02.05	Compliant
CTS.03.01.01	Compliant
CTS.03.01.09	Compliant
CTS.04.03.33	Compliant
EC.02.05.01	Compliant
HRM.01.03.01	Compliant
IC.02.01.01	Compliant
MM.03.01.01	Compliant
NPSG.01.01.01	Compliant
NPSG.15.01.01	Compliant
RC.01.02.01	Compliant
RC.02.03.07	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of ten pounds or more in the last three months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.02.02.05	2	The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis.
CTS.03.01.01	1	The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served. Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.	The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.
CTS.03.01.09	1	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress,

The Joint Commission

Standard	EP	Standard Text	EP Text
			functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care).
CTS.04.03.33	2	For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.	For organizations providing food services: Food and nutrition products are prepared under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
EC.02.05.01	9	The organization manages risks associated with its utility systems.	The organization labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.
HRM.01.03.01	3	The organization provides orientation to staff.	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.
IC.02.01.01	2	The organization implements its infection prevention and control plan.	The organization uses standard precautions, * including the use of personal protective equipment (such as gloves and face shields), to reduce the risk of infection. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
MM.03.01.01	3	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation. Note: This element of performance is also applicable to sample medications.

The Joint Commission

Standard	EP	Standard Text	EP Text
NPSG.01.01.01	1	Use at least two identifiers when providing care, treatment, or services. Note: Treatments covered by this goal include high-risk interventions and certain high risk medications (for example, methadone). In some settings, use of visual recognition as an identifier is acceptable. Such settings include those that regularly serve an individual (for example, therapy) or serve only a few individuals (for example, a group home). These are settings in which the individual stays for an extended period of time, staff and populations served are stable, and individuals receiving care are well-known to staff.	Use at least two identifiers of the individual served when administering medications or collecting specimens for clinical testing. The room number or physical location of the individual served is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11)
NPSG.15.01.01	1	Identify individuals at risk for suicide.	Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.
RC.01.02.01	4	Entries in the clinical/case record are authenticated.	Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.
RC.02.03.07	4	Qualified staff receive and record verbal orders. Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.	Verbal orders are authenticated within the time frame specified by law and regulation.

UHS-FINHELP-00009713 [Redacted]

AHCA POC
Visit 07.14.2020

C052 – Operating Stds-Housekeeping Clean/Safe/Vented – 65E-9.005(7)(a-b), F.A.C.

This Statute or Rule is not met as evidenced by: Based on observation and interview, the RTC failed to maintain the bathrooms, bedrooms, and the cafeteria in a clean and safe condition to prevent condensation and mold growth for 4 of 6 sampled RTC units occupied by residents and the cafeteria, where the residents' and staffs' food is served.

* See Report for specific findings.

PLAN OF CORRECTION	Plant Operations Department immediately deep cleaned all areas that were observed to have unidentified black spots; Ceiling tiles were immediately replaced. Plant Operations continues to maintain daily schedule of deep-cleaning of the bathroom areas. The vent exhaust system is being addressed to control better air exhaust to minimize black spot buildup. The unidentified black spots in the bathrooms were caused by both engineering and design flaws during the construction of those select bathrooms. The Director of Plant Operations is contracting with vendors to install tile in the bathrooms to control water splashing that has resulted in unidentified black spots. The facility boilers are checked Monday thru Friday to ensure they are working on the reheat water for the air conditioning system. This was identified as the cause for water condensation stains on the ceiling tiles.
COMPLETION DATE	09.13.2021
PERSON RESPONSIBLE	[redacted]
MONITORING PLAN	Housekeeping will continue to complete a daily checklist that contains indicators for black spot buildup and ceiling tile stains. Checklist will be collected and monitored by Director of Plant Operations and will report on data monthly.

FACSIMILE COVER LETTER

FAX		
	Date & Time:	09-20-2021 1:48 PM
	Deliver To:	[redacted]Administrator
	Fax Number:	[redacted]
	From:	[redacted]
	Phone:	
	Regarding:	Sandy Pines Event ID [redacted]

Good Afternoon,
Please see the attached report of the Complaint survey concluded on 09/10/21.
Thank You,
[redacted]

[redacted]REGISTERED NURSE CONSULTANT
[redacted]
[redacted] DELRAY BEACH, FL [redacted]
[redacted](Office) - [redacted]or [redacted]
(Fax)
Cell Phone [redacted]
[redacted]@ahca.myflorida.com

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RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

September 20, 2021

[redacted] Administrator
Sandy Pines
[redacted]
Tequesta, FL [redacted]

RE: Complaint Number [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted]

Dear Mr. [redacted]

This letter reports the findings of a complaint survey that was commenced on September 07, 2021 and concluded on September 10, 2021 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified during the visit. Section 408.811(4), Florida Statutes, requires that you correct the deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **The First Page of State 3020 Form must be signed, titled and dated by the Administrator or other authorized official at the bottom where indicated.** **You will not receive a copy of this report in the mail; you will only receive this faxed report. Please attach a summary of your corrective action for the deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of the identified deficiency. Submit summary and documents to the Field Office no later than September 30, 2021.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiency identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at [redacted]

Sincerely,

[redacted] RNC for

[redacted]
Field Office Manager

AMD
Enclosure: State (3020) Form

XG90

Delray Beach Field Office
[redacted]
Delray Beach, Fl[redacted]
Phone:[redacted] Fax:[redacted]
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

PRINTED: 09/20/2021
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
C 000	INITIAL COMMENTS An unannounced Licensure Complaint survey, [redacted] and [redacted] was conducted on September 7, 2021 through September 10, 2021 at Sandy Pines, Residential Treatment Center For Children And Adolescents facility, The facility had a deficiency at the time of the survey.	C 000		
C 052	65E-9.005(7)(a-b), F.A.C. Operating Stds-Housekeeping Clean/Safe/Vented (7) Housekeeping. (a) The facility and its contents shall be kept free from dust, dirt, debris and noxious odors. (b) All rooms and corridors shall be maintained in a clean, safe, and orderly condition, and shall be properly ventilated to prevent condensation, mold growth, and noxious odors. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Residential Treatment Center for Children and Adolescents (RTC) failed to maintain the bathrooms, bedrooms and the cafeteria in a clean and safe condition to prevent condensation and mold growth for 4 of 6 sampled RTC units occupied by residents and the cafeteria, where the residents' and staffs' food is served. The findings included: Observation tour of the RTC was completed on 09/07/21 at 9:50 AM, with the Risk Manager, Director of Nursing (DON) and one other surveyor. The following concerns were observed on the units occupied by residents: Dolphin Unit:	C 052		

PRINTED: 09/20/2021
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
C 052	Continued From page 1 Room 103-Black like substance noted around access panels for the air conditioner. Starfish Unit: Room 203-There are stains, brown soot and rust on and around the vent on the ceiling. Manatee Unit: Room 609-black like substance on wall by the shower. Room 607-Bathroom- Black like substance noted on lower corner of wall by shower. Room 605- Bathroom-Black like substance noted on lower corner wall by shower. Room 603-Bathroom- Black like substance noted on lower corner of wall by shower. Bathroom has a distinct odor of "mildew/mold." Room 601-Bathroom- Black like substance noted on lower corner of wall by shower. Black spots noted on ceiling in bathroom. Room 604-Bathroom- Black like substance noted on lower corner of wall by shower. Room 606- Bathroom- Black like substance noted on lower corner of wall by shower. Room 608-Bathroom- Black like substance noted on lower corner of wall by shower. Seagull Unit: Room 517- Black like substance noted on lower corner of wall by shower. Room 519-Black like substance noted on lower corner of wall by shower. Room 523- Black like substance noted on lower corner of wall by shower. Room 525- Black like substance noted on lower corner of wall by shower. Room 524- Black like substance noted on lower corner of wall by shower. Room 522- Black like substance noted on lower corner of wall by shower.	C 052		

CONFIDENTIAL UHS-FINHELP-00009717

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
C 052	Continued From page 2	C 052		

Room 520- Black like substance noted on lower corner of wall by shower.
Room 518- Black like substance noted on lower corner of wall by shower.

Cafeteria-Ceiling tiles have stains and several of them appear to be wet, water puddle on floor below one of the ceiling tiles. This is above and next to where the salad bar is but not currently being using due to COVID-19. Drink machines are in the vicinity.

Photographic evidence for each room noted.

During an interview on 09/09/21 at 8:56 AM with Maintenance/Plant Ops Tech, when asked about the black like substances that look like mold he states, " I never noticed it, I don't check the bathrooms unless there is a problem." Housekeeping checks it; they do 2 units a day. If there was a problem, it would go to the Maintenance Director or if someone wrote a work order. We had a guy go back the last two days to try to correct the concerns."

During an interview on 09/09/21 at 8:06 AM with Housekeeping Supervisor, he acknowledges the bathrooms are "not in good shape where they should be." The walls in the bathroom where the mildew is in the sheet rock, we need to go back and put a waterproof barrier; when asked if the black like substance can be mold, he stated, "It is mold. We spray with a chemical that we use to remove the mildew it works but the company we have is not good. We have a third-party housekeeping company that comes in to clean. They are cleaning the bathrooms everyday but not getting cleaned properly."

Class III

CONFIDENTIAL UHS-FINHELP-00009718

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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

UHS-FINHELP-00009720 [Redacted]

FACSIMILE COVER LETTER

FAX		
	Date & Time:	09-20-2021 1:39 PM
	Deliver To:	[redacted] Administrator
	Fax Number:	[redacted]
	From:	[redacted]
	Phone:	
	Regarding:	Sandy Pines event ID [redacted]

Good Afternoon,
Please see the attached report of the Recertification Survey survey concluded on 09/10/21.
Thank You,
[redacted]

[redacted] REGISTERED NURSE CONSULTANT
Delray Beach - [redacted]
[redacted] DELRAY BEACH, FL [redacted]
[redacted] (Office) - [redacted] or [redacted]
(Fax)
Cell Phone [redacted]
[redacted]@ahca.myflorida.com

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RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

September 20, 2021

Mr. [redacted] Administrator
Sandy Pines
[redacted]
Tequesta, FL [redacted]

Dear Mr. [redacted]

Re: Recertification Survey

This letter reports the findings of a Recertification survey, including Emergency Preparedness completed on September 10, 2021 by representatives of this office. It was determined the Psychiatric Residential Treatment Facility was not in compliance.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, Form CMS 2567 indicating the standard level deficiency cited. You will not receive a copy of this report in the mail; you will only receive this faxed report.

You must provide the Agency with an acceptable Plan of Correction (PoC) for the deficiency cited within ten calendar days from receipt of the Form CMS 2567. Please complete a Plan of Correction (PoC) for the deficiency, including the date corrective action was accomplished or is anticipated to be accomplished, sign and date page 1 on the bottom, and return to this Field Office within ten calendar days of receipt. All deficiencies must be corrected no later than October 10, 2021.

In order for a PoC to be acceptable, it must include the following elements:

Core Elements of PoC:

- How the corrective action will be accomplished for individuals found to have been affected by the deficient practice;
- How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and

Delray Beach Field Office
[redacted]
Delray Beach, FL [redacted]
Phone [redacted] Fax: [redacted]
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- When corrective action will be accomplished.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. If you have questions, please contact this office at [redacted]

Sincerely,

[redacted] RNC for

[redacted]
Field Office Manager

AMD
Enclosure: Form CMS 2567

BNOB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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) COMPLETION DATE
N 000	Initial Comments An unannounced Recertification survey was conducted on September 7, 2021 through September 10, 2021 at Sandy Pines, Psychiatric Residential Treatment Facility. The facility was not in compliance with 42 CFR Part 483, Subpart G, Conditions Of Participation for Psychiatric Residential Treatment Facilities.	N 000		
N 185	APPLICATION OF TIME OUT CFR(s): 483.368(c) Staff must monitor the resident while he or she is in time out. This ELEMENT is not met as evidenced by: Based on review of the Psychiatric Residential Treatment Facility (PRTF)'s Policies and Procedures, record review, interview and observation, the PRTF failed to document the monitoring of their residents while in "Time Out" for 5 of 14 sampled residents (Resident #14, Resident #15, Resident #16, Resident#17 and Resident #7). The findings included: 1. Review of the PRTF's "Policy and Procedures" for "Time Out," effective 01/08/1990 and revised 09/2020 reveals, under "Documentation" that it is the responsibility of the staff who initiates "Time Out" to document it on the "Log," on the shift that the time out occurs. A note is written by the staff who initiated the "Time Out" in the "Progress Note," regarding the "Time Out," including the reason for the "Time Out," less restrictive alternatives used, duration of "Time Out," the effect of "Time Out," any injuries incurred and	N 185		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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N 185	Continued From page 1	N 185		

treatment provided for the injuries.
A review of the "Time Out Log" for Resident #14 on 09/10/21 reveals the" Time Out Log" is blank and does not document any "Time Outs."
During an interview on 09/10/21 at 12:20 PM, Staff D, a Registered Nurse (RN) states, "I have worked for this facility for 4 months and I am not familiar with any 'Time Out Logbooks;" when asked if she could name a resident that she knows has had "Time Outs," she stated the resident ... (Resident #14) had a "Time Out" yesterday or the day before that and acknowledged that the "Time Out Log" is "blank" for this resident.

2. Observation on 09/09/21 at 2:15 PM, accompanied by Risk Manager Coordinator, reveals Resident#15 was placed in "Time Out" after having a verbal altercation with another resident. A review of the "Time Out Log" on 09/10/21 reveals that this "Time Out," at 2:15 PM was not documented on the "Time Out Log" which documented only two "Time Outs" that are not completely filled out for the location of the "Time Out," if injuries occurred, who initiated the "Time Out" and the exit criteria from "Time Out," as well as the required information to include the disposition at the end of the "Time Out" and the progression of behaviors during the "Time Out" episode.
During an interview on 09/10/21 at 12:28 PM with Staff E, a Mental Health Technician (MHT) he states he only fills out the "Time Out Log" if a resident is in "Time Out" for more than 30 minutes but knows that the night shift will fill them out for consistency.

CONFIDENTIAL UHS-FINHELP-00009724

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	[redacted]	A. BUILDING _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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N 185	Continued From page 2 3. A review of the "Time Out Log" for Resident#16 reveals this resident has had "Time Outs" before including in this month of September. Staff F, MHT states, during an interview, on 09/10/21 at 12:41 PM that Resident#16 has had "Time Outs" in this month of September. Review of the September "Time Out Log" reveals that it is "blank." During an interview on 09/10/21 at 12:41 PM with Staff F, MHT she states the night shift fills out the "Time Out Logs" and will only fill it out if the resident is aggressive. 4. During an interview with Resident #17 at 12:46 PM, she was asked if they have had any "Time Outs" for the month of September and stated, "Yes, you mean the little room they take me to? " A review of the "Time Out Log," for Resident #17, for the month of September, reveals it is "blank." 5. A review of Resident #7's record reveals only two "Time Out Logs," for June 2021 and August 2021 that were not "filled out." Further review reveals the Medical Records Director was able to locate more "Time Out Logs," for the months of December 2020 through May 2021 in her office. A review of the "Time Out Logs reveals all the "Time Out Log" documents are "blank". A review of the "Multidisciplinary Progress Notes," for November 2021 document the resident is aggressive and fighting and placed in "Time Out." Resident #7 was interviewed on 09/07/21 at 3:46 PM and was asked if they have ever been in "Time Out" and stated, "I used to get "Time Outs" all the time, not that much now." During an interview on 09/10/21 at 2:31 PM, the Director of Nursing stated that the staff must complete the "Time Out Logs" even if the resident	N 185		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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N 185	Continued From page 3 is in "Time Out" for two minutes; the nurse is required to check on the resident if it is over 30 minutes; she acknowledges that the "Time Out Logs" are not being completed like they should be and stated, "I need to re-educate the staff; we have many new staff."	N 185		

CONFIDENTIAL UHS-FINHELP-00009726

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	[redacted]	A. BUILDING _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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E 000	Initial Comments	E 000		

During the Health Recertification survey conducted on September 7, 2021 through September 10, 2021 at Sandy Pines, a Psychiatric Residential Treatment Facility, Emergency Preparedness was reviewed. Sandy Pines is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 441.184, Condition of Participation for Psychiatric Residential Treatment Facilities.

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

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UHS-FINHELP-00009728 [Redacted]

Transmission Report

Date/Time	01-24-2020	04:51:11 p.m.	Transmit Header Text	
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Date: 01/24/2020

Send To: AHCA **From:** Sandy Pines - [redacted] Director of Risk Management
Attn: [redacted]

Fax Number: [redacted] **Sandy Pines Fax Number:** [redacted]

Subject: Sandy Pines – ACHA POC

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Tequesta, Florida [redacted]
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Abbreviations:

HS: Host send	PL: Polled local	MP: Mailbox print	CP: Completed	TS: Terminated by system
HR: Host receive	PR: Polled remote	RP: Report	FA: Fail	G3: Group 3
WS: Waiting send	MS: Mailbox save	FF: Fax Forward	TU: Terminated by user	EC: Error Correct

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Date: 01/24/2020

Send To: AHCA **From:** Sandy Pines – [redacted] Director of Risk Management
Attn: [redacted]

Fax Number: [redacted] **Sandy Pines Fax Number:** (561) 575-1445

Subject: Sandy Pines – ACHA POC

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[redacted]
Tequesta, Florida [redacted]
Phone: [redacted]
Fax: [redacted]

Appendix 88.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

January 16, 2020

Mr. [redacted] Administrator
Sandy Pines
[redacted]
Tequesta, FL [redacted]

RE: Complaint Number [redacted] and [redacted]

Dear Mr. [redacted]

This letter reports the findings of a state licensure complaint survey that was concluded on January 2, 2020 by representatives of this office.

Attached is the provider's copy of the State 3020 Form, which indicates the deficiencies that were identified. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **The State 3020 Form must be signed, titled and dated by the Administrator or other authorized official. Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also, include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than January 26 , 2020.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit. ****You will not receive a copy of this report in the mail; you will only receive this faxed report.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. Should you have any questions please call this office at [redacted]

Sincerely,

[redacted] RNC for
[redacted]
Field Office Manager

AMD
Enclosure: State 3020 Form

Delray Beach Field Office
[redacted]
Delray Beach, FL
Phone [redacted] Fax:([redacted]
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Appendix 88.

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
C 000	INITIAL COMMENTS An unannounced Licensure complaint survey, [redacted] and [redacted] was commenced on 12/26/2019 and concluded on 01/02/2020 at Sandy Pines, Residential Treatment Center for Children And Adolescents facility. The facility had deficiencies at the time of the survey.	C 000		1/26/20
C 121	65E-9.007(3)(e), F.A.C. Staff Composition - Direct Care Staff (3) Staff composition. The provider shall have the following staffing, any of which may be part-time, if the required equivalent full-time coverage is provided, except for those positions with a required specified staffing ratio: (e) Direct care staff. At a minimum, two (2) direct care staff shall be awake and on duty at all times. In addition, the following direct care staff-to-child ratios shall be provided and maintained: 1. During hours when children are present in the facility and normally awake, the direct care staff to child ratio shall be no less than 1:4; and 2. During hours when the children are normally asleep, the direct care staff to child ratio shall be no less than 1:6; and 3. While residents are away from the facility, the staffing ratio for those residents shall be no less than 1:4. The need for more intensive staffing will be determined by the child's physician; and 4. Direct care staff shall not divide time on their shift between programs located in other areas of the facility or other buildings; and 5. While transporting residents of residential treatment centers other than group homes, the driver shall not be counted as the direct care staff providing care, assistance or supervision of the child. For therapeutic group home residents, prior	C 121	C 121 65E-0.007(3)(e), F.A.C. Staff Composition – Direct Care Staff ACTION PLAN: A Performance Improvement Team (PIT) met to further develop processes that improve staff communication and flow to maintain ratio. Schedules have been modified to add all off-grounds activities and assignment sheets were modified to add all off-unit activities. This will allow for an accurate analysis of ratio for activities. Charge Nurse or Unit Coordinator will do a body count to ensure proper ratio on the units. If a staff member needs to leave the unit or group, then they will inform the Unit Coordinator or RN to ensure they are covered before they leave the unit/group. The Staffing coordinator/designee will review daily schedules every morning during leadership meeting. Units will continue to be staffed according to unit census. COMPLETION DATE: 1/26/2020 PERSON RESPONSIBLE: CNO MONITORING PLAN: Starting 2/1/2020, Data will be collected monthly regarding ratio checks on units and auxiliary locations. Data will be trended and information used to effectively make any improvements through the Performance Improvement Process.	

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SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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C 121	Continued From page 1 to a single staff person transporting one or more children in a motor vehicle, children must be assessed to ensure the safety of the children and staff. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the Residential Treatment Facility for Children and Adolescents (RTC) failed to provide direct care staff at a minimum of 1 direct care staff to 4 residents on the 7:00 AM-3:30 PM shift and the 3:00 PM-11:30 PM shift and a minimum of 1 direct care staff to 6 residents on the 11:00 AM-7:30 AM shift during November 2019 and December 2019. The findings included: Observation, during a tour of the facility on 12/26/19 beginning at 10:50 AM and ending on 12/26/19 at approximately 4:39 PM, with the Nurse Manager, reveals the following resident to staff ratios; on the Seagull Unit, 22 residents were observed with 5 staff members; on the Sea Turtle Unit, 14 residents were observed with 3 staff members, on the Pelican Unit, 6 residents were observed with 1 staff member, on the Sting Ray Unit, 13 residents were observed with 3 staff members and on the Starfish Unit, 21 residents were observed with 4 staff members. Further observation, during a tour of the facility on 12/26/19 beginning at 10:50 AM, and ending on 12/26/19 at approximately 4:39 PM, with the Nurse Manager, reveals, on the Pelican Unit recreational area outside, Dolphin and Pelican residents were observed playing volleyball, a total of 28 residents with 5 staff members; 5 residents were observed at the pool, with 1 staff member and 9 residents with 2 staff members were	C 121		1/26/20

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	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

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SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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C 121	Continued From page 2 observed on 12/26/19 at 11:15 AM. Continued observation, on 12/26/19 beginning at 10:50 AM and ending on 12/26/19 at approximately 4:39 PM, in the cafeteria during lunch, reveals 24 residents from the Sea Turtle, Starfish and Seagull Units with 4 staff members and 15 residents, from the Dolphin Unit with 3 staff members. Further observation, during a tour of the cafeteria on 12/26/19 at 4:15 PM, reveals 11 Sting Ray and Seagull Unit residents with 2 staff members; on 12/26/19 at 4:39 PM, 10 residents and 2 staff members were observed in the cafeteria and on 12/26/19 at 4:45 PM, observations at the pool reveal 16 residents from the Dolphin Unit with 2 staff members. The findings were acknowledged by the Nurse Manager, during an interview on 12/26/19 beginning at 10:50 AM and ending on 12/26/19 at approximately 4:39 PM. Review, on 12/30/19 of the RTC's resident census to staff ratio documentation, for 11/30/19 reveals on the 3:00 PM-11:30 PM shift, the Seagull Unit had 23 residents with 7 staff members, one resident was on 1:1 observation (one staff member assigned solely to be with only one resident) leaving 6 staff members with 22 residents and continued review reveals evidence that documents a staff member left facility, prior to the shift ending, leaving 5 staff members with 22 residents and the Pelican Unit had 24 residents with 4 staff members. Further review reveals evidence that on Pelican Unit, for the 11:00 PM-7:30 AM shift, there were 23 residents with 3 staff members and the Sea Turtle Unit, for 11:00 PM-7:30 AM had 20 residents with 3 staff members. Review, on 12/30/19, of the RTC's resident to	C 121		1/26/20

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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C 121	Continued From page 3 staff ratio documentation for 12/26/19 reveals on the 7:00 AM-3:30 PM shift, the Sting Ray Unit had 22 residents with 7 staff members, one resident on 1:1 observation and one staff member who was a "no show" which leaves 5 staff members with 21 residents. On the Pelican Unit there were 22 residents with 5 staff members. For the 3:00 PM-11:30 PM shift, the Pelican Unit had 22 residents with 5 staff members and on the 11:00 PM- 7:30 AM shift, the Starfish Unit had 21 residents with 3 staff members. During an interview on 12/26/19 at 4:40 PM, Staff C stated that they "feel that one more staff on duty would be better then what they have now." During an interview on 12/26/19 at 4:47 PM, Staff D, stated they thought that the staffing ratios are 6:1 during the day and that they meet the requirements. During an interview on 12/26/19 at 4:49 PM, Staff E, stated that they do not feel there is enough staff on duty, further stated the Unit Coordinator makes the decision where the staff go with the residents and stated they always keep more staff on the unit then at the pool even if there is more residents at the pool. During an interview on 12/26/19 at 4:54 PM, Staff F and Staff G stated that they are meeting the required ratios and when the surveyor asked what the ratios were, they both stated 6:1 then stated if it's supposed to be 4:1, we don't meet criteria. During an interview on 12/26/19 at 5:00 PM, Staff H stated that we don't meet ratios on a regular basis and never have enough staff on shift. Class III	C 121		1/26/20
CZ815	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses	CZ815	CZ815 408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses ACTION PLAN: Human Resources has implemented a cross-referencing process to avoid any future situations such as the anomaly that was cited. In regards to the infraction, it was immediately corrected and submitted to AHCA for viewing. All other personnel files were confirmed to have the AHCA background screening completed. Human Resources Director has also hired a Human Resources Generalist to assist in ensuring the process is completed. COMPLETION DATE: 01/26/2020 PERSON RESPONSIBLE: Human Resources Director MONITORING PLAN: Starting 2/1/2020, Data will be collected monthly regarding the timely completion of background checks at hire and every 5 years. Data will be trended and information used to effectively make any improvements through the Performance Improvement Process.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
CZ815	Continued From page 4 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or contracting with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person	CZ815		1/26/20

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Appendix 88.

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
CZ815	Continued From page 5	CZ815		1/26/20

named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.
(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(h) Section 817.234, relating to false and fraudulent insurance claims.
(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(k) Section 817.505, relating to patient brokering.
(l) Section 817.568, relating to criminal use of personal identification information.
(m) Section 817.60, relating to obtaining a credit

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Appendix 88.

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	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
CZ815	Continued From page 6 card through fraudulent means. (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (o) Section 831.01, relating to forgery. (p) Section 831.02, relating to uttering forged instruments. (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (u) Section 895.03, relating to racketeering and collection of unlawful debts. (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or contracted with a licensee as of June 30, 2014, and was screened and qualified under ss. 435.03 and 435.04, has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on	CZ815		1/2020

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	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
CZ815	Continued From page 7	CZ815		1/30/20

July 31, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be:
(a) Individuals for whom the last screening was conducted on or before December 31, 2004, must be rescreened by July 31, 2013.
(b) Individuals for whom the last screening conducted was between January 1, 2005, and December 31, 2008, must be rescreened by July 31, 2014.
(c) Individuals for whom the last screening conducted was between January 1, 2009, through July 31, 2011, must be rescreened by July 31, 2015.
(6) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.
(7)(a) As provided in chapter 435, the agency

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	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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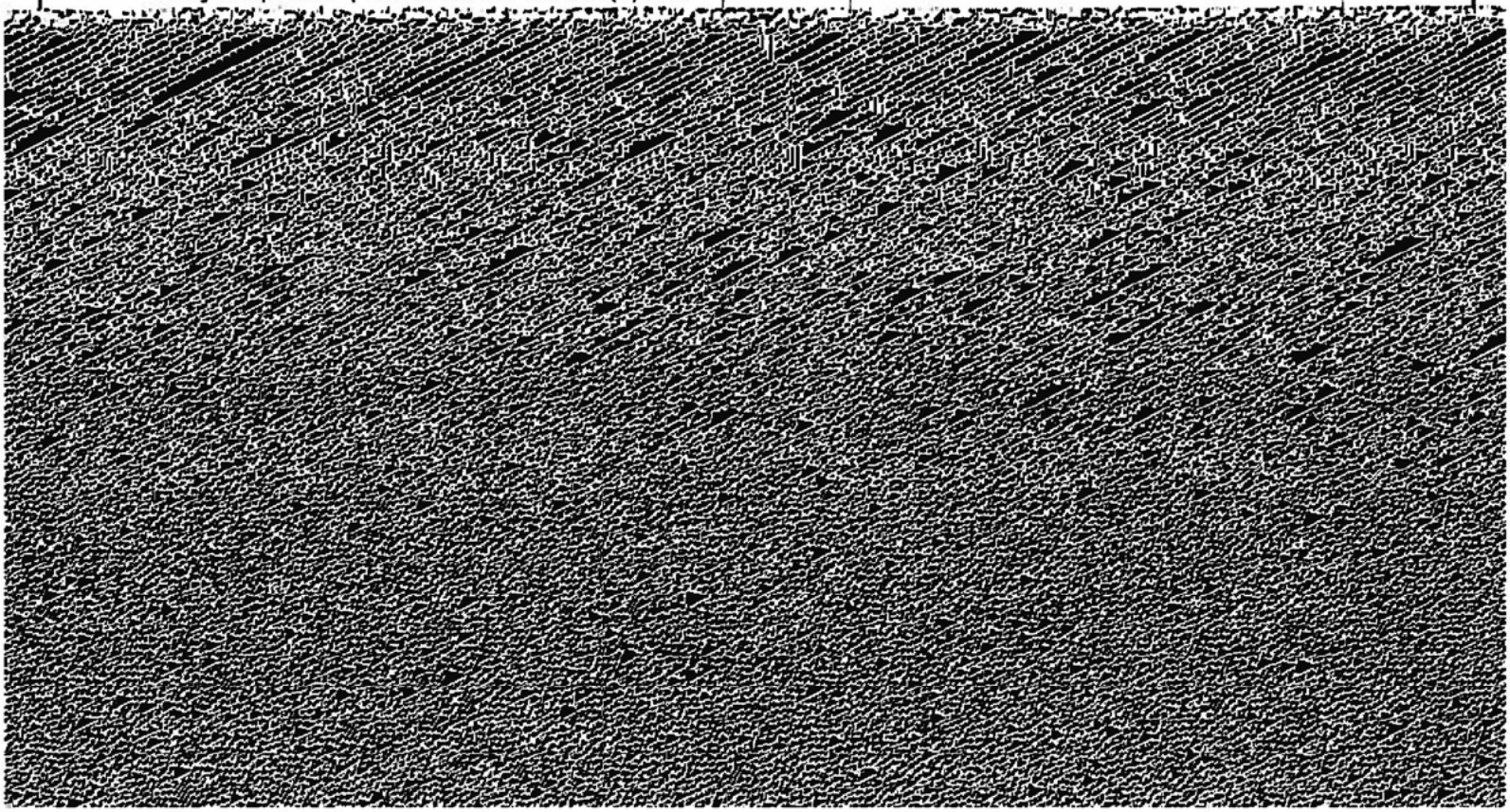
CZ815	Continued From page 8	CZ815		1/26/20

may grant an exemption from disqualification to a person who is subject to this section and who:
1. Does not have an active professional license or certification from the Department of Health; or
2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification.
(b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice.
(8) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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CZ815	Continued From page 9 a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any vulnerable person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any vulnerable person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been arrested for a disqualifying offense, the employer must remove the employee from contact with any vulnerable person that places the employee in a role that requires background screening until the arrest is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption	CZ815		1/24/20

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	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
CZ815	Continued From page 10 from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with vulnerable persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or arrest for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was arrested, regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Residential Treatment Facility for Children and Adolescents (RTC) failed to provide evidence of an "eligible" Agency for Health Care	CZ815		1/26/20

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Appendix 88.

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	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
CZ815	Continued From page 11 Administration (AHCA) Level 2 Background Screening result for 1 of 5 sampled employees (Staff I). The findings included: Record review reveals evidence that documents Staff I was hired on 09/10/2019. A review of Staff I's personnel file, on 12/26/19 reveals Staff I had a "Background Screening" result, from the Department of Children and Families. Continued review reveals no evidence of an AHCA Level 2 Background Screening result. Review of the AHCA Background Screening "website," on 12/26/2019 reveals evidence that documents Staff I's AHCA Level 2 Background Screening result was, "Agency Review Required" without evidence of an "eligibility." An interview was conducted with the Risk Manager on 12/26/2019 at 05:24 PM who reviewed Staff I's personnel file, was unable to find an AHCA Level 2 Background Screening result and stated that she could not provide any additional information at this time regarding Staff I's "eligibility status," as the Human Resources Director was "out for the holidays." Review of the AHCA Background Screening "website," on 12/30/2019 reveals evidence that documents Staff I's Level 2 Background Screening was "Screening in Progress," as of 12/30/2019. An interview was conducted with the Human Resources Director on 01/02/2020 at 11:09 AM who stated that Staff I had an eligible AHCA Level 2 Background Screening result dated 08/08/2019 upon hire however, when the RTC initiated their own AHCA Level 2 Background Screening the "online dates" were replaced, further stated that she did not "print out" Staff I's AHCA Level 2 Background Screening result from 08/08/2019,	CZ815		1/26/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
CZ815	Continued From page 12 used during the hiring process and therefore did not have an available copy. Unclassified	CZ815		1/26/20

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UHS-FINHELP-00009744 [Redacted]

SandyPines
SERVING CHILDREN & ADOLESCENTS

[redacted]
Tequesta, FL [redacted]

FAX COVER SHEET/CONFIDENTIAL

Date: 01/12/2022

Send To: [redacted]

Fax Number: [redacted]@ahca.myflordia.com)

From: [redacted]
Director of Risk & Performance Improvement

Fax Number: [redacted]

Telephone Number: [redacted]

E-mail: [redacted]@uhsinc.com

TOTAL NUMBER OF PAGES INCLUDING COVER PAGE: 10

IMPORTANT WARNING: Documents accompanying this facsimile transmission may contain confidential and privileged information which is protected under Federal Law (CFR 42 part 2; Florida Statues 394.459(9); CFR 45; and Florida Administrative Code 65E. This message is intended for the use of the person or entity to which it is addressed. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is protected by Federal Law and Florida Statute and is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately and destroy the related message.

Appendix 89.

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

January 3, 2022

Mr. [redacted] CEO
Sandy Pines
[redacted]
Tequesta, FL [redacted]

RE: Complaint Number [redacted] and [redacted]

Dear Mr. [redacted]

This letter reports the findings of a state licensure complaint survey that was conducted on December 28, 2021 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct the deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **The First Page of State 3020 Form must be signed, titled and dated by the Administrator or other authorized official at the bottom where indicated. **You will not receive a copy of this report in the mail; you will only receive this faxed report. Please attach a summary of your corrective action for the deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of the identified deficiencies. Submit summary and documents to the Field Office no later than January 17, 2022.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiency identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at [redacted]

Sincerely,

[redacted] RNC for
[redacted]
Field Office Manager

[redacted]
Enclosure: State (3020) Form

XG90

Delray Beach Field Office
[redacted]
Delray Beach, FL [redacted]
Phone: [redacted] Fax: [redacted]
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Appendix 89.

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
C 000	INITIAL COMMENTS An unannounced Licensure Complaint survey, [redacted] and [redacted] was conducted on December 28, 2021 at Sandy Pines, Residential Treatment Center for Children And Adolescents. The facility had a deficiency at the time of the visit.	C 000	**C116 – Communication – Direct Care Staff – 65E-9.007(2)** **F.A.C. Staff Communication:** The facility failed to provide to ensure information regarding their residents was communicated amongst departments and documented in the resident's record for 3 of 4 sampled residents. * See Report for specific findings.	
C 116	65E-9.007(2), F.A.C. Staff - Communication (2) Staff communication. The provider's personnel procedures shall ensure and require the inter-communication among staff of information regarding children necessary to the performance of each staff responsibility, including between working shifts, staff changes and consultations with professional staff. Where one staff member or one program group relies upon information provided through this required free interchange of information, these interactions shall be documented in writing and maintained in the respective children's case files. This Statute or Rule is not met as evidenced by: Based on review of the RTC (Residential Treatment Facility for Children and Adolescents)'s Policy and Procedure, record review and interview, the RTC failed to ensure information regarding their residents was communicated amongst departments and documented in the residents' record for 3 of 4 sampled residents (Resident #1, #3 and #4). The findings included: 1. Review of RTC's Policy and Procedure titled, "Communication Among Staff," effective 5/19/03 reveals, "It is the policy of Sandy Pines (RTC) that communication and collaboration among nursing	C 116	**PLAN OF CORRECTION** All clinical departments began reeducated on the policy for communication among staff and critical incident reporting on December 28, 2022. Documentation of the training was completed by signed training attestations. The Performance Improvement Committee implemented a communication subcommittee meeting to address communication concerns and actions to ensure compliance on December 29, 2021. The bi-weekly subcommittee will be conducted as an ongoing initiative to enhance communication throughout the organization. The Nursing Department reestablished monthly MHT meetings and continues with weekly nurse huddles. **COMPLETION DATE** :01.28.2022 **PERSON RESPONSIBLE**: Director of Nursing **MONITORING PLAN:** The Director of Nursing will continue to complete biweekly nurse huddles and monthly MHT to discuss the patient population, processes, concerns and best practices for residential treatment. The biweekly communication subcommittee will identify areas of concern and process improvements with identified target dates and discussed in monthly Performance Improvement Committee Meeting.	

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE FORM [redacted] If continuation sheet 1 of 8

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
C 116	Continued From page 1	C 116		

staff and between disciplines is an integral part of the provision of resident care."
Review of documentation for Resident #1, dated 2/9/21 reveals the RTC was informed that Resident #1 alleged they were ... (type of) assaulted by a male resident during their stay at the RTC, alleged to have occurred in February, 2020.
Review reveals the RTC investigated the allegation and determined there was a lack of evidence due to the alleged perpetrator never living on the same unit as Resident #1 and their reported personal characteristics. Review of Resident #1's record reveals Resident #1 had multiple ... (type of) hospitalizations between January 2020 and March 2020 due to ... (type of) symptoms. Review of therapy and medical notes reveals no evidence the resident mentioned this incident in sessions/visits.
Review of Resident #1's MHT's documentation reveals a "Note," dated 2/3/21 that documents the resident returned to the RTC from a ... (type of) hospitalization' a "Note," dated 2/3/21, during the night shift reveals, "Resident mood was unstable. Resident had few redirections with staying in area in dayroom. Resident was also going around telling ... peers that ... (Resident #1) had ... (relations) with ... bed and had ... (relations) with a ... (gender) peer as well. Resident was sent to ... (their) room and redirected about situation. While in room, resident started screaming, being disruptive to unit and roommate. Resident was redirected. Nurse was also notified about situation. Resident will continue treatment plan and observations."
An MHT "Note," dated 2/4/21 reveals, "Resident mood appeared to be stable most of the shift. Resident had to be redirected Resident told peers ... (Resident #1) and another ... (type of gender) peer had ... (relations) in ... (Resident #1's) room.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

(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
C 116	Continued From page 2 Resident will continue current treatment plan." Review of Resident #1's Nurses' Note dated 2/4/21 reveals, " Resident wrote note stating ... (Resident #1) and ... (gender) peer equal love and ... (relations). ... (Physician) notified. Resident placed on Q5 checks ATC (around the clock) ... Acting Out." An interview was conducted on 12/28/21 at 1:15 pm with the Risk Management Coordinator who stated that the Risk Management Department does not get the MHT "Notes;" they began investigating the allegation when it was received by the RTC and were unable to substantiate that the incident occurred; it was not reported to the Risk Management Department at the time, in February 2020, that Resident #1 was claiming ... (Resident #1) had ... (relations) with a peer and the Risk Management Department would have looked into it, if they had been alerted. 2. Review of documentation regarding Resident #3 was conducted on December 28, 2021 to reveal Resident #3 informed their therapist, on 2/24/21 that Resident #4, their roommate at the time, kissed and touched Resident #3 inappropriately, the previous day. Further review reveals documentation that Resident #3 stated she informed the Nurse, on 2/23/21 after it happened and the residents were separated, residing on different units. Continued review reveals documentation that Resident #3 stated this has happened before between Resident #3 and Resident #4. Review of Resident #3's record reveals a "Mental Health Technician (MHT) Note," dated 2/20/21 that documents, "Resident reported ... (their) roommate being inappropriate with ... (them). Nurse was informed." Continued review of the "MHT Note" reveals no	C 116		

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	[redacted]	A. BUILDING: _____ B. WING _____	12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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C 116	Continued From page 3	C 116		

evidence of documentation of the type of inappropriate behavior that was being reported at the time and no further documentation was found regarding a follow-up.
Review of Resident #3's "Nursing Progress Note," dated 2/20/21 reveals evidence of documentation of Resident #3 "expressing a concern" about a male peer making sexual comments and about a fight with other peers while outside. Continued review reveals no evidence of documentation regarding Resident #3's concern about their roommate or any follow up interventions. Further review reveals no evidence of documentation that Resident #3's concern, on 2/20/21, was communicated to the RTC's "Risk Management Department" for potential investigation.
An interview was conducted with the Risk Management Coordinator and the Director of Risk Management on 12/28/21 at 3:31 pm; the Risk Management Coordinator reviewed Resident #3's "Notes" and stated that the MHT who wrote the "Note," on 2/20/21 clearly stated she informed the Nurse of the allegation but the Nurse's Note discusses the fight; it appears there was a breakdown in communication between the MHT and the Nurse; the MHT who wrote the "Note" no longer works at the RTC; the Risk Management Coordinator stated her department receives copies of "Nurses' Notes but not "MHT Notes," to review; since the Nurse did not include the other allegation in her notes, the Risk Management Department was unaware and if they had been made aware, they would have investigated.
A follow up interview was conducted with the Risk Management Coordinator and the Director of Risk Management on 12/28/21 at 3:51 pm; the Risk Management Coordinator stated that the Risk Management Department investigated the incident when they were made aware on 2/23/21 and the residents remained separated; she

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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C 116	Continued From page 4	C 116		

explained the RTC's process for investigating incidents was, ideally, any incident that requires a report, the MHT is expected to report to the Nurse, if nurse was not present at the time of the incident; the Nurse is expected to fill out a "Progress Note" and a report; the report is automatically generated to the Risk Management Department; a report will be run the following morning, unless it involves a critical incident in which case the Risk Management staff will come to the RTC at that time; the following morning, the reports will be reviewed by the whole management team so they are aware and if there needs to be an investigation; it is reported the following day to AHCA (Agency for Health Care Administration); a copy of the "Nurses' Progress Notes" goes into the Risk Management mailbox; in the "Progress Note, the Nurses outline who they notified, including the physician, family, police, or DCF (Department of Children And Families)"; other vital information will be included in the "Progress Note; the Risk Management Department investigates all allegations so ideally, if an incident is reported in an "MHT Progress Note," it should be communicated to the Nurse, who will communicate it to Risk Management; for a situation like the one involving Resident #3, if a resident is reporting their roommate is overly sexual, they would be moved or placed on a "... (type of) observation;" sometimes this information will be added to their "Treatment Plan and staff will provide interventions, including a staff member who may sit outside the room or frequency of checks will be increased.

3. Review of documentation regarding Resident #4 was conducted on December 28, 2021 to reveal a "MHT Note," dated 2/20/21 that documents, "Resident advised the nurse that a

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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C 116	Continued From page 6	C 116		

peer was being sexually inappropriate with ... (them). Resident also was accused by a different peer of being sexually inappropriate." Continued review reveals no further evidence of documentation regarding this issue, found in the "MHT Notes." Review of Resident #4's "Nursing Progress Notes" reveals no evidence of a "Note," dated for 2/20/21. Further review reveals no evidence of documentation found that the Nurse was aware of any follow up interventions. Continued review reveals no evidence of documentation was found that this information was communicated to the RTC's "Risk Management Department" for potential investigation.

Review of Resident #4's "Observation Checklists reveals the resident was placed on Q5 (every 5) minute "checks," since admission due to the resident's "Precaution Protocols." Review of the "Checklist Sheets," on 2/18/21, reveals Q5 minute checks were discontinued and the resident was placed on Q15 (every 15) minute checks; on 2/19/21 and 2/20/21, the resident remained on Q15 minute checks; on 2/21/21, the resident was placed back on Q5 minute checks until 12:15 pm, when the resident was returned to Q15 minute checks and on 2/22/21, the resident had "Checklists" for both Q5 minute checks and Q15 minute checks.

A follow up interview was conducted with the Risk Management Coordinator and the Director of Risk Management on 12/28/21 at 3:51 pm; the Risk Management Coordinator stated that the Risk Management Department investigated the incident when they were made aware on 2/23/21 and the residents remained separated; she explained the RTC's process for investigating incidents was, ideally, any incident that requires a report, the MHT is expected to report to the Nurse, if nurse was not present at the time of the

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	[redacted]	A. BUILDING: _____ B. WING _____	12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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C 116	Continued From page 6	C 116		

incident; the Nurse is expected to fill out a "Progress Note" and a report; the report is automatically generated to the Risk Management Department; a report will be run the following morning, unless it involves a critical incident in which case the Risk Management staff will come to the RTC at that time; the following morning, the reports will be reviewed by the whole management team so they are aware and if there needs to be an investigation; it is reported the following day to AHCA (Agency for Health Care Administration); a copy of the "Nurses' Progress Notes" goes into the Risk Management mailbox; in the "Progress Note, the Nurses outline who they notified, including the physician, family, police, or DCF (Department of Children And Families)"; other vital information will be included in the "Progress Note; the Risk Management Department investigates all allegations so ideally, if an incident is reported in an "MHT Progress Note," it should be communicated to the Nurse, who will communicate it to Risk Management; for a situation like the one involving Resident #4, if a resident is reporting their roommate is overly sexual, they would be moved or placed on a "sexual observation;" sometimes this information will be added to their "Treatment Plan and staff will provide interventions, including a staff member who may sit outside the room or frequency of checks will be increased.
An interview was conducted with the Risk Management Coordinator and the Director of Risk Management on 12/28/21 at 4:22 pm who reviewed Resident #4's record and found Resident #4 was admitted on Q5 minute checks due to their precautions; the Risk Management Coordinator explained that the Physican is contacted and a Physician Order is given whenever there is a change in observation level; they found a "Privilege Order" form, dated 2/18/21

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C 116	Continued From page 7 to discontinue Q5 minute checks due to good behavior and a "Privilege Order" form, dated 2/23/21 documented the re-instatement of Q5 minute checks due to sexual acting out. Review of Resident #4's "Physician Orders," during this time period did not reveal physician's orders were given to change Resident #4's observation status. Class III	C 116		