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-00009754 [Redacted]

FACSIMILE COVER LETTER

FAX		
	Date & Time:	02-28-2023 3:50 PM
	Deliver To:	Mr [redacted] Administrator
	Fax Number:	[redacted]
	From:	[redacted]
	Phone:	
	Regarding:	Sandy Pines Event ID [redacted]

Good afternoon,
Please see the attached report of the IJ Removal survey conducted on 02/20/23.
Thank You,
[redacted]

[redacted] REGISTERED NURSING CONSULTANT
SURVEYOR

[redacted] DELRAY BEACH, FL.

+1 [redacted] (Office) - [redacted] or [redacted] (Fax)
[redacted]@ahca.myflorida.com

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

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RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

February 28, 2023

Mr. [redacted], Administrator
Sandy Pines
[redacted]
Tequesta, FL [redacted]

RE: Complaint Number [redacted]

Dear Mr. [redacted]

This letter reports the findings of a federal survey visit on February 20, 2023 to determine the status of immediate jeopardy findings identified on January 30, 2023 by a representative of this office.

Also, enclosed is the provider copy of the Statement of Deficiencies and Plan of Correction, Form CMS-2567.

Please provide a plan of correction to this Field Office for the identified deficiencies **within ten days of receipt of the faxed report. All deficiencies shall be corrected no later than March 22, 2023.**

On February 20, 2023, it was determined that the immediate jeopardy was removed effective February 20, 2023. But deficient practice remains.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

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.

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

Thank you for the assistance provided to the surveyor. If you have any questions, please contact [redacted] at [redacted]

Sincerely,

[redacted] RNC for

[redacted]
Field Office Manager

[redacted]
Enclosure: Form CMS 2567

B9EX

PRINTED: 02/28/2023
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	R-C 02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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{N 000}	Initial Comments	{N 000}	By submitting this Plan of Correction, the Hospital does not agree that the facts alleged are true or admit that it violated the rules. The Hospital submits this Plan of Correction to document the actions it has taken to address the citations and the allegations of deficiencies with respect to compliance with Conditions of Participation for hospitals.	2/7/2023

An unannounced Complaint [redacted] was commenced on 01/21/2023 and concluded on 01/30/2023 at Sandy Pines, Psychiatric Residential Treatment Facility (PRTF).
The facility is not in compliance with 42 CFR (Code Of Federal Regulations) Part 483.354, Subpart G, Condition Of Participation for Psychiatric Residential Treatment Facilities.

The allegations were substantiated and noncompliance was identified at the Condition of Participation:

42 CFR Part 483.354- Use Of Restraint And Seclusion (N0100):

The Standard at: 42 CFR Part 483.376 (a)-Education And Training (N0214) and

The Element at: 42 CFR Part 483.76 (d)-Education And Training (N0220).

The PRTF failed to provide education, training and demonstrated knowledge for their Mental Health Technicians and Nurses and failed to include exercises that they have demonstrated, in practice, the techniques they have learned for managing an emergency safety crisis situation (Staff #A through #V).
This caused an emergency safety crisis situation that involved fourteen (14) of 135 residents on 5 of 6 of the PRTF's Units, who caused an uncontrollable disturbance in the facility and on the facility's property on 01/20/23 at 8:08 PM (Resident #1 through #14) necessitating Emergency Medical Services and Law Enforcement to enter the PRTF's premises and

Corrective Actions:

The Director of Nursing and the Director of Residential Services developed and provided a re-education program for nurses and MHTs related to management of patient behavior. The training was conducted in person in groups or individually. The training included a competency test with scenarios and a signed attestation of understanding. Staff who have not completed training have been removed from the work scheduled until training has been completed.
Training included:
- Use of Verbal De-escalation including:
  - Crisis Management: Crisis Management included a review of the recent Mass Behavioral Disturbance as an example of how staff should respond in these events.
  - Communication in a Crisis
  - Stages of Crisis and Working styles in Crisis
- Avoiding Power Struggles
- Safely Managing Altercations/Breaking up Fights

LABORATORY DIRECTOR'S OR PROV [redacted] TITLE CEO/Managing Director (X6) DATE 03/08/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: [redacted] Facility ID: [redacted] If continuation sheet Page 1 of 24

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(N 000)	Continued From page 1 provide services to control the residents. Immediate Jeopardy is a situation in which the provider's non-compliance with one or more requirements has caused, or is likely to cause serious injury, harm, or death to a resident receiving care in the facility. Facility deficient practice allowed the facility's residents to cause an emergency safety crisis situation. The facility's Administrator was notified of Immediate Jeopardy and provided the IJ Template on 01/30/23 at 10:20 AM. The cumulative effect of the facility's systemic practices resulted in the facility's inability to ensure that the residents' safety needs would be met. On 02/13/2023, 02/14/2023 and 02/15/2023, an unannounced IJ Removal onsite was conducted and was not removed due to concerns with staffing not meeting the staffing ratios. During the onsite revisit, on 02/20/2023, it was verified by review of staffing schedule, census, training records and interviews that the Immediate Jeopardy was removed.	(N 000)		
(N 100)	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One.	(N 100)	Corrective Actions The Director of Clinical Services, Director of Risk, Director of Performance Improvement and the Director of Nursing have conducted evaluations of high utilizers and resident that would benefit from a different level of care in weekly clinical team meetings. Those residents who are identified as meeting the maximum benefits of treatment have been reviewed with the psychiatrist. Residents who have maximized treatment have been provided with a 30-day notice to their guardian, to aid in transition to the appropriate level of care.	2/20/23

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{N 100}	Continued From page 2 This CONDITION is not met as evidenced by: Based on observation, record review, Review of the facility's Policy and Procedures, and interview, it was determined that the Psychiatric Residential Treatment Facility (PRTF) failed to provide education, training and demonstrated knowledge for their Mental Health Technicians and Nurses (N0214) and failed to include exercises that they have demonstrated, in practice, the techniques they have learned for managing an emergency safety crisis situation (N0220). The emergency safety crisis situation involved fourteen (14) of 135 residents on 5 of 6 of the PRTF's Units, Pelican (Residents 12 to 17 years old); Seagull (Residents 12 to 17 years old); Star Fish (Residents 12 to17 years old); Manatee (Residents12 to 17 years old) and Sea Turtle (Residents 5 to 12 years) old, who caused an uncontrollable disturbance in the facility and on the facility's property on 01/20/23 at 8:08 PM (Resident #1 through #14). The facility's own Policy and Procedure titled, "Appropriate Staffing Levels" documents, "... Addendums - Staffing includes at least three nurses (minimally one RN (Registered Nurse) and a staffing ratio of nurses and MHT (Mental Health Technician)s combined with a 1:4 staff to resident ratio while the residents are awake and a 1:6 ratio after bedtime..." Staff work shifts from 7:00 AM-7:30 PM and/or 7:00 PM-7:30 AM. The staffing ratio should be 1 staff to 4 residents while the residents are awake and 1 staff to 6 residents while the residents are asleep. The facility is staffing the units as though the residents go to sleep at shift change which occurs	{N 100}	Additionally, the Human Resources Director has increased orientation classes to every 2 weeks upon receipt of clearance of documentation such as background screening and education verification. The Human Resources Director has scheduled another orientation class for 3/13/23, 3/27/2023, 04/10/2023, and 4/24/2023. The Chief Executive Officer implemented in person coverage by 2 leadership members daily from 630am-930pm and 630pm – 930pm to monitor staff to ensure that staff are covering the shift as assigned. Any identified coverage issues are immediately addressed by the in house leadership to including having the current staff stay over until relief arrives, or if necessary, the leadership will provide coverage. The Chief Executive Officer implemented additional staff (two staff at a minimal) to each shift to encompass acuity and unexpected absences. Monitoring Plan: To monitor compliance, the Chief Executive Officer implemented a twice a day review in the morning and in the evening prior to shift change of staffing with the Director of Nursing and the Director of Residential Services to ensure that all shifts are staffed to ratio. The Performance Improvement Committee will review the aggregated data weekly for 3 months, then every 2 weeks for the next 3	2/20/23 2/15/2023 2/20/2023

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{N 100}	Continued From page 3 at 7:00 PM-7:30 PM but the youngest residents do not go to sleep until 8:30 PM and the oldest residents do not go to sleep until 9:30 PM. On 01/20/23, the night of the emergency crisis situation, the PRTF's own 1:4 staffing ratios were below their minimum staffing requirements, while awake. The Facility Census was 136; total staff was 37 on the 7:00 AM-7:30 PM shift; 22 staff on the 7:00 PM-7:30 AM shift. One staff was to be dedicated to provide 1:1 for a resident. The Director of Nursing was on the Units but not for the whole morning shift. The PRTF was understaffed, per their own Policy and Procedure, as follows on 01/20/23-Dolphin Unit- 24 residents: 7:00 PM-7:30 AM- 2 staff until 9:00 PM, then 3 staff until 10:00 PM then 4 staff after 10:00 PM. 1 staff advised not to come in until 9:00 PM and 1 staff in at 10:00 PM Star Fish Unit- 23 residents: 7:00 PM-7:30 AM- 4 staff. 1 resident on 1:1. Manatee Unit- 24 residents: 7:00 PM-7:30 AM- 2 staff until 9:00 PM. 1 staff advised not to come until 9:00 PM Seagull Unit-24 residents: 7:00 PM-7:30 AM and 4 staff. Pelican Unit 24 residents: 7:00 PM-7:30 AM- 2 staff until 9:00 PM then 3 staff until 10:00 PM. The following is a description of the emergency crisis situation the occurred while the facility was understaffed: On 01/20/23 at approximately 8:08 PM, camera review reveals Resident #1 was seen lying on the floor rolling around, a "Code Blue" was called; Resident #1 told staff that he snorted his medications, 5 staff responded and at 8:27 PM, two more responded; a "smelling salt" was put in	{N 100}	months, then monthly for a minimum of 6 additional months. Governing Body will review in a special monthly meeting the data (3/27/23, 4/24/23, 5/29/23) and update reports of compliance to the plan of correction for 4 months, then ongoing quarterly (4/27/23, 7/27/23, 10/26/23, 01/25/24) with sustained improvement of 100%, and then ongoing it will be monitored as part of the department performance improvement indicators.	

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(N 100)	Continued From page 4	(N 100)		

front of Resident #1, he got up and stated he was upset with his roommate and was "faking" the whole incident.

On 01/20/23 at 8:28 PM, Resident #2 was pacing back and forth on the Pelican Unit in the common area; at 8:33 PM, Resident #2 is seen attempting to push a coffee like table that is in the common area, towards the exterior door that has impact glass and there are no staff observed stopping the resident from doing this; at 8:34 PM, Resident #2 continues to attempt to push the table into the exterior door, and staff is seen coming to the area to redirect the resident.

Resident #1 begins kicking the door causing the glass on the door to spider/crack; at 8:36 PM two staff trying to redirect the resident's but continue to kick door but Resident #1 continues to kick door. Another resident, attempts to put the table away from the door and another resident stops him; (unable to identify these residents on camera) at 8:37 PM, Resident #3 on the Pelican Unit is seen at the Nurses' station moving items on the countertop away from her, she then jumps the Nurses' station to go to Seagull Unit which shares the Nurses station and is open to both units at the Nurses' station. (There is a locked wooden door between the Pelican and Seagull Unit, that has an approximately 1 inch opening that allows you to see between the two units); at 8:37 PM Resident #2 is throwing what appears to be a metal garbage can at the exterior door on the Pelican Unit and Resident #1 continues to kick the door. Staff is seen standing in front of the exterior door. The House Supervisor arrives at 8:40 PM and at 8:41 PM the House Supervisor puts Resident #2 into a restraint on the floor and other staff assist.

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(N 100)	Continued From page 5 On the Seagull Unit at 8:42 PM Resident #5 is standing on a chair and pulls the fire alarm; at 8:42 PM, Resident #6 and Resident #8 jump over the nurse's station from the Seagull unit to go to Pelican Unit; at 8:43 PM Resident #5 and Resident #8 are kicking the door. Resident #5 picks up a chair to attempt to break the door. Multiple residents are observed running around the common area and attempting to pull items off the wall. Staff is observed standing by the exterior door. Residents are lining up rocking chairs in front of the door; at 8:42 PM staff are seen standing around. Approx 5 to7 residents (unable to identify these residents on camera) are seen running in and out of a bedroom. No staff are seen going into that room to get the residents out. Two residents (unable to identify these residents on camera) are seen at 8:42 PM running through the Nurses' station door and another resident (unable to identify the resident on camera) jumping over the Nurses' station. Staff are seen leaning over the Nurses' station; at 8:43 PM staff are seen attempting to get Resident #6 out of the Nurses' station; at 8:43 PM Resident #14 pulls a staff's badge from around their neck, this badge included the badge that opens the Unit's doors; Resident #5 was observed throwing a chair at the door; at 8:43 PM Resident #8 is seen jumping the Nurses' station, there are 4 staff observed to be standing at the Nurses' station; at 8:45 PM Resident #14 was observed trying to get over into the Nurses' station. Eight (8) (Unable to be identified) Residents are observed to be "hanging out" at the Nurses' station; Staff are standing at the exterior door and 5 residents are at door; at 8:49 PM, 6 residents are seen going into a bedroom by the exterior door that is not their room. On the Pelican Unit at 8:49 PM, Resident #2	(N 100)		

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{N 100}	Continued From page 6	{N 100}		

remains in a restraint; at 8:50 PM residents are seen standing by the Pelican Unit exterior door; staff on the Seagull Unit are observed standing around.
On 01/20/23 at 8:54 PM, residents continue to go back into a bedroom on the Seagull Unit, no staff are observed by the door; at 8:57 PM staff are observed standing behind the Nurses' station while the residents are running around the unit destroying property;
At 8:57 PM, Resident #5 is standing on a chair on the Seagull unit trying to disarm the fire alarm that has been going off; Staff are trying to get him off chair; at 8:59 PM Fire Rescue is seen behind Nurses' station, on the Seagull unit; at 9:00 PM residents are trying to use the staff badge to get out the door; eventually get the door open and 4 residents (unable to be identified) run out to an area that leads to a large fenced in area outside but is still on facility grounds; at 9:01 PM, 6 staff (unable to be identified) are by the door and Resident #7 is attempting to get out, pushing on the door at 9:01 PM while staff are trying to get her to stop.
There are 8-10 (unable to identify) residents running back and forth in the common area. There are 3 staff (unable to identify) with Resident #2, who is still in restraints on the Pelican Unit; at 9:04 PM, 6 residents (unable to identify) are seen running out the entrance door to the Seagull Unit and 4 staff seen running behind them.

Six (6) Residents (unable to identify) are running down a hallway and exit the building with 2 staff (unable to identify) behind them, which leads to the outside fenced area where the other 4 residents (unable to identify) are located. There are now 10 residents (unable to identify) outside

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{N 100}	Continued From page 7	{N 100}		

In this area; at 9:06 PM, Resident #2's restraint is stopped/removed and the resident is lying on the floor; Staff (unable to identify) are seen walking in from the outside fenced area with no residents; at 9:07 PM, 2 staff (unable to identify) are seen going back outside; at 9:08 PM, shadows of residents are seen running around outside and in the bushes; at 9:08 PM residents (unable to identify) are seen with staff running onto the Star Fish Unit, out of control.
Star Fish residents (unable to identify) are out of their room and the residents that ran inside from outside are seen running through the unit and run back outside in the fenced area; Resident #9 and Resident #10 begin to "act out;" at 9:12 PM, residents (unable to identify) from outside are seen walking inside with staff (unable to identify) from a side door; at 9:14 PM, 2 residents and 1 staff (all unable to identify) are seen walking down the hallway; the residents are running around the hallways with staff who are seen standing in the hallway while another staff is attempting to follow them (unable to identify); at 9:15 PM, Resident #8 is seen pushing staff, there are now 4 residents and 3 staff (unable to identify).

On 01/20/23 at 9:17 PM, the Police arrive in the hallway; residents see them and try to "take off;" at 9:18 PM, residents (unable to identify) are detained by Police; at 9:19 PM, Police are on Sea Turtle Unit as well as Pelican; Resident #2 remains on the floor on the Pelican Unit; at 9:22 PM Police are on the Seagull Unit; at 9:23 PM Resident #3 is handcuffed as well as other residents (unable to identify) on the Star Fish Unit; at 10:23 PM staff are attempting to restrain Resident #11 who put a metal binder clip and screw in her mouth and the Emergency Medical Service (EMS) staff injected the resident with

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(N 100)	Continued From page 8	(N 100)		

Ketamine (medication) at approximately 10:30 PM; Resident #11 was taken to .. (name of Hospital) and eventually placed under the Baker Act; Resident #13 was observed to agitated on the Sea Turtle unit and was detained by Police for being non-compliant.

Several staff were injured while applying restraints with two being bitten by a resident, one reported an injured back and another injured an elbow (unable to identify).

Review of 22 staff training records (Staff #1 through #22) reveal that they have had training in "Handle With Care" which teaches how to physically restrain a resident and to verbally de-escalate a resident during a crisis situation. Review of the "Student Manual" documents that the goal for verbal de-escalation is to recognize the development of a crisis and communicate to de-escalate the crisis. Training includes key points of crisis management, working styles in crisis and stages of crisis, communication in crisis, preventing power struggles, active listening, anger management and setting limits.

There is no evidence of documentation that staff have demonstrated their knowledge of their training and ability to implement this knowledge as evidenced staff being observed on video camera idly standing by during the emergency crisis situation; and by the staff's lack of ability to control an emergency crisis situation that occurred on the evening of 01/20/23 resulting in Emergency Medical Services and Law Enforcement coming into the facility to control the residents.
There was no evidence that staff had been trained in securing their badges to prevent the

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	[redacted]	A. BUILDING _____ B. WING _____	R-C 02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 100}	Continued From page 9 residents from acquiring them to gain access to the outside. Due to the cumulative effect of the facility's systemic practices resulting in the facility's inability to ensure that the residents' safety needs would be met, the Condition of Participation is out of compliance and a determination of Immediate Jeopardy was made. ***Facility Actions to Remove the Immediate Jeopardy, and Implementation were verified by the Surveyor during onsite revisits on 02/13/2023, 02/14/2023 and 02/15/2023 but were not able to be remove the Immediate Jeopardy due to staffing concerns not met on the PRTF's units and classrooms. Removal of Immediate Jeopardy took place on 02/20/1023.	{N 100}		
{N 214}	EDUCATION AND TRAINING CFR(s): 483.376(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of - This STANDARD is not met as evidenced by: Based on observation, record review of staff training and interview, the Psychiatric Residential Treatment Facility (PRTF) failed to demonstrate and implement knowledge of their training during an emergency safety crisis situation (Staff #A through #V) Due to these findings, it was determined the facility was in Immediate Jeopardy (IJ) that was identified on 01/21/23 and was ongoing at the	{N 214}	Training Corrective Actions: The Director of Nursing and the Director of Residential Services developed and provided a re-education program for nurses and MHTs related to management of patient behavior. The training was conducted in person in groups or individually. The training included a competency test with scenarios and a signed attestation of understanding. Staff who have not completed training have been removed from the work scheduled until training has been completed. Training included:	2/7/2023

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{N 214}	Continued From page 10 time of facility exit. The findings included: Observation of the facility's video camera footage, reviewed on 01/23/23 at 11:15 AM with the Risk Manager and the CEO (Chief Executive Officer) reveals an uncontrollable emergency safety crisis involving multiple residents occurring on 01/20/23 at approximately 8:28 PM on two units, Pelican and Seagull units; Staff (unable to identify) were observed standing around, not getting control of the residents while the residents (unable to identify) were running into other resident's rooms that were not theirs, jumping into the Nurses' Station to get to the other units, pushing a coffee table into an impact glass door that cracked, pulling the fire alarm and then tearing it off the wall, pulling off the lanyard that snapped off the staff's neck, containing the staff's identification and door opener badge, allowing approximately 10 residents (unable to identify) to leave their units, four of whom went to the outside fenced area of the facility while six of the residents grabbed another staff member's lanyard that snapped off the staff's neck, containing the staff's identification and door opener badge and left the locked unit, running into other hallways and exited to a door that led to the outside fenced area of the facility. Four residents came into another unit, woke another resident and ran around the unit and then went to the outside fenced in unit. One staff member, who was wearing eyeglasses, assisting in a restraint, had multiple residents grab the staff's glasses of their face, punch the staff in their back and the residents broke the staff's glasses; several staff were observed to lock themselves in the	{N 214}	Training included: • Use of Verbal De-escalation including: o Crisis Management: Crisis Management included a review of the recent Mass Behavioral Disturbance as an example of how staff should respond in these events. o Communication in a Crisis o Stages of Crisis and Working styles in Crisis o Avoiding Power Struggles o Safely Managing Altercations/Breaking up Fights The Director of Risk Management revised the New Employee Orientation and the bi-annual Handle with Care Training to include a separate section of training on the management of a mass behavioral disturbance in which staff will demonstrate in practice competency through a return demonstration of action to be taken.	2/7/2023
			The Director of Human Resources developed a tracking system to track all required training. Monitoring Plan: To monitor compliance the Human Resources Director implemented a weekly staff training audit to include review of 100% of all newly hired nurses and MHTs and 30 records of current nurses and MHTs to ensure that required training including Handle with Care, Management of a mass behavioral disturbance, Verbal De-escalation, Crisis Management, Avoiding Power struggles, and Safely Managing Altercations, any identified deficiencies will be immediately addressed by removing the staff member from working until required training has been completed.	2/7/2023

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(N 214) Continued From page 11

Medication room, calling the police, 911 Emergency Services telephone number to respond to the facility for "out of control" residents.

Review of 22 staff training records (Staff #A through #V) reveal that they have had training in "Handle With Care" which teaches how to physically restrain a resident and to verbally de-escalate a resident during a crisis situation. Review of the "Student Manual" documents that the goal for verbal de-escalation is to recognize the development of a crisis and communicate to de-escalate the crisis. Training includes key points of crisis management, working styles in crisis and stages of crisis, communication in crisis, preventing power struggles, active listening, anger management and setting limits.

There is no evidence of documentation that staff have demonstrated their knowledge of their training and ability to implement this knowledge as evidenced staff being observed on video camera idly standing by during the emergency crisis situation; and by the staff's lack of ability to control an emergency crisis situation that occurred on the evening of 01/20/23 resulting in Emergency Medical Services and Law Enforcement coming into the facility to control the residents.
There was no evidence of documentation that staff had been trained in securing their badges to prevent the residents from acquiring them to gain access to the outside.

During an interview on 01/21/23 at 7:39 PM, Staff A, RN (Registered Nurse) stated, "Resident came right up to me in my face talking to me and grabbed my badge, one resident used my badge

(N 214) Aggregated data is reported weekly to the Performance Improvement Committee and quarterly to the Governing Body for a minimum of 4 months with sustained improvement of 100%, then ongoing it will be monitored as part of the HR Department performance improvement indicators.

The Director of Plant Operations revised the planned emergency drills to include a mass behavioral disturbance as a drill to be conducted 3 per month (1 for week days day shift, 1 for week days night shift and 1 for weekend shift) for a minimum of 4 months with sustained correct response, then the drills will be conducted 1 per month ongoing. Observation of drills will be done by a team of senior leaders and HWC trainers with immediate feedback provided to staff following the drill and an analysis of the drill completed to identify any systemic or individual training needs. Results of drills will be reported monthly to the PI Committee and quarterly to the Governing Body. 2/17/2023

Proxy Card access:
Corrective Actions:
The Director of Human Resources revised Policy Dress Code to prevent residents access to staff's proxy badge as follows:
facility proxy cards are to be maintained in staff pocket or tucked in their clothing that is not visible, non-proxy identification badges are to be worn in a visible location.

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{N 214}	Continued From page 12 to get out, the rest of the residents were beating me up and went to another staff and took her badge and escaped." During an interview on 01/21/23 at 8:20 PM, Staff C, MHT (Mental Health Technician) stated, "The unit was in chaos, residents were running around destroying property. Resident #2 kept touching me and pushing me. We are trained with Handle With Care (HWC) physical portion and verbal de-escalation." During an interview on 01/23/23 at 4:26 PM, Staff D, MHT, stated that she was not working the night of the incident but stated, " If I saw a group of children (residents) coming at me and wanted my badge, I would hand it over;" Staff D was asked about the training that she gets, and she stated that they have the Handle With Care (HWC) training that has to do with physical restraints and de-escalation, the rest of the training is online. During a telephone interview on 01/23/23 at 6:50 PM with Staff E, Unit Coordinator, she was asked if she gets any training for high level crisis situations such as the one that occurred the day before; She stated, "We have HWC, and we watch videos to get CEU (Continuing Education Unit)'s." During a telephone interview on 01/23/23 at 7:17 PM, Staff G, stated, "MHT I think we are trained for patient management being aggressive but not a full-blown uncontrollable crisis situation." During a telephone interview on 01/24/23 at 12:45 PM, Staff H, MHT stated, "When the unit was chaotic and the residents were running around,	{N 214}	The Director of Human Resources issued new pictured non-proxy card ID badges. The Director of Human Resources and/or her department directors have reeducated all staff individually on the revised policy. Staff have signed an attestation of understanding and compliance. The Director of Human Resources revised new employee orientation to include training related to badge and proxy security. Monitoring Plan: During daily rounds the Director of Nursing, the Director of Residential Services and the House Supervisors through direct observation monitor compliance. Identified noncompliance is immediately addressed with the involved staff member. Aggregated data is reviewed monthly at the Performance Improvement Committee for a minimum of 4 months with sustained improvement.	2/3/2023 2/7/2023 2/7/2023

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{N 214}	Continued From page 13	{N 214}		

my job was to do Q 5 and 15 (observe and document where residents were every 5 and 15 minutes). A whole bunch of residents ran into Room 524. It was like 7 residents, this was after 7:30 PM, they were acting up and I wasn't paying attention. I tried and talked to them. They called me names, I tried for them not to grab me, so they wouldn't punch me, I told them to go in their rooms but they wouldn't listen. A resident was banging on a glass door, I just ignored them and just worked on the Q. I tried to take a chair away from a resident but he tried to attack me."

During an interview on 01/24/23 at 1:04 PM, the Director of Residential Services stated, "We do crisis management, verbal de-escalation manual. Code Green is a crisis, a show of support, a problem is escalation. No crisis management occurred. For HWC, it is 2 days during orientation. We have drills all year round, that includes fire drills, hurricanes, natural disasters, active shooter, We did not do training for what occurred Friday, it was a crisis situation but at a higher level. Refresher HWC is 4 hours that includes 2 hour of verbal de-escalation and 2 hours of physical restraints."

During an interview on 01/30/23 at 10:25 AM, the CEO stated, "Our trainings don't specify on the behaviors that deal with uncontrollable crisis management. The staff get a lot of education and training, we talk about what goes around with crisis management, the training is with verbal de-escalation dealing with crisis, we just don't say the word "riot." We do additional training on de-escalation and milieu management. It's not that we don't train them (staff); it is they (staff) that choose not to do it. What I saw could have been resolved if they immediately responded to

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(N 214)	Continued From page 14	(N 214)		

how they were trained. We do training at orientation, HWC every 6 months. HWC covers a crisis. ... If the staff choose not to do anything, that throws me off. It has nothing to do with training, it has to with the staff, they froze up and didn't do what they were supposed to do. Is it lack of training or they just chose not to do it, I don't know the answer to that part."

***Facility Actions to Remove the Immediate Jeopardy, and Implementation were verified by the Surveyor.
Removal of Immediate Jeopardy took place on 02/20/2023.

On 1/30/2023, the Chief Operations Officer in training conducted a reconciliation of HR (Human Resources) training documentation and all staff are current with Verbal De-Escalation Competency, which includes Crisis Management and Handle with Care (use of restrictive intervention) in accordance with the PRTF's Policy and Procedures.

On 1/30/2023, the Chief Operation Officer in training began conducting a reconciliation of staff training and education to ensure that all staff (Nurses and Mental Health Technicians) have been retrained and documented competency in de-escalation and managing emergency uncontrollable resident situations.

On 1/30/2023, the Director of Nursing and the Director of Residential Services identified staff (Nurses and Mental Health Technicians) to begin retraining and competency immediately on 1/30/23 in verbal de-escalation and managing emergency uncontrolled situations to ensure

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{N 214}	Continued From page 15	{N 214}		

resident safety. The training includes a competency with scenarios and a signed attestation of understanding.

On 1/30/2023, the Director of Nursing and the Director of Residential Services began immediately retraining all staff (Nurses and Mental Health Technicians) in verbal de-escalation and managing of emergency uncontrolled situations to ensure resident safety. Staff training includes a competency with scenarios and signed an attestation of understanding. Identified staff who have not completed the training by 2/7/23 will be removed from schedule until training has been completed.

On 1/31/2023, to identify staffing learning deficits, the Director of Nursing and the Director of Residential Services began having Nurses and Mental Health Technicians; complete a self-assessment prior to the conclusion of the shift they are working.

The Chief Executive Officer removed all unweighted chairs from the resident care area and added the documentation responsibility to the Administrator on Call rounds.

On 02/01/23, the Director of Residential Services began re-educating staff on remaining awake and vigilant while on shift, including while in the classrooms with House Supervisor and Leadership conducting hourly rounds to ensure staff are awake.

On 2/1/2023 The Chief Operation Officer, Director of Intake, Director of Residential Services, Director of Performance Improvement and Director of Clinical Services, began

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(N 214)	Continued From page 16 conducting staff reeducation through signature attestation to ensure that all staff (Therapist, Nurses, Mental Health Technicians) are always maintaining and accountability of their Proxy (Door Access) card. Staff were reeducated on appropriate location of their Proxy card to be maintained in staff pocket or tucked into their clothing that is not visible. On 2/2/2023, Staff were educated that effective 2/2/2023, paper nametags will be utilized for identification with direct signature attestation, retained in the employee file with daily leadership rounds and house supervisor rounds to assure compliance. On 2/1/2023, the Director of Risk Management revised and educated leadership on monitoring compliance of staff Proxy cards not visible on the person, but located in the staff pocket or tucked into their clothing and the PRTF's policy was revised on 02/14/2023. On 02/13/2023 between 8:30 AM and 4:30 PM, reviewed documentation of staff that had the training that included hands on scenarios verbal de-escalation, milieu management, avoiding power struggles, and crisis management. Staff that had the training signed an attestation acknowledging that they had and understand the training. Interviews were conducted on 02/13/2023 between 8:30 AM and 4:30 PM and 02/14/2023 between 8:50 AM and 4:45 PM with 10 Staff acknowledging the training they received since Incident on 01/20/2023.	(N 214)		
(N 220)	EDUCATION AND TRAINING	(N 220)		

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{N 220}	Continued From page 17 CFR(s): 483.376(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the Psychiatric Residential Treatment Facility (PRTF) failed to provide staff training exercises that the staff have demonstrated, in practice, for the techniques they have learned for managing an emergency safety crisis situation (Staff #A through #V). Due to these findings, it was determined the facility was in Immediate Jeopardy (IJ) that was identified on 01/21/23 and was ongoing at the time of facility exit. The findings included: Observation of the facility's video camera footage on 01/23/23 at 11:15 AM, with the Risk Manager and the CEO (Chief Executive Officer) reveals an uncontrollable emergency safety crisis involving multiple residents occurring on 01/20/23 at approximately 8:28 PM on two units, Pelican and Seagull units; residents were running around their units causing chaos and destruction to property that included breaking an impact glass exterior door with a coffee table, setting off the fire alarm and pulling it off the wall, jumping over the Nurses' station to the other unit that is adjacent to their unit, 6 residents running in and out of other residents' rooms that were not theirs, pulling two staff badges off from around staff's neck and	{N 220}	Training: Corrective Actions: The Director of Nursing and the Director of Residential Services developed and provided a re-education program for nurses and MHTs related to management of patient behavior. The training was conducted in person in groups or individually. The training included a competency test with scenarios and a signed attestation of understanding. Staff who have not completed training have been removed from the work scheduled until training has been completed. Training included: • Use of Verbal De-escalation including: o Crisis Management: Crisis Management included a review of the recent Mass Behavioral Disturbance as an example of how staff should respond in these events. o Communication in a Crisis o Stages of Crisis and Working styles in Crisis • Avoiding Power Struggles • Safely Managing Altercations/Breaking up Fights The Director of Risk Management revised the New Employee Orientation and the bi-annual Handle with Care Training to include a separate section of training on the management of a mass behavioral disturbance in which staff will demonstrate in practice competency through a return demonstration of action to be taken.	2/7/2023 2/7/2023

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{N 220}	Continued From page 18 using the badge/FOB (keyless entry remote) to leave the unit. Further observation reveals that while this was going on, staff were observed to be standing around not de-escalating the residents from their behaviors; there were 6-7 staff observed standing at the Nurses' station and another staff standing against the wall holding a "clip board." There is no evidence of documentation that staff have demonstrated their knowledge of their training and ability to implement this knowledge as evidenced staff being observed on video camera idly standing by during the emergency crisis situation; and by the staff's lack of ability to control an emergency crisis situation that occurred on the evening of 01/20/23 resulting in Emergency Medical Services and Law Enforcement coming into the facility to control the residents. There was no evidence of documentation that staff had been trained in securing their badges to prevent the residents from acquiring them to gain access to the outside. There was no evidence of documentation that the PRTF had a Policy and Procedure for securing their staffs' badges that provide access to the outside of the facility. During an interview on 01/21/23 at 7:39 PM, Staff A, RN (Registered Nurse) stated, "I saw the residents breaking the exterior door that leads to the enclosed fence area with a chair; I stood at door to prevent them from breaking door, they moved away from the door, I took the chair to the Nursing Station then went back to stand at the door; they were now trying to kick door with their feet. They came right up to me, in my face, talking to me and grabbed my badge, one resident used my badge to get out, the rest of the	{N 220}	The Director of Human Resources developed a tracking system to track all required training. Monitoring Plan: To monitor compliance the Human Resources Director implemented a weekly staff training audit to include review of 100% of all newly hired nurses and MHTs and 30 records of current nurses and MHTs to ensure that required training including Handle with Care, Management of a mass behavioral disturbance, Verbal De-escalation, Crisis Management, Avoiding Power struggles, and Safely Managing Altercations, any identified deficiencies will be immediately addressed by removing the staff member from working until required training has been completed. The Performance Improvement Committee will review the aggregated data weekly for 3 months, then every 2 weeks for the next 3 months, then monthly for a minimum of 6 additional months. Governing Body will review in a special monthly meeting the data (3/27/23, 4/24/23, 5/29/23) and update reports of compliance to the plan of correction for 4 months, then ongoing quarterly (4/27/23, 7/27/23, 10/26/23, 01/25/24) with sustained improvement of 100%, and then ongoing it will be monitored as part of the department performance improvement indicators.	2/17/2023

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{N 220}	Continued From page 19 residents beat me up and went to another staff and took her badge and escaped." During an interview on 01/21/23 at 8:20 PM, Staff C, MHT (Mental Health Technician) stated, "Resident #2 broke the exterior door window with a table, she was sliding the table, the door (impact glass) shattered; this was on Pelican (Unit). I have a good ... (connection) with her. She kept touching me and pushing me, I said, What is wrong with you. I told her to look at me. All the residents were running around the unit screaming, it was very chaotic." During an interview on 01/23/23 at 4:26 PM, Staff D, MHT, stated that she "was not working the night of the incident but if" she "saw a group of children (residents) coming at me and wanted my badge, I would hand it over;" Staff D was "asked about training that she gets" and she stated that "have the Handle With Care (HWC) training that has to do with physical restraints and de-escalation, the rest is online.; asked "if they do any drills for incidents that occur such as a "riot (emergency crisis situation)" and she stated, No." During a telephone interview on 01/23/23 at 6:50 PM with Staff E, Unit Coordinator she was asked if she gets any training for scenarios that occur such as the "riot;" she stated, "We have HWC and we watch videos to get CEU (Continuing Education Unit)'s" but no we do not have any training to prepare us for incidents that occur when multiple residents have taken over the unit." During a telephone interview on 01/23/23 at 7:17 PM, Staff G, MHT stated, "I don't think we have been trained if a riot occurs but are trained for patient management being aggressive but not a	{N 220}	'The Director of Plant Operations revised the planned emergency drills to include a mass behavioral disturbance as a drill to be conducted 3 per month (1 for week days day shift, 1 for week days night shift and 1 for weekend shift) for a minimum of 4 months with sustained correct response, then the drills will be conducted 1 per month ongoing. Observation of drills will be done by a team of senior leaders and HWC trainers with immediate feedback provided to staff following the drill and an analysis of the drill completed to identify any systemic or individual training needs. Data from conducted drills are reported in the weekly PI meeting. The Performance Improvement Committee will review the aggregated data weekly for 3 months, then every 2 weeks for the next 3 months, then monthly for a minimum of 6 additional months. Governing Body will review in a special monthly meeting the data (3/27/23, 4/24/23, 5/29/23, 6/26/23) and update reports of compliance to the plan of correction for 4 months, then ongoing quarterly (4/27/23, 7/27/23, 10/26/23, 01/25/24) with sustained improvement of 100%, and then ongoing it will be monitored as part of the department performance improvement indicators.	2/17/2023

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 _____	R-C 02/20/2023

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 220}	Continued From page 20	{N 220}		

full-blown riot."

During a telephone interview on 01/24/23 at 12:46 PM, Staff H, MHT stated, " Last time I got in trouble by the Unit Coordinator for changing units, two other staff came when a "show of support" was called. I said my job is to do Q 5 & 15 (observe and document where residents are every 5 and 15 minutes). A whole bunch of residents ran into Room 524. It was like 7 residents; this was after 7:30 PM, they were acting up and I wasn't paying attention. I tried and talked to them, I talk and talked. They called me names, I tried for them not to grab me, so they wouldn't punch me, I told them to go in their room but they wouldn't listen."

During an interview on 01/24/23 at 2:49 PM, Staff I stated she, "left Friday 01/20/22 at 7:30 PM; asked if she ever received training for a high level uncontrollable crisis situation; she stated, "No, but do get training for Verbal De-escalation with HWC. We get training for hurricanes and fire stuff at least twice a year but not like what happened Friday. We get the HWC twice a year, we do the physical and verbal part of it."

During a telephone interview on 01/24/24 at 3:45 PM, Staff J stated, "We have Handle With Care training and de-escalation, but there is no training when there is an uprising like what happened Friday night."

During a telephone interview on 01/25/23 at 11:02 AM, Staff K stated, We have drills all year round, that includes fire drills, hurricanes, natural disasters, active shooter; we did not have training for what occurred Friday night, it was a crisis situation but at a higher level."

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	[redacted]	A. BUILDING _____ B. WING _____	R-C 02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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(N 220)	Continued From page 21	(N 220)		

During a telephone interview on 01/25/23 at 11:20 AM Staff L stated, "I was on the floor; I called the Director of Nursing, I told her that I only see 1 MHT on the floor; I started seeing the residents jumping the Nurses' station; I couldn't hear what she said, I saw residents jumping the Nurses' Station, someone threw something at my head, I went into the "Medication Room; some nurses were in there, a nurse was crying; I said we need to call 911 (Police Emergency Services) and someone said call the CEO. I told the CEO that there was not enough staff; the residents were breaking the doors and a riot was going on. He said to call 911. I called 911 and told them that a riot was going on and there was not enough staff. It is such a dangerous place. So many nurses have quit, everything is unsafe. I was having a panic attack from this place. I had no idea what to do, we are not trained on anything like this. We ended up locking ourselves in the Medication Room, there was a couple of staff that were with me."

During an interview on 01/30/23 at 10:25 AM, the CEO stated, "Our trainings don't specify on the behaviors that deal with uncontrollable crisis management. The staff get a lot of education and training, we talk about what goes around with crisis management, the training is with verbal de-escalation dealing with crisis, we just don't say the word "riot." We do additional training on de-escalation and milieu management. It's not that we don't train them (staff); it is they (staff) that choose not to do it. What I saw could have been resolved if they immediately responded to how they were trained. We do training at orientation, HWC every 6 months. HWC covers a crisis. ... If the staff choose not to do anything,

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	[redacted]	A. BUILDING _____ B. WING _____	R-C 02/20/2023

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 220}	Continued From page 22	{N 220}		

that throws me off. It has nothing to do with training, it has to with the staff, they froze up and didn't do what they were supposed to do. Is it lack of training or they just chose not to do it, I don't know the answer to that part."

***Facility Actions to Remove the Immediate Jeopardy, and Implementation were verified by the Surveyor.
Removal of Immediate Jeopardy took place on 02/20/2023.

On 1/30/2023, the Chief Operations Officer in training conducted a reconciliation of HR (Human Resources) training documentation and all staff are current with Verbal De-Escalation Competency, which includes Crisis Management and Handle with Care (use of restrictive intervention) in accordance with the PRTF's Policy and Procedures.

On 1/30/2023, the Chief Operation Officer in training began conducting a reconciliation of staff training and education to ensure that all staff (Nurses and Mental Health Technicians) have been retrained and documented competency in de-escalation and managing emergency uncontrollable resident situations.

On 1/31/2023, to identify staffing learning deficits, the Director of Nursing and the Director of Residential Services began having Nurses and Mental Health Technicians; complete a self-assessment prior to the conclusion of the shift they are working.

On 02/01/2023, the Director of Residential Services began re-educating staff on remaining

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	R-C 02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	[redacted] TEQUESTA, FL [redacted]

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{N 220}	Continued From page 23 awake and vigilant while on shift, including while in the classrooms with House Supervisor and Leadership conducting hourly rounds to ensure staff are awake. On 02/13/2023 between 8:30 AM and 4:30 PM, reviewed documentation of staff that had the training that included hands on scenarios verbal de-escalation, milieu management, avoiding power struggles, and crisis management. Staff that had the training signed an attestation acknowledging that they had and understand the training. Interviews were conducted on 02/13/2023 between 8:30 AM and 4:30 PM and 02/14/2023 between 8:50 AM and 4:45 PM with 10 Staff acknowledging the training they received since incident on 01/20/2023.	{N 220}		

Appendix 90.

FACSIMILE COVER LETTER

FAX		
	Date & Time:	03-27-2023 2:18 PM
	Deliver To:	Mr [redacted] Administrator
	Fax Number:	[redacted]
	From:	[redacted]
	Phone:	
	Regarding:	Sandy Pines Event ID [redacted]

Good afternoon,
Please see the attached report of the Complaint Revisit survey conducted on 03/21/23.
Thank You,
[redacted]

[redacted] - REGISTERED NURSING CONSULTANT
SURVEYOR

[redacted]
[redacted] DELRAY BEACH, FL.
+1 [redacted] (Office) - [redacted] or [redacted] (Fax)
[redacted]@ahca.myflorida.com



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Appendix 90.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

March 27, 2023

Mr. [redacted] Administrator
Sandy Pines
[redacted]
Tequesta, FL [redacted]

RE: Complaint Number [redacted]

Dear Mr. [redacted]

This letter reports the findings of a Federal Complaint survey revisit conducted on March 21, 2023 by a representative of this office.

The previously cited deficiencies were found corrected on the day of the 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 surveyor. Should you have any questions please call this office at [redacted]

Sincerely,

[redacted] RNC for

[redacted]
Field Office Manager

[redacted]
Enclosure: Form CMS 2567

J5XD

[redacted]
Delray Beach, [redacted]
Phone: [redacted] Fax: [redacted]
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Appendix 90.

PRINTED: 03/27/2023
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	R-C 03/21/2023

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	{N 000}		

An unannounced Revisit to the Complaint survey, #2023001473, was conducted on 03/21/2023 at Sandy Pines Residential Treatment Center for Children and Adolescents Facility.
The facility is in compliance with 42 CFR (Code Of Federal Regulations) Part 483.354, Subpart G, Condition Of Participation for Psychiatric Residential Treatment Facilities. Previously cited deficiencies were found corrected.

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.

CONFIDENTIAL UHS-FINHELP-00009783

UHS-FINHELP-00009784 [Redacted]

The Joint Commission

Final Accreditation Report

SP Behavioral, LLC
[redacted]
Tequesta, FL [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 1/12/2021 - 1/15/2021

Program Surveyed
Behavioral Health Care and Human Services

Final Report: Posted 1/19/2021

The Joint Commission
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The Joint Commission
Executive Summary

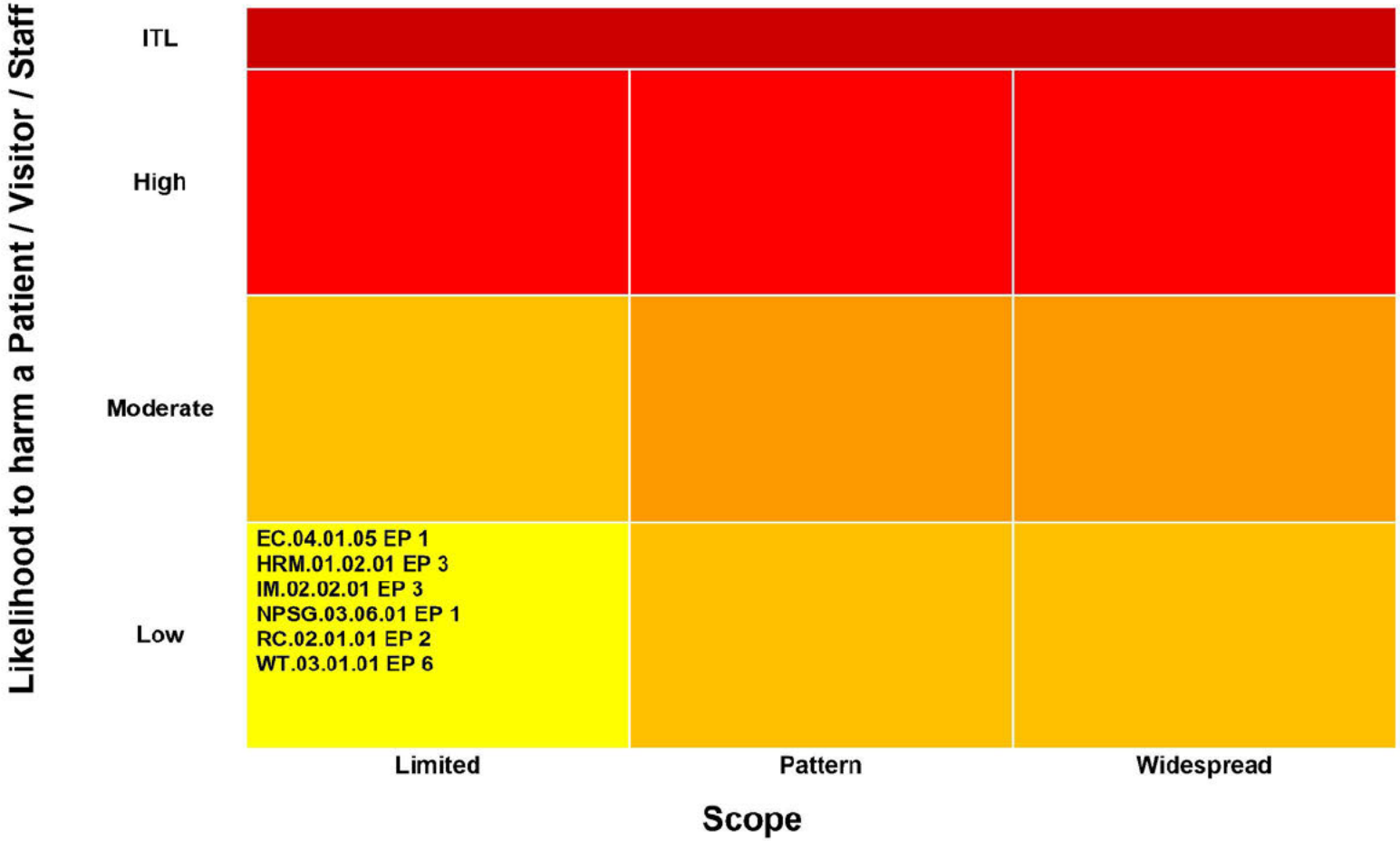
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	01/12/2021 - 01/15/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards 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)
EC.04.01.05	1	Low / Limited	✓
HRM.01.02.01	3	Low / Limited	✓
IM.02.02.01	3	Low / Limited	✓
NPSG.03.06.01	1	Low / Limited	✓
RC.02.01.01	2	Low / Limited	✓
WT.03.01.01	6	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
EC.04.01.05	1	Low Limited	The organization takes action on the identified opportunities to resolve environmental safety issues.	1) Observed in Building Tour at SP Behavioral, LLC [redacted] Tequesta, FL) site . The HCO had showers that were not being cleaned well, the area where residents would walk in the basin of the shower (90 bathrooms). The facilities director stated cleaning is a contracted service with a housekeeping manager who is an employee who to has oversight. Before the end of the day the facilities director stated he contacted the cleaning service to discuss what would be done differently to clean the showers that are not cleaned properly.
HRM.01.02.01	3	Low Limited	The organization verifies the identity of the job applicant by viewing a valid picture identification issued by a state or federal agency (for example, a driver's license or passport).	1) Observed in Competency Session at SP Behavioral, LLC [redacted] Tequesta, FL) site . The HCO had a staff member who had not provided government issued identification or picture ID in their human resources chart. This had been discussed with HR staff.
IM.02.02.01	3	Low Limited	The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following: - U,u - IU - Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d, qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MSO4 - MgSO4 Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.	1) Observed in Record Review at SP Behavioral, LLC [redacted] Tequesta, FL) site . When reviewing an order in the chart QD a prohibited abbreviation had been observed, this had been a hand written order. This had been discussed with staff present.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
NPSG.03.06.01	1	Low Limited	Obtain and/or update information on the medications the individual served is currently taking. This information is documented in a list or other format that is useful to those who manage medications. Note 1: The organization obtains the individual's medication information during the first contact. The information is updated when the individual's medications change. Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 3: It is often difficult to obtain complete information on current medications from the individual served. A good faith effort to obtain this information from the individual and/or other sources will be considered as meeting the intent of the EP.	1) Observed in Record Review at SP Behavioral, LLC [redacted] Tequesta, FL) site . The HCO at discharge had documented medication frequency as QAM, QHS. Not in a manner that could be clearly understood by the resident or family in plain language. This had been discussed with director of clinical services and CNO.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
RC.02.01.01	2	Low Limited	The clinical/case record of the individual served contains the following information: - The reason(s) for admission or initiation of care, treatment, or services - The initial diagnosis, diagnostic impression(s), condition(s), or circumstances requiring care or services - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the medical history and physical examination - Any diagnoses or conditions established during the course of care, treatment, or services - Any consultation reports - Any observations relevant to care, treatment, or services - The response to care, treatment, or services - Any emergency care, treatment, or services provided prior to arrival - Any progress notes - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration - Any access site for medication, administration devices used, and rate of administration (for intravenous therapy) - Any adverse drug reactions - Care, treatment, or service goals - Plan of care and revisions to the plan of care, treatment, or services - Orders for diagnostic and therapeutic tests and procedures and their results	1) Observed in Record Review at SP Behavioral, LLC [redacted] Tequesta, FL) site . Per HCO own policy when a resident is on psychotropic/polypharmacy an AIMS (Abnormal Involuntary Movement Scale) is done at the time of admissions and every 3 months. In this specific chart the resident had one at the time of admission however no other AIMS form in the chart. This had been observed by CNO and staff present.
				2) Observed in Record Review at SP Behavioral, LLC [redacted] Tequesta, FL) site . The HCO had a round sheet that documented different behavior from the documented progress note for the same time on the resident who's chart had been reviewed. Discussion with CNO, she stated it had been identified as a problem previous to the survey and leadership team is working on changes.
WT.03.01.01	6	Low Limited	Competence for waived testing is assessed according to organization policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.	1) Observed in Competency Session at SP Behavioral, LLC [redacted] equesta, FL) site . The HCO had 2020 WT competencies however could not locate 2018, 2019 to illustrate annual training. This had been discussed with HR staff and CNO.

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Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
EC.04.01.05	1	The organization improves its environment of care.	The organization takes action on the identified opportunities to resolve environmental safety issues.
HRM.01.02.01	3	The organization verifies and evaluates staff qualifications.	The organization verifies the identity of the job applicant by viewing a valid picture identification issued by a state or federal agency (for example, a driver's license or passport).
IM.02.02.01	3	The organization effectively manages the collection of clinical/case information.	The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following: - U,u - IU - Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d, qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MSO4 - MgSO4 Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.
NPSG.03.06.01	1	Maintain and communicate accurate medication information for the individual served.	Obtain and/or update information on the medications the individual served is currently taking. This information is documented in a list or other format that is useful to those who manage medications. Note 1: The organization obtains the individual's medication information during the first contact. The information is updated when the individual's medications change. Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 3: It is often difficult to obtain complete information on current

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Standard	EP	Standard Text	EP Text
			medications from the individual served. A good faith effort to obtain this information from the individual and/or other sources will be considered as meeting the intent of the EP.
RC.02.01.01	2	The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.	The clinical/case record of the individual served contains the following information: - The reason(s) for admission or initiation of care, treatment, or services - The initial diagnosis, diagnostic impression(s), condition(s), or circumstances requiring care or services - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the medical history and physical examination - Any diagnoses or conditions established during the course of care, treatment, or services - Any consultation reports - Any observations relevant to care, treatment, or services - The response to care, treatment, or services - Any emergency care, treatment, or services provided prior to arrival - Any progress notes - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration - Any access site for medication, administration devices used, and rate of administration (for intravenous therapy) - Any adverse drug reactions - Care, treatment, or service goals - Plan of care and revisions to the plan of care, treatment, or services - Orders for diagnostic and therapeutic tests and procedures and their results
WT.03.01.01	6	Staff performing waived tests are competent.	Competence for waived testing is assessed according to organization policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.

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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

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.

The Joint Commission

Final Accreditation Report

SP Behavioral, LLC
[redacted]
Tequesta, FL [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 3/12/2021

ESC Programs Reviewed

Behavioral Health Care and Human Services

Final Report: Posted 3/19/2021

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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	3/12/2021	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health Care and Human Services

Standard	Level of Compliance
EC.04.01.05	Compliant
HRM.01.02.01	Compliant
IM.02.02.01	Compliant
NPSG.03.06.01	Compliant
RC.02.01.01	Compliant
WT.03.01.01	Compliant

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Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
EC.04.01.05	1	The organization improves its environment of care.	The organization takes action on the identified opportunities to resolve environmental safety issues.
HRM.01.02.01	3	The organization verifies and evaluates staff qualifications.	The organization verifies the identity of the job applicant by viewing a valid picture identification issued by a state or federal agency (for example, a driver's license or passport).
IM.02.02.01	3	The organization effectively manages the collection of clinical/case information.	The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following: - U,u - IU - Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d, qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MSO4 - MgSO4 Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.
NPSG.03.06.01	1	Maintain and communicate accurate medication information for the individual served.	Obtain and/or update information on the medications the individual served is currently taking. This information is documented in a list or other format that is useful to those who manage medications. Note 1: The organization obtains the individual's medication information during the first contact. The information is updated when the individual's medications change. Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 3: It is often difficult to obtain complete information on current

The Joint Commission

Standard	EP	Standard Text	EP Text
			medications from the individual served. A good faith effort to obtain this information from the individual and/or other sources will be considered as meeting the intent of the EP.
RC.02.01.01	2	The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.	The clinical/case record of the individual served contains the following information: - The reason(s) for admission or initiation of care, treatment, or services - The initial diagnosis, diagnostic impression(s), condition(s), or circumstances requiring care or services - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the medical history and physical examination - Any diagnoses or conditions established during the course of care, treatment, or services - Any consultation reports - Any observations relevant to care, treatment, or services - The response to care, treatment, or services - Any emergency care, treatment, or services provided prior to arrival - Any progress notes - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration - Any access site for medication, administration devices used, and rate of administration (for intravenous therapy) - Any adverse drug reactions - Care, treatment, or service goals - Plan of care and revisions to the plan of care, treatment, or services - Orders for diagnostic and therapeutic tests and procedures and their results
WT.03.01.01	6	Staff performing waived tests are competent.	Competence for waived testing is assessed according to organization policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.

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March 19, 2021

[redacted]
CEO
SP Behavioral, LLC
[redacted]
Tequesta, FL[redacted]

Joint Commission ID #: [redacted]
Program: Behavioral Health Care and Human Services
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 3/12/2021

Dear Mr. [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 January 16, 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.

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]RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

UHS-FINHELP-00009809 [Redacted]

JB Pritzker
Governor

Illinois Department of DCFS Children & Family Services

Marc D. Smith
Director

25 January 2023

[redacted] Divisional Vice President for Behavioral Health
Pavilion
[redacted]
Champaign, IL

Dear Mr. Sheehy:

On July 31, 2020, Pavilion received notification that the program met the requirements under The Family First Prevention Services Act (FFPSA) to be designated as a Qualified Residential Treatment Program (QRTP).

As stated in that notification there would be ongoing assessments to determine both compliance with and the quality of your agency's maintenance and fidelity of the requirements for QRTP designation. The plan moving forward is a yearly review.

On January 9 and 10, 2023 an onsite review was conducted by [redacted] LCSW and [redacted] LCSW for the purpose of redetermination of QRTP designation. The following materials were also reviewed: Copy of Accreditation, License, Mission Statement, Trauma Informed Model, Job Descriptions for therapist, nursing, direct care staff, case managers, aftercare staff, Quality Improvement Plan, list of new staff training and ongoing training

.

Based on the review Pavilion continues to MEET the family first requirements for QRTP designation:

- Licensed – CCI – 1/18/24
- Accreditation – JCAHO 2/12/20 to 2/12/23 (the 3-year accreditation review was in process at the time of this redetermination review)
- Registered or Licensed Nursing – During working hours they have 1 RN and 2 LPN staff, overnight shift is managed by the Pavilion hospital House supervisor who manages the hospital and QRTP.
- Registered or Licensed Clinical Staff – Chief Clinical Officer holds LCPC licensure, provide supervision and available 24/7
- Trauma Informed Treatment Model- Think Trauma – Pavilion staff had previously been trained in Think Trauma; however, with change in leadership and staff turnover, the agency has reengaged in training staff on the Think Trauma model. In January, the agency has 3 staff involved in train the trainer, Think Trauma offered through Northwestern University. Although the agency has had some limited trauma training, they are in the beginning phases.
- Family engagement- Staff reported contact with family members, participation in child and family team meetings, encouraging family connections.
- 6 months Aftercare – Aftercare is provided by case managers and/or therapist for 6 months.

The reviewers had the following recommendations:

- A CQI plan that measure outcomes for monitoring trauma informed treatment, family engagement, sibling connections, participation in CFTM, and 6 months after care. Plan should reflect how staff are evaluated and assessed for incorporating trauma-informed care into practice

1911 South Indiana Avenue • Chicago, Illinois 60616-1310
312-808-5000
www2.illinois.gov/DCFS

- Establish timeline for Think Trauma training for all staff within the QRTP. A timeline should be developed for completion, integration into the onboarding process and ongoing training to support the model
- All staff, to include ancillary staff, should receive trauma training.
- Consider incorporating additional training such as provided by DCFS, Trauma 101 and 201
- Job Descriptions: adding trauma-informed care, and for therapist adding criteria having LCSW or LCPC license or ability to obtain.
- If a therapist is providing an Evidenced Based Practice model of therapy (i.e. TF-CBT, EMDR, DBT), the therapist and/or the clinical supervisor shall have formal training and (if appropriate) certified in the EBP to ensure fidelity to the model of treatment. The current "gold standard" of training in EBP includes a workshop, manual and clinical supervision
- Ensure unlicensed therapists receive individual clinical supervision by a master's level clinician or licensed clinician at least monthly
- Ensure behavior treatment plans/crisis plans and Comprehensive Transition Plans (CTP) are completed for all youth and reviewed per policy/procedures
- Add a quality assurance measure for IM+CANS scoring. All assessment information should be integrated and scoring consistent with the youth trauma history
- Physical plant should be aesthetically pleasing, youth centered. Youth should have the option to personalize their bedroom. Consideration should be given to developing additional therapeutic spaces for youth such as sensory rooms and alternative therapy spaces
- Any physical plant issues should be addressed in a timely fashion.
- Family contact and attempts should be documented.
- Education/training for all QRTP staff on Family First requirements, culture shift needed to support treatment, discharge planning and family engagement. Inclusion of Family First Preservation Act requirements and principles in orientation training for all staff moving forward.
- Agency should adhere to contracted ratios.

DCFS is grateful for your partnership in our collective efforts to improve outcomes for Illinois' most vulnerable children and families.

If you have any questions or concerns, please contact me at [redacted]@Illinois.gov.

Sincerely,

[redacted]
Chief Deputy Director Clinical & Child Services
Department of Children & Family Services

CC:
[redacted] Pavilion, Chief Clinical Officer
[redacted] Pavilion, Residential Director
[redacted] Deputy Director Child Services
[redacted] Associate Deputy of ILO/TLP/Residential Monitoring
[redacted] Downstate Field Service Manager

UHS-FINHELP-00009822 [Redacted]

The Joint Commission

Final Accreditation Report

The Pavilion Foundation
[redacted]
Champaign, IL [redacted]

Organization Identification Number [redacted]
Unannounced Full Event: 11/29/2022 - 12/1/2022

Programs Surveyed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 12/14/2022

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	11/29/2022 - 12/01/2022	Accreditation with Follow-up Survey	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
			Unannounced Accreditation Follow-up Survey	Survey approximately 120 Calendar Days from final posted ESC report date
Behavioral Health Care and Human Services	11/29/2022 - 11/30/2022	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.02.01.03	2	Low / Limited	✓
CTS.02.01.09	2	Low / Limited	✓
CTS.03.01.03	1	Low / Limited	✓
	4	Low / Limited	✓
CTS.03.01.09	2	Low / Widespread	✓
CTS.05.05.21	1	Moderate / Limited	✓
EC.02.06.01	1	Low / Limited	✓
IC.01.02.01	3	Low / Limited	✓
LS.02.01.35	5	Low / Limited	✓
MM.03.01.01	2	Low / Limited	✓
RC.01.04.01	1	Low / Widespread	✓

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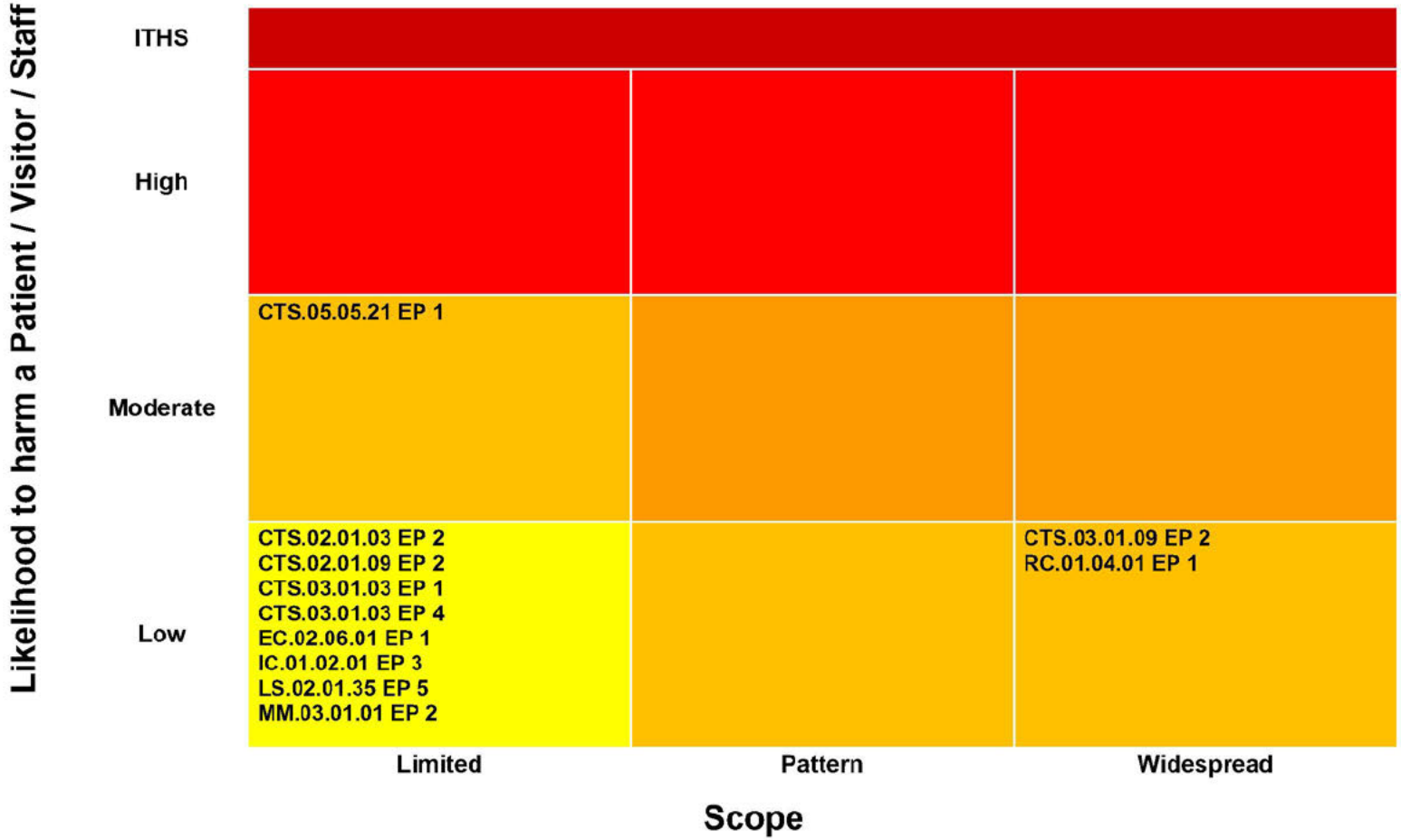
SAFER™ Matrix
Program: Behavioral Health Care and Human Services



The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.03	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 Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, it was observed that the H&P started on 10/5/21 was incomplete with several blank sections. Section 3,4, and 5 were blank.
CTS.02.01.09	2	Low Limited	Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment. Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the health care practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.	1) Observed in Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, pain was identified on the screen but not all of the follow up questions were answered. There were several blanks indicating the questions were not asked.
				2) Observed in Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, it was observed that pain was indicated and marked "yes". All of the following questions for further assessment were left blank.
CTS.03.01.03	1	Low Limited	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 Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, it was observed that the identified medical issues are not listed on the treatment plan. The client was assessed as having foot pain, Asthma and using a CPAP machine for sleep. There were services indicated and referred to in the record for these problems but not reflected on the treatment plan.
CTS.03.01.03	4	Low Limited	The organization reevaluates 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 the individual's response to care, treatment, or services. If no change(s) occurs, the goals and objectives are reevaluated at a specified time interval established by organization policy.	1) Observed in Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, it was observed that there were no treatment plan reviews per the organization policy.

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Standard	EP	SAFER™ Placement	EP Text	Observation
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 The Pavilion Residential Treatment Center [redacted]Champaign, IL) site . During review of Residential charts, it was observed that the organization is periodically administering a standardized outcome tool but they have not begun using this information to evaluate and/or modify the goals and objectives of the treatment plan.
CTS.05.05.21	1	Moderate Limited	For organizations that use physical holding on a child or youth: The organization follows its written policies and procedures regarding physical holding that include details about the following: - Staffing - Staff competence and training - Initial assessment of the child or youth - The role of nonphysical techniques - Limiting physical holding to emergencies - Notification of the parent(s) or guardian of the child or youth - Initiation of physical holding by an authorized staff member - Monitoring of the child or youth - Discontinuation of the physical hold - Debriefing - Reporting injuries and deaths to the organization's leadership and appropriate external agencies consistent with applicable law and regulation - Documentation of physical holding - Data collection and the integration of physical holding into performance improvement activities (See also CTS.05.05.07, EP 5)	1) Observed in Record Review at The Pavilion Residential Treatment Center [redacted]Champaign, IL) site . During review of a residential record, it was observed that a physical hold and medication restraint occurred on 7/30/22. The documentation was not fully completed per the organization policy. The Post Face to Face Intervention form did not have the time the doctor was notified, it was blank. The debrief form used for clients had no date/time listed. The form specifically states to be complete within 24 hours, but it is unknown with no date/time. The Interval Monitoring form had no intervention codes during 1935-1955.
EC.02.06.01	1	Low Limited	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 The Pavilion Residential Treatment Center [redacted]Champaign, IL) site . During the environmental tour of the girl's residential unit of floor 2, there was a stained ceiling tile above the observation desk where a shower had been leaking. CEO reports the leak was fixed previously and the tile was replaced during the survey.
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 required to provide supplies for use outside of these locations.	1) Observed in Building Tour at The Pavilion Residential Treatment Center [redacted]Champaign, IL) site . During the environmental tour of the boy's residential unit of floor 2, There was no hand sanitizer or soap available in two of the bathrooms. The soap was replaced during the survey.

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Standard	EP	SAFER™ Placement	EP Text	Observation
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 The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During the environmental tour of the girl's residential unit of floor 3, there was an escutcheon plate missing from one sprinkler in the day room. The plate was replaced during the survey.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 The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During the environmental tour of the medication room on the residential unit floor 3, It was observed that dietary supplements were being stored in the medication refrigerator along with medications.
RC.01.04.01	1	Low Widespread	According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.	1) Observed in Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, it was observed that the Q15 checks for the following dates and times were missing. 11/4/22 from 1415-1630, and 10/30/22 at 0915.
				2) Observed in Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, it was observed that the Q15 checks for the following dates and times were missing. On 11/29 from 0900-1345, 11/25 at 2115, 11/21 from 1200-1330 and 0815-1145, 11/18 from 0815-1400, and 11/17 from 1215-1345.
				3) Observed in Record Review at The Pavilion Residential Treatment Center [redacted] Champaign, IL) site . During review of a residential record, it was observed that the following dates and times were missing from the 15 minute check forms. On 11/29 at 2315, 11/27 at 2330, 2345, and 0145, on 11/5 at 2345, 9/5 at 530 and 545, and 9/4 at 1700.

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Standard	EP	Standard Text	EP & Addendum Text
			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.
WT.04.01.01	2	The hospital 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 documented quality control rationale for waived testing is based on the following: - How the test is used - Reagent stability - Manufacturers' recommendations - The hospital's experience with the test - Currently accepted guidelines

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP & Addendum 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.02.01.09	2	The organization screens all individuals served for physical pain.	Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment. Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the health care practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.
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	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 reevaluates 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 the individual's response to care, treatment, or services. If no change(s) occurs, the goals

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Standard	EP	Standard Text	EP & Addendum Text
			and objectives are reevaluated 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.
CTS.05.05.21	1	For organizations that use physical holding on a child or youth: The organization's policies and procedures address the prevention of the use of physical holding and, when employed, guide its use.	For organizations that use physical holding on a child or youth: The organization follows its written policies and procedures regarding physical holding that include details about the following: - Staffing - Staff competence and training - Initial assessment of the child or youth - The role of nonphysical techniques - Limiting physical holding to emergencies - Notification of the parent(s) or guardian of the child or youth - Initiation of physical holding by an authorized staff member - Monitoring of the child or youth - Discontinuation of the physical hold - Debriefing - Reporting injuries and deaths to the organization's leadership and appropriate external agencies consistent with applicable law and regulation - Documentation of physical holding - Data collection and the integration of physical holding into performance improvement activities (See also CTS.05.05.07, EP 5)
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.
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, 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.
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.	For organizations that store medications: The organization stores

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Standard	EP	Standard Text	EP & Addendum Text
		Note: This standard is applicable only to organizations that store medications at their sites.	medications according to the manufacturers' recommendations or a pharmacist's instructions. Note: This element of performance is also applicable to sample medications.
RC.01.04.01	1	The organization audits its clinical/case records.	According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

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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.

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

February 21, 2023

[redacted] RN
Chief Executive Officer
The Pavilion Foundation
[redacted]
Champaign, IL [redacted]

Joint Commission ID #[redacted]
Program: Behavioral Health Care and Human Services
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 2/9/2023

Dear Mr. [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 December 1, 2022 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

UHS-FINHELP-00009837 [Redacted]

MENTAL HEALTH & ADDICTION SERVICES | Ohio

Promoting wellness and recovery

Mike DeWine, Governor • Lori Criss, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

November 25, 2019

Foundations for Living
Attn: [redacted]
[redacted]
Mansfield, Ohio [redacted]

Re: License No. [redacted]

Dear Ms. [redacted]

Foundations for Living has been surveyed in accordance with Section 5119.34 of the Ohio Revised Code. **Your corrective actions have been determined to be in compliance with Ohio Administrative Code (OAC), chapter 5122-30.** You are licensed to operate a residential facility as specified on the enclosed license(s). Each license specifies the term of the license, the maximum number of residents for the facility, the maximum number of household members, and the classification type of the residential facility.

The license is not transferable to any other site or property. The operator of the residential facility shall be responsible for notifying the Department of any changes or proposed changes concerning the information submitted and attested to in the application, or in operation of the facility which alter or modify the type of activity for which the facility is licensed, and/or the continued compliance of the facility with the requirements for licensure.

As a reminder, you are required to submit a Residential Incident Notification form for any reportable incident. within twenty-four hours of discovery, excluding weekends and holidays.

If you have any questions regarding any of the above, please do not hesitate to contact [redacted] at [redacted]

Sincerely,

[redacted]
[redacted] Chief
Bureau of Licensure and Certification

pc: [redacted] Executive Director, Richland County MHRS Board
[redacted] BSN, Behavioral Health Standards Surveyor
[redacted] JD, MSN, RN, Behavioral Health Standards Surveyor Supervisor
[redacted] Office of the State Long-Term Ombudsman

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Bureau of Licensure and Certification

Survey Report

September 16, 2019

Date of Survey: August 8, 2019

Residential Facility: Keystone Richland Center, LLC DBA Foundations for Living

Facility Type: ☒ Class One ☐ Class Two ☐ Class Three

Response due date: October 16, 2019

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] r fax at [redacted] r 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 5122-30-12 Safety. **(J)** Each facility shall hold and provide documentation of an evacuation drill at least quarterly on each shift for all staff and residents. Drills shall be conducted at different and varying times of day and night, and shall be conducted utilizing different exit routes. **(DD)** All stairways, inclines, ramps, and open porches shall have hand railings installed in accordance with the rules of the board of building standards.	**Finding:** The facility is holding evacuation drills on each shift at least quarterly; however, the facility does not document the exit routes being utilized. Art Room Area – There are four steps; however, there are no handrails.	**Additional corrective action requirements:** The facility shall develop and submit for review a plan that ensures the exit routes being utilized during an evacuation drill are being documented. The facility shall submit evidence that handrails have been installed.	Exit routes have been added to drill documentation. Handrails added to Art Room steps.	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____
OAC 5122-30-14 Sleeping and living space. **(C)** …Each bedroom shall be adequately ventilated, and shall have at least one screened window to the outside. Bedroom window exceptions may only be granted by local building code officials or certified fire authorities.	**Finding:** The bedroom windows are not capable of being opened due to the population the facility serves.	**Additional corrective action requirements:** The facility shall obtain or submit documentation from the local building code officials or certified fire authorities approving the	Please see documentation included with POC.	**Review Results:** Approved ☐ Date: _____ **Notified**

(G) Any locks on bedroom doors shall meet both of the following requirements: **(1)** Any lock to residents' bedroom entrance doors shall be capable of being opened from the inside without the use of a key, such as by pushing a panic bar, releasing a deadbolt, or using similar means. The lock shall also be capable of being opened from the outside. The facility shall provide each resident with a key to his or her bedroom if it has a keyed lock; and **(2)** If resident bedrooms have locks, the facility shall have duplicate keys or a master key available and accessible to the staff members on duty at all times for use in cases of emergency.	Each bedroom has a entrance door that requires a key to lock and unlock the doors; however, the facility does not provide keys to residents due to the population the facility serves.	windows. Facility shall submit a waiver request.	Please see documentation included with POC.	**agency of additional response** ☐ Date(s): _____
OAC 5122-30-20 Qualifications of operator and staff. **(A)** Each person shall: **(4)** Test negative for tuberculosis within one year prior to employment. **(D)** Each person shall have written evidence of successfully completed prior training, or shall successfully complete training described in paragraph (C) of this rule, within thirty days of employment. Untrained staff who are within the first thirty days of employment or who have not completed all training shall work with trained staff.	**Finding:** Staff member Redacted - PII was hired on April 29, 2019; however, her TB test was initiated on April 30, 2019 after her date of hire. Staff members Redacted - PII and Redacted - PII did not complete the required trainings described in paragraph (C) of this rule, within thirty days of employment.	**Additional corrective action requirements:** The facility shall develop and submit for review a plan that ensures a person will test negative for tuberculosis within one year prior to employment. The facility shall develop and submit for review a plan that ensures new hires will complete training described in paragraph (C) of this rule within thirty days of employment.	Date of hire column has been added to check list for tracking of employment requirements to ensure all trainings have been completed and qualifications have been met and verified prior to hire. We have a new Director of Human Resources who is also looking at the process and will be developing system processes to ensure compliance. As these are developed, we can send.	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____

OAC 5122-30-23 Facility records.	**Finding:**	**Additional corrective action requirements:**	Admission coordinator will check for medical assessment within 12 months of admission. Will obtain documentation from guardian if records are not included with admission packet.	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____
(A) Each facility shall maintain resident and staff records, including at a minimum: **(2)** For each resident, the facility shall maintain: **(c)** Class one and class two facilities, shall have records of a medical assessment conducted by a qualified healthcare practitioner within twelve months prior to the date of admission.	There was no assessment for resident 4044.	The facility shall develop and submit for review a plan that ensures a medical assessment is conducted by a qualified healthcare practitioner within twelve months prior to the date of admission.		
(A)(2)(k) Notation of provision of personal care services, including the resident's progress or functional status, in accordance with the following schedule: **(i)** For residents of a class one facility, at least monthly.	There was no evidence that the facility documented at least monthly the notation of provision of personal care services, including the resident's progress or functional status for resident 4059.	The facility shall develop and submit for review a plan that ensures monthly notations are being documented on the personal care services plan for each resident of their progress or of their functional status.	Re-structuring residential department to increase accountability. New Dir. of Residential Services hired 10/8/19. The PCP's will now be completed and brought to weekly level meetings. The Unit Manager will be responsible for collecting and distributing to medical records.	
(A)(3) For each resident with a mental illness or severe mental disability, a copy of the written notification to the board serving the county in which the facility is located of the resident's placement in the facility within seven days of the resident's admission, including date of notification.	The facility did not have verification that a written notification was submitted to the board within seven days of admission for residents 4030, 4054, 4090 and 4101.	The facility shall develop and submit for review a plan that ensures when the facility admits a resident with a mental illness or severe mental disability, a copy of the written notification is sent to the board serving the county in which the facility is located of the resident's placement in the facility within seven days of the resident's admission and the facility documents in the record the date of notification.	Admission Coordinator will fax notification to the board within 7 days of admission. Joe Trolian was notified of the system process and will be starting a file of our admissions.	

OAC 5122-30-31 Background investigations for employment. **(C)** Requirements for owners, operators, managers, and prospective operators. **(2)** An owner, operator, manager or prospective operator shall: **(b)** Attempt to obtain references from the applicant's present and former employers and maintain written evidence that reference checks were attempted and/or completed. **(C)(3)** An owner, operator, manager, or prospective operator shall check each of the following databases to determine if the applicant is included. **(a)** The list of excluded persons and entities maintained by the office of inspector general in the Unites States department of health and human services pursuant to section 1128 of the Social Security Act, 94 Stat. 2619 (1980), 42 U.S.C. 1320a-7, and section 1156 of the Social Security Act, 96 Stat. 388 (1982), 42 U.S.C. 1320c-5 (available at http://exclusions.oig.hhs.gov/); **(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;	**Finding:** Staff member Redacted - PII [redacted] was hired on July 10, 2019; however, her reference checks were not completed until July 26, 2019. Staff member Redacted - PII was hired on April 24, 2019; however, the facility did not complete the database checks until May 20, 2019.	**Additional corrective action requirements:** The facility shall develop and submit for review a plan that ensures the facility shall obtain references from the applicant's present and former employers and will maintain written evidence. The facility shall develop and submit for review a plan that ensures the facility will check each of the six databases prior to hire.	Date of hire column has been added to check list for tracking of employment requirements to ensure all trainings have been completed and qualifications have been met and verified prior to hire. We have a new Director of Human Resources who is also looking at the process and will be developing system processes to ensure compliance. As these are developed. we can send.	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____

(d) The sex offender and child-victim offender database established pursuant to division (A)(11) of section 2950.13 of the Revised Code (available at http://icrimewatch.net/index.php?AgencyID=55149&disc=); (e) The United States general services administration system for award management database (available at https://www.sam.gov/); and, (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/OffffenderSearch				
OAC 5122-26-16 Seclusion, Restraint and Time-Out. (D) General requirements (1) Seclusion or restraint shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is identified. (b) Absent a co-existing crisis situation that includes the imminent risk of physical harm to the individua or others, the destruction of property by an individual, in and of itself is not adequate grounds for the utilization of these methods. **AND** **5122-26-16.2 Physical restraint** (B) Physical restraint shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to	**Finding:** Resident 4059 – Restraint documentation was reviewed for an incident that occurred on June 26, 2019. The resident was placed in a Handle with Care (HWC) hold for destruction of property and stealing staff radio. Resident 4059 was not an imminent risk to self or others and was improperly restrained for property damage (breaking fire alarm) and stealing a staff radio. Resident 4044 – Restraint documentation was reviewed for an incident that occurred on June 26, 2019. The resident refused to give a rod that she had in her pants to the nurses. The documentation stated she was uncooperative but noncombative. Resident 4044 was not an imminent risk to self or others and was	**Additional corrective action requirements:** The facility must provide training to all staff regarding use of least restrictive alternatives in an escalating resident situation and proper procedure for implementing restraints. The facility must submit evidence of trainings to the Department. The facility must also train all staff on proper reporting of incidents, including what constitutes a reportable incident, and provide evidence to the Department.	Director of Risk Management and Director of Residential Services will conduct training on imminent threat to self/others to ensure staff have a working understanding of the proper use of our HWC Restraints. This training will take place the last week of October. HWC training is conducted bi-annually. All staff have also participated in a mandatory verbal de-escalation training	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____

the individual or others, and no other safe and effective intervention is possible. It shall be employed for the least amount of time necessary in order that the individual may resume his/her treatment as quickly as possible.	improperly restrained. Resident S.U. - Restraint documentation was reviewed for an incident that occurred on February 15, 2019 involving resident S.U. According to the restraint documentation, S.U. was an imminent threat to others. After reviewing the incident report and video that was submitted to the Department for review, there was no justification for use of restraint on this individual. S.U. was not an imminent risk to self or others and was improperly restrained for stealing staff keys and running from unit to unit.		review August 2019. This training is conducted at new hire and 3 times per year throughout the year.	
5122-30-16 **(G) 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 ISP or ITP for each child or adolescent resident of a department licensed residential facility, for each client known to have experienced seclusion or restraint, 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: **(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.	Resident 4090 was admitted to the facility on June 11, 2019; however, the crisis plan was not developed until July 5, 2019. Resident 4059 was admitted to the facility on March 20, 2019; however, the crisis plan was not developed until March 22, 2019. Resident 4054 was admitted to the facility on March 13, 2019. The assessment was completed on March 18, 2019; however the crisis plan was developed on March 14, 2019. Therefore, the crisis plan was not based on the initial alcohol and other drug (AoD) or mental health assessment. For those records reviewed, the facility is not capturing through documentation, the identification of techniques and strategies for staff in	The facility shall develop and submit for review a plan on how the facility will address these findings and ensure continued compliance with the rule requirements. In addition, the provider needs to ensure that the crisis plan which is to be developed at time of admission is based on the initial mental health assessment. The provider also needs to ensure that they are properly identifying individual-specific contraindications that are identified in the mental health assessment and any other documentation provided to the provider for	SAT's will be completed within 48 hours after completing the Diagnostic Assessment; reviewing contraindicators and residents' history. Director of Risk Management and Director of Residential Services will conduct training on properly identifying individual-specific	

	assisting the person to maintain control of his or her own behavior. Also the facility is not consistently capturing the 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.	the youth when they are admitted to ensure they are obtaining pertinent information regarding each youth's history of abuse, medical issues and/or other trauma experiences.	contraindications (history of abuse, trauma, medical issues, etc.). Training will also include teaching on documentation of least restrictive to most restrictive interventions. This training will take place the last week of October.	
(G)(3) Initial and ongoing identification of individual-specific contraindications to the use of seclusion or restraint shall be documented.	In two out of six records reviewed, the facility did not consistently document the initial and ongoing identification of individual-specific contraindications to the use of seclusion or restraint.	The facility shall develop and submit for review a plan on how the facility will address these findings and ensure continued compliance with the rule requirements.		
(G)(4) Debriefings following the conclusion of each incident of seclusion or restraint shall be documented, and shall include, at a minimum: **(b)** What actions might have prevented the use of seclusion or restraint; and what techniques and tools might help the individual manage his or her own behavior in the future.	For those records reviewed, the facility's documentation does not consistently capture the youth's response to the restraint.	The facility shall develop and submit for review a plan on how the facility will address these findings and ensure continued compliance with the rule requirements.	Mandatory Training in October will also review patient debriefing forms.	

CONFIDENTIAL

OAC 5122-30-16.2 Physical restraint	**Finding:**	**Additional corrective action requirements:**	Director of Risk Management and Director of Residential Services will conduct training on properly identifying individual-specific contraindications (history of abuse, trauma, medical issues, etc.). Training will also include teaching on documentation of least restrictive to most restrictive interventions. This training will take place the first week of November. DON will conduct training with nursing department to address documentation expectations related to physical restraints. Training will be completed by the end of October.	**Review Date:** Approved ☐ Date: _____ **Notified agency of additional response** ☐ Date(s): _____
(D) Documentation of each episode of the use of physical restraint shall be made in the clinical record and shall include: **(2)** All prior attempts to use less restrictive interventions; **(3)** Notation that any previously identified contraindication to the use of physical restraint were considered and the rationale for continued implementation of physical restraint despite the existence of such contraindication; **(5)** Documentation of the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions; **(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; **(7)** The condition of the person at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address attention to vital signs, circulation, range of motion, nutrition, hydration, hygiene, toileting, need for continued restraint, and other needs as necessary, and the appropriate actions taken.	For those records reviewed, the least restrictive intervention was proximity control and/or verbal redirection. For those records that were reviewed, the previously identified contraindication was assault risk and/or suicide risk. The restraint form does not capture the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions; therefore, the traumatic experiences were not consistently documented. In two of the six records reviewed, the staff did not consistently document the 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. In two of the six records reviewed, the staff did not consistently document the vital signs, circulation, range of motion, nutrition, hydration, hygiene, toileting, need for continued restraint, and other needs as necessary, and the appropriate actions taken during the restraint. Staff is documenting resident is comfortable, no skin irritation, respiratory good and general condition appears normal.	The facility shall develop and submit for review a plan on how the facility will address these findings and ensure continued compliance with the rule requirements.		

MENTAL HEALTH & ADDICTION SERVICES Ohio

Promoting wellness and recovery

Mike DeWine, Governor • Lori Criss, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

November 25, 2019

Foundations for Living
Attn: [redacted]
[redacted]
Mansfield, Ohio [redacted]

Re: License No. [redacted]

Dear Ms. [redacted]

Foundations for Living has been surveyed in accordance with Section 5119.34 of the Ohio Revised Code. **Your corrective actions have been determined to be in compliance with Ohio Administrative Code (OAC), chapter 5122-30.** You are licensed to operate a residential facility as specified on the enclosed license(s). Each license specifies the term of the license, the maximum number of residents for the facility, the maximum number of household members, and the classification type of the residential facility.

The license is not transferable to any other site or property. The operator of the residential facility shall be responsible for notifying the Department of any changes or proposed changes concerning the information submitted and attested to in the application, or in operation of the facility which alter or modify the type of activity for which the facility is licensed, and/or the continued compliance of the facility with the requirements for licensure.

As a reminder, you are required to submit a Residential Incident Notification form for any reportable incident. within twenty-four hours of discovery, excluding weekends and holidays.

If you have any questions regarding any of the above, please do not hesitate to contact [redacted] at [redacted]

Sincerely,

[redacted]
[redacted] Chief
Bureau of Licensure and Certification

pc: [redacted], Executive Director, Richland County MHRS Board
[redacted] BSN, Behavioral Health Standards Surveyor
[redacted] ID, MSN, RN, Behavioral Health Standards Surveyor Supervisor
[redacted] Office of the State Long-Term Ombudsman

Ohio MHAS
Promoting wellness and recovery
Mike DeWine, Governor
Lori Criss, Director

License to Operate a Residential Facility

This Residential Facility has been surveyed in accordance with Section 5119.34 of the Ohio Revised Code, is in compliance with rules adopted pursuant to this Chapter, and is hereby issued this license for the maximum number of residents and household members specified.

Name of Facility: **Foundations for Living**

Address: [redacted] City: **Mansfield** Zip: [redacted]

Operator: **Keystone Richland Center, LLC**

Community Mental Health Board: **Richland County Mental Health & Recovery Services Board**

Date Issued: **07/08/2019** Date Expires: **07/07/2022**

License Number: **06-2079** Maximum Number of Residents: **84** Number of Household Members: **84**

Type: **1** Term of License: **Full** License to Admit: **Children**

[redacted]

Director, Ohio Department of Mental Health and Addiction Services

MENTAL HEALTH & ADDICTION SERVICES Ohio

Promoting wellness and recovery

Mike DeWine, Governor • Lori Criss, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

November 25, 2019

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Attn: [redacted]
[redacted]
Mansfield, Ohio [redacted]

Re: License No. [redacted]

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The license is not transferable to any other site or property. The operator of the residential facility shall be responsible for notifying the Department of any changes or proposed changes concerning the information submitted and attested to in the application, or in operation of the facility which alter or modify the type of activity for which the facility is licensed, and/or the continued compliance of the facility with the requirements for licensure.

As a reminder, you are required to submit a Residential Incident Notification form for any reportable incident. within twenty-four hours of discovery, excluding weekends and holidays.

If you have any questions regarding any of the above, please do not hesitate to contact [redacted] at [redacted]

Sincerely,

[redacted]
Chief
Bureau of Licensure and Certification

pc: [redacted] Executive Director, Richland County MHRS Board
[redacted] BSN, Behavioral Health Standards Surveyor
[redacted] JD, MSN, RN, Behavioral Health Standards Surveyor Supervisor
[redacted] Office of the State Long-Term Ombudsman

Ohio MHAS
Promoting wellness and recovery
Mike DeWine, Governor
Lori Criss, Director

License to Operate a Residential Facility

This Residential Facility has been surveyed in accordance with Section 5119.34 of the Ohio Revised Code, is in compliance with rules adopted pursuant to this Chapter, and is hereby issued this license for the maximum number of residents and household members specified.

Name of Facility: **Foundations for Living**

Address: [redacted] City: **Mansfield** Zip: [redacted]

Operator: **Keystone Richland Center, LLC**

Community Mental Health Board: **Richland County Mental Health & Recovery Services Board**

Date Issued: **07/08/2019** Date Expires: **07/07/2022**

License Number: **06-2079** Maximum Number of Residents: **84** Number of Household Members: **84**

Type: **1** Term of License: **Full** License to Admit: **Children**

[redacted]

Director, Ohio Department of Mental Health and Addiction Services

Ohio MHAS
Promoting wellness and recovery
Mike DeWine, Governor
Lori Criss, Director

License to Operate a Residential Facility

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Name of Facility: **Foundations for Living**

Address: [redacted] City: **Mansfield** Zip: [redacted]

Operator: **Keystone Richland Center, LLC**

Community Mental Health Board: **Richland County Mental Health & Recovery Services Board**

Date Issued: **07/08/2019** Date Expires: **07/07/2022**

License Number: **06-2079** Maximum Number of Residents: **84** Number of Household Members: **84**

Type: **1** Term of License: **Full** License to Admit: **Children**

[redacted]

Director, Ohio Department of Mental Health and Addiction Services

UHS-FINHELP-00009863 [Redacted]

Copper Hills Corrective Action Plan Response

Date: 12/22/21

R501-1-11 General Provisions for Licensing. Licensing Code of Conduct and Client Rights.
(1) Licensees and staff shall:
(h) Maintain the health and safety of clients in all program services and activities, whether on or offsite;
(i) provide services and supervision that is commensurate with the skills, abilities, behaviors, and needs of each client;

Violation Description: CPS supported on allegations of Non-Supervision by staff EG for allowing clients to stay up unsupervised, which allowed the client to engage in sexual misconduct.

Corrective Action Plan or Action Taken:
Copper Hills is in complete agreement with DHS of maintaining the safety and health of all clients according to the Utah State Code of Conduct. We also believe and teach that all students should be free from potential harm or acts of violence. All of our policies, procedures and training is consistent with providing a safe secure environment to our students. We also have current auditing processes to observe staff performance coupled with training processes to correct performance issues.

- Ernesto was provided with the training that is consistent with the Utah state code of conduct and chose to not comply with it. *(Please see attached training documents)*
- Camera reviews were performed weekly of Grave shift auditing staff performance and compliance with safety and all other expectations including 15 minute checks. Prior to this incident we did not see anything in the camera review audits that would evidence concern or the types of performance/behaviors that occurred the night of the incident. *(Please see attached camera reviews)*
- When it was discovered that Grave Staff member [redacted] was negligent in supervision, allowing students into other student's rooms, he was placed on administrative leave the following morning by Program Director Tevita Makalo (8/9/21). Once allegations from students were substantiated regarding SAO interactions with one another resulting from [redacted]s negligence, CPS was notified and staff member [redacted] was terminated.
- As a preventative measure Copper Hills Program Directors have implemented a monthly training to regularly cover supervision expectations, cover trending issues through training (discovered in camera review audits) and to also provide a forum for Grave staff to ask questions and have them answered by an administrator.
- The Facility Risk Manager and Program Directors conduct monthly camera review audits with the Regional Corporate Risk Manager to assure that staff are conducting routine observation rounds, are stationed in the hallway to monitor all rooms and are not using electronic devices.
- The Night Watch Supervisors documents nightly in the Communication Log as well as Tiger Text to all facility leadership any incidents of residents being awake and out of bed at night.

- The Night Watch Supervisor will have the ability to do real time camera reviews at night in conjunction with nursing by utilizing the live camera feeds located in the nursing stations. These reviews and any departure for policy or deficiencies will be documented in the 24-hour Communication Log so appropriate training and/or corrective action can be taken.

R501-1-11. Licensing Code of Conduct and Client Rights.
(2) Clients have the right to:
(b) Be free from potential harm or acts of violence;

Violation Description: Multiple clients disclosed that staff [redacted] showed them a photo/video of a fully naked woman on his phone. CPS supported the Dealing in Harmful Materials to a Child against staff [redacted]

Corrective Action Plan or Action Taken:

- Grave shift staff have been trained on the Copper Hills guideline that they are not permitted to bring any electronic devices including cell phones onto the unit. This will be audited weekly during camera reviews moving forward and progressive corrective action will be taken if it is not adhered to.

R501-2-7. Behavior Management.
D. Passive physical restraint shall be used only as a temporary means of physical containment to protect the consumer, other persons, or property from harm.
62A-2-123. Congregate care program regulation.
(1) A congregate care program may not use a cruel, severe, unusual, or unnecessary practice on a child.

Violation Description: During our interviews, we were notified of an incident regarding client AL. Upon camera review, we observed that the client was sitting down and did not present harm to self, others, or property. The physical restraint used was not justified or necessary.

Corrective Action Plan or Action Taken:
To assure that camera reviews are done accurately and to ensure that students are only placed into a passive restraint when imminent risk is posed the following action was taken.

- Redacted - PII was trained on progressive intervention, steps that should be used to verbally de-escalate a student and what he is looking for in a camera review that defines imminent risk. Evidence of corrective training was placed in Redacted - PII personnel file.
- Redacted - PII was trained on verbal de-escalation *(verbal de-escalation that is coupled with handle with care)* and how imminent risk is defined. Evidence of the corrective training was placed in AA personnel file.

R501-16-4. Staffing.
G. The Program shall maintain a minimum staff ratio of one staff to every five consumers, but shall never have less than two staff on duty at any time.

Violation Description: During our interviews and camera review, multiple units were out of staffing ratio of one staff to every five consumers.

Corrective Action Plan or Action Taken:
CHYC administration put into place a staffing performance improvement plan on 7/24/2021 to address staffing issues caused by the unemployment stimulus. The CEO and Risk Manager met with licensor [redacted] *(DHS licensure representative)* and reported to her the difficulties in meeting the state mandated staffing ratios and the measures that had been taken to rectify the problem. The Office of Licensure requested that a written Plan of Correction be submitted to their office for review and approval. The Plan of Correction was submitted to the Office of Licensure on 8/13/2021 and was accepted and approved on 8/15/2021. The corrective action plan is listed below:

1. Census Reduction

- Admissions was placed on hold for a month and reduced itself to a number that could be competently managed. The administrative team reconvened and capped census at 9 students below what we had been running.
- Weekly meetings have been implemented between Admissions, Clinical and Residential to review and discuss appropriate census in comparison to staff numbers.
- *(Added since the original plan which replaces the Thursday meeting)* A staffing headcount meeting also takes place every Monday morning to discuss any shifts that might need additional staffing and better manage staffing needs at the beginning of the week.

2. Trained administrators and qualified office staff work in ratio on units as needed to maintain proper ratio to licensing expectations. Starting on 7/24/21 and on-going, the CEO, Program Directors and UM director have worked in ratio every weekend to assure that the program is properly staffed.

- Weekend staffing numbers are assessed every Thursday to determine the need for assistance from administrative staff. *(This meeting is still taking place but the need has subsided over the last two weeks due to increase in staffing numbers. For the first 3 to 3.5 months CEO, UM Director worked 7 days a week to support the milieu and assure safety)*

3. Three Program Directors have been assigned to run shifts, mentor staff and are included in ratio. *(Has changed over the last few weeks since staffing numbers have improved. The Program Directors have moved back to Mon. – Fri.)*

4. New Hire classes are held bi-weekly.

5. Two staffing agencies have been contracted to assist with the hiring of qualified staff.

6. Revised Day Program schedules and processes have been revised and implemented to increase staff to patient ratios.

Examples of schedule changes:

- Two units attend the cafeteria for meals on a rotating basis instead of all nine units. The rest of the units are in a classroom setting with milieu staff and a teacher allowing us to maintain ratio at 2:10.
- A Medication Administration area has been implemented in the cafeteria to allow staff to maintain ratio vs. having them go to the medical station.

7. Increased entry level Milieu pay from $14.50 an hour to $16.00 an hour to attract applicants. Also increased the shift differential pay for weekends *(more difficult shift to staff)* from $2.35 an hour to $5.00 per hour.

- Implemented a $200 dollar stipend for weekend shifts to incentivize staff to pick up extra shifts.

8. Implemented a new observation based, hands on training program to improve staff competence and retention. Implemented on 8/24/21.

R501-1-9 General Provisions for Licensing. Investigations of Alleged Violations.
(2) Licensed Program Complaints and Critical Incidents.
(d) Critical incidents that involve one or more clients and/or on-duty staff in a licensed setting or under the direct responsibility and supervision of the program shall be reported by the licensee as follows:
(i) Report shall be made to DHS and legal guardians of involved clients within one business day;

Violation Description: During our review of internal incident reports for the months of August and September, we identified multiple incidents that were not reported to the Office of Licensing.

Copper Hills has changed their incident reporting process over the last year creating internal systems in efforts to create efficiency due to the high number of funding sources that are worked with. As a part of this change incident reporting was divided into three sections and an internal protocol was written to help all parties involved accurately report out internally (to clinicians, nursing etc.) and externally (funding sources, Medicaid etc.). Below is how the responsibilities were divided.

1. Risk Manager – Reports to the administrative team, corporate clinical and to DHS.
2. Utilization Management – Reports out to caseworker, funding source, school district/selpa all "Critical Incidents."
3. Program Director – Reports out all incident reports to those on the "Resident List with IR recipients." *(Typically caseworkers, funding sources, school districts / selpas identified by utilization management at time of admittance.)*

Approximately 3 to 4 months ago the Copper Hills CEO realized that DHS was not receiving reports and talked to the Risk Manager who reported that he thought the Program Director was reporting all incident reports *(that were not "Critical Incidents")* including the DHS reports. Risk Manager was again in-serviced on the "Incident Reporting Internal Guideline" and his

responsibility to report out to DHS. This has not posed an issue since the misunderstanding was resolved. Since then, the guideline document was revised to better define roles. *(Please see attached document "Incident Reporting Internal Guideline)*

State of Utah
SPENCER J. COX
Governor
DEIDRE M. HENDERSON
Lieutenant Governor

Department of Human Services
TRACY S. GRUBER
Executive Director
Office of Licensing
AMANDA SLATER
Director

December 16, 2021

Copper Hills Youth Center
[redacted]
West Jordan, Utah [redacted]

RE: **Corrective Action Plan Required**

[redacted]

In an effort to assist your program in complying with Licensing Rules/Statutes and in accordance with R501-1-10 the Office of Licensing is requesting a Corrective Action Plan (CAP) in regards to the following Administrative Rule/Statutory violations:

R501-1-11 General Provisions for Licensing. Licensing Code of Conduct and Client Rights.
(1) Licensees and staff shall:
(h) maintain the health and safety of clients in all program services and activities, whether on or offsite;
(i) provide services and supervision that is commensurate with the skills, abilities, behaviors, and needs of each client;

Violation Description: CPS supported on allegations of Non-Supervision by staff [redacted] for allowing clients to stay up unsupervised, which allowed the client to engage in sexual misconduct.

R501-1-11. Licensing Code of Conduct and Client Rights.
(2) Clients have the right to:
(b) be free from potential harm or acts of violence;

Violation Description: Multiple clients disclosed that staff [redacted] showed them a photo/video of a fully naked woman on his phone. CPS supported the Dealing in Harmful Materials to a Child against staff EG.

R501-2-7. Behavior Management.
D. Passive physical restraint shall be used only as a temporary means of physical containment to protect the consumer, other persons, or property from harm.

62A-2-123. Congregate care program regulation.
(1) A congregate care program may not use a cruel, severe, unusual, or unnecessary practice on a child.

Violation Description: During our interviews, we were notified of an incident regarding client [redacted] Upon camera review, we observed that the client was sitting down and did not present harm to self, others, or property. The physical restraint used was not justified or necessary.

R501-16-4. Staffing.
G. The Program shall maintain a minimum staff ratio of one staff to every five consumers, but shall never have less than two staff on duty at any time.

Violation Description: During our interviews and camera review, multiple units were out of staffing ratio of one staff to every five consumers.

R501-1-9 General Provisions for Licensing. Investigations of Alleged Violations.
(2) Licensed Program Complaints and Critical Incidents.
(d) Critical incidents that involve one or more clients and/or on-duty staff in a licensed setting or under the direct responsibility and supervision of the program shall be reported by the licensee as follows:
(i) report shall be made to DHS and legal guardians of involved clients within one business day;

Violation Description: During our review of internal incident reports for the months of August and September, we identified multiple incidents that were not reported to the Office of Licensing.

Please create a plan of action to address the violations noted in this letter and submit it to the Office of Licensing at [redacted]@utah.gov within 10 business days. The action plan you submit must contain at a minimum: a statement of each violation identified by the Office; a detailed description of how you will correct each violation and prevent additional violations; and the date by which you will achieve compliance with administrative rules and statutes.
Failure to include these rule-required contents could result in an additional violation notation and/or a denial of the plan. Denied or omitted elements must be submitted within 5 business days

of the 2nd request in order to avoid further Licensing action. Please refer to General Provisions R501-1-10 below.

R501-1-10 License Violations:
(1) When the Office finds evidence of violations of statute or rule, the Office shall do one of the following:
(a)
(b) provide written notification of violation and request a licensee to submit a corrective action plan in response to written notification of a violation;
(i) a licensee shall submit a written corrective action plan to the Office within ten calendar days of the request from the Office and the corrective action plan shall include:
(A) a statement of each violation identified by the Office;
(B) a detailed description of how the licensee will correct each violation and prevent additional violations;
(C) the date by which the licensee will achieve compliance with administrative rules and statutes;
(c) The Office shall review the submitted corrective action plan and either inform the licensee that the corrective action plan is approved; or inform the licensee that the corrective action plan is not approved and provide explanation;
(i) the Office may permit a licensee to amend and resubmit its corrective action plan within five additional calendar days.
(d) The Office shall issue a Notice of Agency Action imposing a penalty for violation(s) if the licensee fails to submit and comply with an approved corrective action plan.
(e) A corrective action plan is not a penalty. Programs have the right to refuse the corrective action plan process and may preserve their appeal rights by requesting a penalty through an Office-initiated Notice of Agency Action.

Please note that R501-1-10-1-a(d) additionally states: "The Office shall issue a Notice of Agency Action imposing a penalty for violation(s) if the licensee fails to submit and comply with an approved corrective action plan. Your license may be placed on conditional or suspended status to include admission restrictions if a Notice of Agency Action is issued".

Thank you for your cooperation in this process, I look forward to working together with you to achieve a compliant program status for you, your employees, and the clients you serve.

Sincerely,

[redacted]
Licensing Investigator
Department of Human Services/Office of Licensing
[redacted]
Salt Lake City, Utah [redacted]

[redacted]
Licensing Investigator
Department of Human Services/Office of Licensing
[redacted]
Salt Lake City, Utah [redacted]

Cc: [redacted]
Licensing Specialist
Department of Human Services/Office of Licensing
[redacted]
Salt Lake City, Utah [redacted]

[redacted]
Investigations Manager
Department of Human Services/Office of Licensing
[redacted]
Salt Lake City, Utah [redacted]

UHS-FINHELP-00009872 [Redacted]

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

In Attendance: [redacted] CEO; [redacted], RM; [redacted] Administrative Assistant; [redacted]
Director of Admissions; [redacted] Director of Utilization Management; [redacted] DCS; [redacted]
Director of Health Information Services and IT; [redacted] Director of Recreational Therapy.

Finding	Corrective Action	Staff Responsible Date Due
Admissions packet has mention that property damage is cause for restraint; need to remove property damage paragraph. Needs to be imminent risk to self or others, not property damage.	Remove portion from Page 9 "seclusion and restraint" with the consent	The Director of Admissions removing and sending back out to team Due: 2/12/21
CON missing both signatures	A form was created to require physician signature and print, and clinical team member sign and print	Director of Admissions created form, the DCS or Director of Utilization Management will sign for the clinical team member in addition to the M.D.
IM consent form potentially can be added to the admissions packet in order to further explain the rationale for using such medications	The Facility made a decision that (IM) medications will not be allowed during a restraint/seclusion	The DON retrained her staff in not using (IM) medications during a seclusion/restraint

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

Specific discharge providers should be listed in the ITP and the overall discharge plan for each patient	Therapists will note two potential discharge resources noting specific resources for each resident in the discharge section of the treatment plan.	The DCS is already auditing and will continue auditing to ensure completion at 100% compliance
TPR's should include; at minimum, the following team members: Psychiatrist, Nurse, Primary therapist, patient, and guardian/ custodian. As part of the TPR process with documentation, there must be specificity when contacting third part participants such as "guardian participated by telephone" or "attempted to contact guardian via telephone but the guardian did not answer". Third part participants will be interviewed by auditing agencies to confirm participation in the TPR process.	• The Director of Health Information Services will revamp the TPR signing sheet • Treatment team will document why individual did not participate • Therapists will document invitations to the meetings.	• UM and clinical will audit therapists to ensure they are documenting invitations to TPR's • Medical records will audit to ensure that treatment team is documenting why an individual did not participate.

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

TPRs do not require UM involvement. We should look to eliminate the signature line for UM but can still have UM facilitate the scheduling and functionality of the TPR process	Medical records revising the sheet to remove the UM signature line. UM will still sign to show participation, but will not have a required line.	The Director of Health Information Services will make revisions.
TPR sheets must be authenticated by an LCSW. Authentication process can take place after the TPR have been performed. An LCSW is not required to attend if there is participation from a primary therapist.	DCS and Clinical Supervisor will sign all TPR sheets	Medical records will audit to ensure signatures are completed at 100% compliance.
Residents should have a TPR every **30 days** (place on a 4 week rotation)	• The facility has hired an APRN to assist the physician in conducting TPR and will be supervised by the Medical Director. • The DCS and Director of Utilization will develop a calendar to ensure that	The process will be audited by the DCS, UM and medical records to ensure 100% compliance.

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

	resident receive a TPR within the 30 day timeframe.	
10/12 charts had missing signatures for the MAR	• The DON and her assistant audit 100% of Medication Administration Records for completeness. • Remedial action will be taken with individual nurses failing to consistently document medication given.	The process will be audited by the DON, Assistant DON and medical records to ensure 100% compliance.
Two missed PRN follow-ups were identified.	• The DON and her assistant audit 100% of Medication Administration Records for completeness. • Remedial action will be taken with individual nurses failing to consistently document medication given.	The process will be audited by the DON, Assistant DON and medical records to ensure 100% compliance.

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Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

An auditing system must be in place to ensure signatures and follow-ups are being documented appropriately	• MAR will be audited by the off-going and on-coming shift to assure that all medications are documented by the end of the shift. • The DON and her assistant audit 100% of Medication Administration Records for completeness. • Remedial action will be taken with individual nurses failing to consistently document medication given.	The process will be audited by the DON, Assistant DON and medical records to ensure 100% compliance.
Current OTC consent form appears to have boxes which indicate that a medication was approved. These boxes are currently being left blank which has the appearance that no OTC medications have been approved. Modify the form from checkboxes to bullets to prevent confusion.	The DON has revised the OTC consent form to correct this deficiency.	

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

IM restraint consent shows guardian consent, recommended to take out guardian consent portion removed.	• The guardian consent has been removed from the restraint form. • The facility decided not to give (IM) medications during restraint.	Revised by DON
dietary information (if any) should be indicated as part of Nursing summary of progress by service in the TPR form	• The DON retrained nursing staff to include dietary information in the TPR. • The new EMR will make this information much more available to all nurses and members conducting the TPR.	The DON will audit the nursing section of the TPR to assure 100% compliance of addressing dietary information.
Q15 shortcuts being taken in the initials portion where line is being drawn down to indicate that a check has taken place. Initials must be present in every box indicating that a 15-min. check did occur	Q15 is being reformatted training to take place after form approved on appropriate documentation on the Q15	Audited by leadership observation rounds and medical records

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

names must be printed legibly on the Q15 as well as the initials so that staff members can be identified	Q15 is being reformatted training to take place after form approved on appropriate documentation on the Q15	Audited by leadership observation rounds and medical records
If a transfer is occurring, both the transfer box and the initials box must be filled.	Q15 is being reformatted training to take place after form approved on appropriate documentation on the Q15	Audited by leadership observation rounds and medical records
Too many signature lines, not all are used. Should be removed	Q15 is being reformatted training to take place after form approved on appropriate documentation on the Q15	Audited by leadership observation rounds and medical records
Missing large chunks of observation time on Q15	Q15 is being reformatted training to take place after form approved on appropriate documentation on the Q15	Audited by leadership observation rounds and medical records
Restraint feedback was that during restraints, residents were pushed into and being held against walls	All restraints are reviewed on the security cameras by the Program Directors and Risk Manager. There's been no evidence of residents being shoved against the wall.	Completed by Risk Manager and Program Directors

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey 2021
February 11th, 2021

Resident claimed that debriefings were being held too quickly after a restraint and sometimes took place in front of their peers.	• Staff will be retrained in Joint Commission and CMS guidelines that the debriefing can occur anytime within a 24-hour time period. • Staff will also be retrained to perform debriefings in privacy	Program Directors will ensure that trainings take place with milieu staff. To be completed by the end of Feb 2021

FACSIMILE COVER SHEET
CONFIDENTIAL

State of Alaska
Department of Health & Social Services
Division of Behavioral Health
[redacted]
Anchorage, AK [redacted]

Phone #: [redacted]
Fax #: [redacted]

DATE: 2/12/24

TO: [redacted]	FROM: DBH
RE:	
FAX: [redacted]	

PLEASE NOTE: *This fax contains confidential and sensitive information protected by the State of Alaska and the Federal Government. In the event this message was faxed to you in error and you are not the addressee listed, please call* [redacted] *and destroy your copy.*

☐ URGENT ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Faxed at your Request

Number of Pages Including Cover Sheet -

Remarks:
Hard copy to follow

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of
Health and Social Services

DIVISION OF BEHAVIORAL HEALTH
Anchorage Regional Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

February 12, 2021

Copper Hills Youth Center
[redacted]
West Jordan Utah [redacted]

Dear: [redacted]
Fax: [redacted]
[redacted]@uhsinc.com

Re: Site Review

As you are aware, the Code of Federal Regulations (42 CFR 456.600-614) requires State Medicaid Agencies to conduct reviews of inpatient psychiatric facilities on an annual basis.

Copper Hills was reviewed on February 2-4, 2021; and conducted by [redacted] RN IV and [redacted] MHC III. State of Alaska Department of Health and Social Services (DHSS) representatives from Division of Behavioral Health (DBH).

TYPE OF REVIEW
Annual

REPORT
Enclosed is the **Site Review Summary of Findings** report dated February 12, 2021. This document contains a description and history of your organization, purpose and process of the site review, a summary of Behavioral Health findings and recommendations. This report also contains detailed information pertaining to the medical necessity clinical chart review conducted by Behavioral Health staff.

This report is also available without Medicaid numbers. This non-confidential version is submitted to your licensing organization.

Plan of Improvement
Plan of improvement (POI) is required as a result due to deficit found during the site/chart review process. Your facility must take corrective action based on the recommendations of the review team (42 CFR 456.613). If a POI is requested, is expected to respond in writing to DBH by March 19, 2021.

Address: State of Alaska
Attention: [redacted]
Department of Health and Social Services
[redacted]
Anchorage, AK [redacted]

Fax: [redacted]

If you have any questions in regard to areas for improvement identified in the HSS integrated site review report please contact [redacted] DBH Medicaid Section Manager at [redacted]

The Alaska site review team thanks the staff at Copper Hills for their hospitality, flexibility and willingness to accommodate our requests while on site.

Sincerely,

[redacted]

DBH Medicaid Section Manager / Tribal Liaison
Division of Behavioral Health
Department of Health and Social Services
State of Alaska

cc: Utah State Licensing
Utilization Review

State of Alaska Department of Health and Social Services
Division of Behavioral Health
Site Review Summary of Findings

Provider: Copper Hills Youth Center
Provider ID: 1006504

Start Date of Review: 2/2/2021
End Date of Review: 2/4/2021

Lead Reviewer: [redacted] CBC and program Integrity Supervisor

Other Reviewers:
[redacted] RN BSN
[redacted] LPC

Date of Report: 2/12/2021

Number of Charts Reviewed: 12

ORGANIZATIONAL DESCRIPTION AND HISTORY

Copper Hills is licensed to treat up to 197 youth, 12-17 years of age.
---Administrative staff typically keep the census below 110 youth. (Each year we are slowly increasing our census. Last year it was 111-113 and this year it is 113-115).
Copper Hills is accredited by the Joint Commission, Cognia, and is licensed by the Utah Department of Human Services.
Each unit has access to a large out door area.
Facility has added doors between the bedroom hallway and the main living area.
Bunk beds are being replaced with pedestal style beds.

The program has been rebuilding itself.
---Units are rewarded for "safest" unit and "clean" unit weekly.
---Staff are nominated to receive awards.
---Facility continues to move forward with positive reinforcement and de-escalation techniques to help decrease the use of restraint and seclusion.
---When needed additional training is provided.
Copper Hills has a general behavioral health program which is divided up between males and females and cognitive level of functioning.
The program also provides substance abuse treatment.
Copper Hills has 2 units for their Autism Spectrum Disorder (ASD) Asperger's program which are divided by level of functioning.
Staff employed in these units receive specialized training.
The ASD program is designed for individuals with Asperger's Syndrome or High Functioning Autism and continues develop.
Programming changes include new Arcade Rooms (daily incentive), SPARCS Rooms to provide additional therapeutic support (in process of being built on each unit), implementation of additional clinical platforms: Mindfulness Model and EMDR)

The program has implemented a therapeutic recreation program which is integrated into overall treatment.
---This provides recreation activities on and off campus for the youth.
---There is a low ropes course which allows youth to work as a team and provides the opportunity to learn problem solving skills.
---The recreation therapy program is working more in collaboration with a new physical education teacher to offer more options for youth.
---The facility also offers animal assisted therapy programs.
---Facility has created a basketball team to compete with a sister facility. The focus will be on having appropriate interactions with one another especially during competitions i.e. no bullying.

The facility has a full education department which provides special educational services and regular education to students.
Added Study Halls around the education areas and on the units to provide more support to residents and to help residents stay on course with their studies.

SITE REVIEW PURPOSE AND PROCESS

Per 42 CFR 456.606 site reviews are required to be performed yearly.

FINDINGS

Plan of Care: ***42 CFR 441.155(b)(1); 42 CFR 441.155 b(2); 42 CFR 456.609;7 AAC 140.410 (a)(3); 42 CFR 441.155(b)(3); 42 CFR 441.155 (c)(2); 42 CFR 441.156; 7 AAC 140.405(b)(5); 7 AAC 140.410 (a)(4); 7 AAC 140.410 (a)(6)***

The plans of care for twelve (12) recipients at Copper Hills were reviewed. The initial and master, and ongoing plans of care are part of their electronic health record and are developed for each recipient with the signature page scanned into the electronic health record.
All twelve (12) plans of care were based upon an initial psychiatric evaluation after admission to Copper Hills. The initial evaluations yielded psychiatric diagnoses and any updates were noted in the electronic health record.

All twelve (12) plans of care had some documentation of being developed by a team of professionals, as evidenced by signatures from the recipient, the parent/guardian, clinician, social worker, psychiatrist and director of nursing on the initial treatment plan and subsequent monthly treatment plans. The documentation of the involvement of the required teams in the development of the plan of care was inconsistent and eleven (11) of twelve (12) charts had missing documentation of one or more of the required team members. This was discussed with leadership and it was noted with leadership this has been a problem in previous site reviews. Leadership discussed a process of having all signatures showing involvement in the plan of care development. This process will be part of the new electronic health record which is coming on line. The review team will ask them to send documentation of the process in the new electronic health record.
All twelve (12) plans of care prescribed an integrated program of therapies, activities and experiences to include individual therapy, group therapy, family therapy, recreation therapy, treatment plan reviews, milieu skills development, educational skills, health and wellness and medication management, designed to meet treatment objectives.

Ten (10) of twelve (12) plans of care included discharge plans on the plan of care that mentioned a discharge date, anticipated aftercare providers and living arrangements for recipients. Two (2)

of the twelve (12) charts were missing specific discharge providers at the time of admission. This does not warrant a plan of improvement as it is much better than the previous site review from September 30-October3, 2019.
Ten (10) plans of care had review dates outside of the every thirty (30) day time frame required by Federal regulations. This has been an ongoing problem for the facility. It was discussed with leadership and the utilization manager about a solution to have the plans of care completed within the thirty (30) day requirement. A plan of improvement will be required for the deficiency.

The clinical record review demonstrated compliance with 42 CFR 441.155 with the exception of findings noted above.

Progress Notes: ***42 CFR 456.610 (a); 42 CFR 456.610 (b)(1); 42 CFR 456.610 (c); 42 CFR 456.610 (d)***
Psychiatrist staff document monthly contact with youth. Psychiatrist notes identify their direct engagement of youth in their evaluation of progress; notes are reflective of psychiatric needs and any changes of physical condition of the youth. Psychiatric staff review prescribed medications, reflect on medications that have been previously tried and provide rationale for medication changes.
Nursing staff assess youth upon admission and complete monthly summary for treatment team review. RNs also document behavioral and medical issues by exception. All minor injuries or illnesses are assessed by the RNs. Nursing notes provide clear documentation of care, follow up, and outcomes.
Medication Consent forms for previously prescribed medication are completed at the time of admission and signed by a parent/guardian.
Monthly Body Mass Index (BMI) and biannual laboratory monitoring for fasting glucose levels and fasting lipid level for youth on atypical antipsychotics are completed and documented in the records as required by Department of Health and Social Services (DHSS) State of Alaska (SOA).
Random audit of Medication Administration Records (MARs) was found to be lacking initials to indicate that scheduled medication was administered in eight (8) of twelve (12) reviewed records. Additionally, administered PRN medications were missing the follow-up comments in seven (7) of twelve (12) reviewed records. The deficiencies noted above were also identified during the previous site review conducted from on September 30 to October 3, 2019. It was evident during site review conducted on February 2-4, 2021 that frequency of these occurrence in each individual record has decreased. The leadership of the facility is working on developing an interdisciplinary internal audit process that will allow any noted deficiency to be addressed in a timely manner. The facility was provided on-site technical assistance with audit tools used by the Division of Behavioral Health (DBH) staff. The Director of Nursing Department (DON)was very open for feedback provided by DBH auditors. DBH will not be requesting a Plan of Improvement (POI) at this time. DBH will require DON of the facility provide monthly updates regarding monitoring MAR deficiencies to a Nurse Consultant at DBH by e-mail.
Random audits of milieu progress notes for safe supervision of the patients revealed missing Q 15 minute checks. The numbers of deficiencies compare to all reviewed Q 15 minute checks, are not significant to warrant a POI. The leadership of the facility conducts random audit of q 15 minutes checks on regular bases.

Clinical progress notes document the presenting problem, the goal being addressed in the session, client presentation, the intervention utilized, progress toward the goal and the plan moving forward in the next session.

The clinical record review demonstrated compliance with 42 CFR 456.610 (a); 42 CFR 456.610 (b); 42 CFR 456.610 (c); 42 CFR 456.610 (d) with the exception of findings noted above.

Restraint and Seclusion: ***42 CFR 483.350 through 42 CFR 483.376***

The facility utilizes physical restraints to manage behavioral crises that rise to the level of potential for self-harm or harm to others.
The majority of reviewed physical restraint events were found to be compliant with Center for Medicare &Medicaid Services (CMS) regulations. This is a significant improvement compare to 2019 site review. The numbers of the events with the deficiencies compared to all events reviewed, were not significant to warrant a Plan of Improvement.
Patient Observation flowsheets are consistently utilized; staff observations recorded every 5 minutes.
Three (3) youth reported some concerns regarding a restraint in which they had been placed. These concerns were shared with the leadership of the facility for follow-up. Some of the concerns were addressed immediately and others will require a review of some of the documentation prior to follow-up.
There is evidence in reviewed records the parent and youth had been notified of the facility's philosophy for the use of physical restraint.
The Director of Risk Management continues to utilize closed circuit video monitoring (CCVM) for effective risk management and review of behavioral crisis events as a teaching tool.

The clinical record review demonstrated compliance with 42 CFR 483.350 through 42 CFR 483.376 with the exception of findings noted above.

Youth Interview Findings: ***42 CFR 456.608(a)(1)***

Student interviews: Were done differently due to COVID-19.
Twelve (12) youth were given the interview forms to fill out and return in an envelope. After the return of the forms the reviewers met with the youth as a group with masks and social distancing and asked if anyone wanted to meet on a one (1) to one (1) basis. Eight (8) youth asked for a one (1) to one (1). These interviews were completed with masks and social distancing. In most cases the youth wanted to touch base with someone from Alaska since they have not been able to see any family members since admission. All the youth could indicate why they were in treatment. All of them were able to share treatment goals they have. All of them had the opportunity to meet with their treatment team members and were able to give input into their treatment.
Ten (10) of the youth stated they had helped decide their treatment goals. Eleven indicated they are making progress in treatment. Overall, they get along with their peers but did indicate there is drama on the units. Relationships with staff are good overall as well.
Youth knew their medications and why they were taking the specific medication and are able to discuss it with the doctor.
Youth talk to their families regularly. Two (2) youth are in OCS custody and they talk with their case worker on a regular basis of at least monthly.
Ten (10) of the youth reported having been put into a hold or seclusion. Youth were able to describe the actions which preceded them being put into a hold. Staff were right there during the hold. The youth who had been in holds reported not having the incident talked about in the treatment team meeting. Three youth reported some concerns with a restraint they had been part of, and this was discussed with leadership regarding their concerns. Leadership was looking into the concerns and would talk with students about the incidents.

All the youth knew the grievance policy and had signed paperwork which was scanned into the electronic health record regarding how to file a grievance.
Two (2) youth reported they didn't think the facility was a safe place. One (1) had concerns about specific girls on the unit who" scream at staff, say racist comments etc". One stated "this place is just unsafe generally."

Nine (9) of ten (10) non custody parents/guardians were interviewed regarding the facilities engagement with them on seclusion and restraint use and provided feedback for parent questionnaire. Two (2) Office of Children's Services(OCS) guardians provided their feedback in a written form with the same questionnaire as non-custody guardians.
All parents/guardians reported that they were involved in formulation of treatment plan and discharge plans for their youth.
All parents/guardians were aware of the psychiatric medications their child is taking and/or being prescribed while in treatment.
All parents/guardians reported that they able to communicate with members of treatment team on a regular basis.
All parents/guardians reported that they were informed of the facility's policy on restraint and seclusion and were contacted after a restraint or seclusion intervention.
Ten (10) of twelve (12) parents/guardians reported that their child was placed in hold.
Nine (9) of ten (10) parents/guardians reported that they were given an opportunity to participate in the debriefing following restraint/seclusion use.
Ten (10) of twelve (12) parents/guardians identified no concerns regarding their child's safety at the facility and made positive comments about the program and communication with the facility.
One (1) parent expressed some concerns regarding "girls fight on the unit."
One (1) parent reported they had some safety concerns and had "called CPS and police. Girls are rude to staff. Staff afraid of girls. Staff need re-education. Girls shouldn't be sworn at. "

Staff Interviews:
Four (4) Milieu staff, two (2) clinicians and three (3) nurses were given the staff interview sheets to complete. The range of employment was one (1) month to over three (3) years.
The milieu staff indicated they had not given information or participated in the interdisciplinary treatment team. The clinicians and the nurses had participated.
All nine (9) staff reported they were able to handle a resident's emergency safety situations and knew when to utilize a restraint or seclusion. All were able to give examples of de-escalation techniques such as; Talking to them, modeling, listening to them, supportive, not to engage in arguing, and many other options were identified.
Staff reported the importance of following the behavior support plans for each client to help integrate treatment plan goals and objectives as the result of any seclusion or restraint episodes.
All staff felt the training was very thorough and facility continues to update training and educate staff.

QUALITY OF CARE

Per Leadership report, the facility takes every measure to protect their clients and families along with their employees during the COVID-19 pandemic. The Leadership of the facility actively monitors and responds to all recommendations made by the CDC and the local regulatory and health authorities.
The facility screens everyone entering the campus each day including staff, patients and visitors for exposure, symptoms and temperature. CHYC requires use of KN95 masks for all staff and visitors.

All in-person visitation of youth has been suspended. Families are strongly encouraged to use electronic methods to stay connected with loved ones including telemedicine, zoom, and extended phone time.

PLAN OF IMPROVEMENT (POI)
Provide a POI that addresses how you will correct the following deficiency/s:

Identified CFR / State of Alaska Regulation and Deficiency
Select...
Findings:
Plans of care did not have the documentation of the required team involvement in the formulation of the plan of care.

Please provide a plan of how this will be monitored and corrected in the future.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(c)
Findings:
Plans of care are not completed every 30 days.

Please submit a plan of improvement of how plans of care will be completed within the 30 day requirement.

Submit POI by: 3/19/2021

Mail To:
State of Alaska
Department of Health and Social Services
Division of Behavioral Health
Attn: [redacted] CBC and program Integrity Supervisor
[redacted]
Anchorage, AK [redacted]

Or
E- Mail To: [redacted]@alaska.gov
Or
Fax POI To: [redacted] attention
[redacted] CBC and program Integrity Supervisor

Summary of Chart Review Findings

42 CFR 441.155(a) and 456.180

12 out of 12 chart(s) met this requirement.

42 CFR 441.155(b)(1)

12 out of 12 chart(s) met this requirement.

42 CFR 441.155(b)(3)

12 out of 12 chart(s) met this requirement.

42 CFR 441.155(b)(2)

1 out of 12 chart(s) met this requirement.

MB 0601090953	Missing documentation of required team member in development of plan of care
TC 0601066749	Missing documentation of required team member in development of plan of care
PF 2004947028	Missing documentation of required team member in development of plan of care
EJ 0601382051	Missing documentation of required team member in development of plan of care
SK 0601073131	Missing documentation of required team member in development of plan of care
KK 2005478852	Missing documentation of required team member in development of plan of care
KL 0601101103	Missing documentation of required team member in development of plan of care
DP-P0601023385	Missing documentation of required team member in development of plan of care
JW 0601348720	Missing documentation of required team member in development of plan of care
AA 0601032900	Missing documentation of required team member in development of plan of care
CD 0601078944	Missing documentation of required team member in development of plan of care

42 CFR 441.155(b)(4)

12 out of 12 chart(s) met this requirement.

42 CFR 441.155(b)(5) and 7 AAC 140.410(6)

9 out of 12 chart(s) met this requirement.

TC 0601066749	Initial plan of care missing specific discharge providers
EJ 0601382051	Initial plan of care missing specific discharge providers

42 CFR 441.155(c)

3 out of 12 chart(s) met this requirement.

PF 2004947028	Not consistently completed every 30 days
EJ 0601382051	Not consistently completed every 30 days
SK 0601073131	Not consistently completed every 30 days
KK 2005478852	Not consistently completed every 30 days
KL 0601101103	Not consistently completed every 30 days
DP-P0601023385	Not consistently completed every 30 days
JW 0601348720	Not consistently completed every 30 days
AA 0601032900	Not consistently completed every 30 days
CD 0601078944	Not consistently completed every 30 days

42 CFR 441.156 and 7 AAC 140.405(d)

12 out of 12 chart(s) met this requirement.

42 CFR 456.609(a)(b)(c)(d)

12 out of 12 chart(s) met this requirement.

42 CFR 456.610(a)

12 out of 12 chart(s) met this requirement.

42 CFR 456.610(b)(1)

12 out of 12 chart(s) met this requirement.

42 CFR 456.610(c)

2 out of 12 chart(s) met this requirement.

MB 0601090953	MAR lacks sign off for scheduled medication on 12/12/2020. Missing PRN follow-up on 12/19/2020 and 1/16/2021.
TC 0601066749	Missing PRN follow-up on 11/4/2020.
PF 2004947028	Missing PRN follow-up on 10/20/2020.
SK 0601073131	MAR lacks sign off for scheduled medication on 8/25/2020 and 1/7/2021.
KK 2005478852	MAR lacks sign off for scheduled medication on 8/7/2020, 11/21/2020, and 1/7/2021. Missing PRN follow-up on 8/1/2020 and 10/17/2020. Q 8 hours PRN Ibuprofen administered 50 min earlier of allowed time on 10/24/2020.
KL 0601101103	MAR lacks sign off for scheduled medication on 3/20/2020. Missing PRN follow-up on 4/14/2020, 4/15/2020, 4/18/2020, 5/7/2020, 7/1/2020, 10/7/2020 and 10/11/2020.
DP-P0601023385	MAR lacks sign off for scheduled medication on 4/10/2020, 4/18/2020, 7/11/2020,11/21/2020, and 12/7/2020.

JW 0601348720	MAR lacks sign off for scheduled medication on 1/31/2020, 2/8/2020, and 2/20/2020. Missing PRN follow-up on 7/23/2020, 8/27/2020, 8/28/2020, and 10/1/2020.
AA 0601032900	MAR lacks sign off for scheduled medication on 7/3/2020. Missing PRN follow-up on 5/4/2020, 5/8/2020, 6/7/2020, and 7/3/2020.
CD 0601078944	MAR lacks sign off for scheduled medication on 12/12/2020.

42 CFR 456.610(d)

4 out of 12 chart(s) met this requirement.

PF 2004947028	Missing Q 15 minute safety checks on 9/18/2020 from 20:25 to 22:15, on 10/3/2020 from 19:30 to 21:45, and 10/9/2020 at 07:45.
EJ 0601382051	Missing Q 15 minute safety checks on 10/1/2020 at 23:45.
KK 2005478852	Missing Q 15 minute safety checks on 10/21/2020 from 07:15 to 07:45.
KL 0601101103	Missing Q 15 minute safety checks on 8/15/2020 at 23:30 and 23:45, and on 9/20/2020 at 15:45.
DP-P0601023385	Missing Q 15 minute safety checks on 11/19/19 from 23:00 to 23:45.
RT-M0601117943	Missing psychiatrist progress note for December of 2020.
JW 0601348720	Missing Q 15 minute safety checks on 10/4/2019 at 11:00, on 10/8/2019 at 23:30 and 23:45, and on 10/4/2019 from 22:15 to 22:45.
AA 0601032900	Missing Q 15 minute safety checks on 8/4/2020 from 21:00 to 22:15, on 8/8/2020 at 22:00 and 22:15, on 8/22/2020 at 21:45 and 22:00, on 8/26/2020 at 23:30 and 23:45, on 9/12/2020 from 23:15 to 23:45, on 9/16/2020 at 22:30 and 22:25.

42 CFR 456.610(e)

12 out of 12 chart(s) met this requirement.

42 CFR 483.350 through 42 CFR 483.376

10 out of 12 chart(s) met this requirement.

EJ 0601382051	1 hour face-to-face assessment 15 min pass due on 11/29/2020 and 8 min pass due on 10/10/2020.
KL 0601101103	1 hour face-to-face assessment 20 min pass due on 11/21/2020.

It should be noted that the actions described in this report, or the plan of improvement, do not limit any administrative, civil, or criminal liability of the provider either for conduct which is the subject of this report, or the plan of improvement, or other instances of provider misconduct, or noncompliance with Behavioral Health or the Alaska Medicaid Program.

UHS-FINHELP-00009908 [Redacted]

The Joint Commission
Connect™ / Quality Monitoring System for Healthcare Organizations

Kids Behavioral Health of Utah Inc
[redacted]
West Jordan UT [redacted]
HCO ID [redacted] Incident ID: [redacted]

Back to *Incident Selection* **Organization response to a safety event** Print

Incident Number: [redacted]
Incident Date: 12/2/2021
Programs: Behavioral Health Care and Human Services

Incident Sites

Site Name	Address
Kids Behavioral Health of Utah Inc.	[redacted] West Jordan, UT [redacted]

Document Upload
Upload documents to be attached to your incident

File Description
general information
Response to complaints
New Admit Procedure
Follow up question and data

Did you contact Reporter?
No Yes N/A

Safety Event Summary

Attached is a general event template to ensure that all systems-based factors are considered as potential contributors and to assist you with completing a thorough analysis of the safety allegations provided. Please ensure that all areas identified as contributing factors to the event are included as part of your response. This list is not all inclusive, and you may wish to provide any additional information or factors identified.
You may also refer to the organization response guidelines within your extranet site for further guidance on preparing your response. Please feel free to reach out to the Patient Safety Specialist with any questions you may have.
For additional questions contact the Patient Safety Specialist [redacted] RN MS at [redacted]
****
-Children go a week without a pillow
-Parents bring pillow to lobby and the patient/child does not get the pillow
-Communication process between parents/guardians and children are not being followed per process
-Parents and guardians are complaining about the lack of communication
-High up leadership staff are yelling and swearing at the children
-Admission protocol is to include the child speaking with family to let them know they arrived at the facility and not being done
-Patient and family rights are not being honored as promised regarding phone calls and communication
-Staff member signs as a Doctor of Jurisprudence, despite not having a Doctor of Jurisprudence.

Address the Specific allegation(s) and provide an analysis and review of related systems and processes:

Allegation: 1
- Children go a week without a pillow
- Parents bring pillow to lobby and the patient/child does not get the pillow.

Response:
Every student receives a "Laundry Basket" with essential supplies on the day of admission including a pillow. A few months ago, the General Service Team (transportation) was told by the unit staff a pillow was available on the unit for the new admission, and that there was no need to provide a pillow for the incoming student. At this point of time the General Services Manager took the pillow out of the new admit basket. When the student arrived to the unit, the staff did not hand out the pillow. The student informed Mom on a phone call that she did not have a pillow. The mother brought a pillow in and left it with the operator. The next day one of the milieu staff picked up the pillow and delivered the pillow to the student. This was an unusual occurrence due to miscommunication and not a representation of the normal admission processes at Copper Hills Youth Center.

Allegation: 2
- Communication process between parents/guardians and children are not being followed per process.
- Parents and guardians are complaining about the lack of communication.
- Patient and family rights are not being honored as promised regarding phone calls and communication.

Response:
After a review of documentation discussing parent and student communication, the analysis revealed an inconsistency. One of our handbooks state we provide three phone calls a week, when our actual practice is to provide two calls per week. We have since corrected the handbook to read two phone calls a week. One call during residential hours and one call a week during family therapy sessions.

Allegation: 3
High up leadership staff are yelling and swearing at the children.

Response:
All staff are trained to the Abuse and Neglect policy upon hire and annually. Copper Hills Youth Center does not condone or tolerate verbal abuse by staff towards students or staff to co-workers. There have been no student grievances, nor parent complaints, addressing allegations of verbal abuse. Each student is educated on the Grievance process during the admission process, and the guidelines are in the student handbook. Anytime that there is inappropriate staff behavior that is reported that is not consistent with our Abuse and Neglect policy, the allegation is taken seriously, an investigation open, and corrective action will occur as indicated.

Allegation: 4
Admission protocol is to include the child speaking with family to let them know they arrived at the facility is not being done.

Response: Copper Hills Youth Center does not have an admission protocol that states we will have the child speak with the family at the end of the admit process.

Allegation: 5
Staff member signs as a Doctor of Jurisprudence, despite not having a Doctor of Jurisprudence.

Response: The Copper Hills Youth Center Utilization Management Director signs paperwork with the initials "LPC, MPA, JD." This staff member is a licensed professional clinician, has a masters of public administration, and a law degree. This is an appropriate signature.

Systems Improvements and/or Follow-up Actions:

1.) The Admission Procedure Policy was revised to clarify the responsibility of issuing supplies to new residents. The Manager is now responsible to ensure each resident receives all essential supplies with accountability to document resident in the EMR.
2.) We implemented a new phone call system with scheduled phone calls for students including date and times. This occurs once a week during residential times according to the unit schedule. In cases of emergency, or for other therapeutic reasons, students may receive an additional phone call scheduled on an individual basis. All staff will receive retraining on 01/31/2022 to the current procedure to ensure consistency throughout the facility and in communication with parents and families.

Measurement/sustainability of compliance to related standards:

1. All clinical staff will be trained on the Admission Procedure Policy upon hire, annually, and as needed. Training will be verified by the Human Resources Director and available in staff personnel files. Any staff receiving complaints involving students not receiving essential supplies upon admission will forward the complaint to the Patient Advocate or Director of Performance Improvement. Complaints are reported in Quality Committee monthly, and to the Governing Board quarterly.

2. All clinical staff will be trained on the Phone Call Procedure upon admission, annually, and as needed. Any staff receiving complaints involving phone calls will forward the complaint to the Patient Advocate for investigation. Complaints are reported in Quality Committee monthly, and to the Governing Board quarterly.

Request for Additional Information (First):

Thank you for your response. In order to close this incident additional information is requested:

- How is patient/family/guardian satisfaction assessed? (for example, a satisfaction survey with benchmarks)
-Have trends related to communication and/or patient rights been identified in the past twelve months?
If so, please describe them and any subsequent improvements.

You may contact me with questions.

[redacted]RN, MSPH
[redacted]@jointcommisison.org

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Additional Information (First):

Patient satisfaction is assessed through patient satisfaction surveys that are administered by the facility and tracked in the UHS clinical dashboard. There are benchmarks for the overall standard and for the corporation and the facility score is compared to the benchmarks on a monthly basis. As a facility we are required to address lower scoring questions/patient concerns. (See attachment " Follow up question and data"

Request for Additional Information (Second):

Additional Information (Second):

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UHS-FINHELP-00009917 [Redacted]

Copper Hills Action Plan for DHS violations

R495-876-5. Provider Code of Conduct.

(1) Providers and provider staff:
(c) may not abuse, neglect, harm, exploit, mistreat, or act in a way that compromises the health and safety of clients through acts or omissions, by encouraging others to act, or by failing to deter others from acting;

Violation(s) associated with Sections R501-1-27 and R495-876-5:

1. On 01/02/22 multiple staff interviews disclosed and video coverage supported that staff acted outside the scope of behavior management training and Copper Hills Policy and Procedure. The staff engaged in a verbal altercation with a client and failed to use de-escalation techniques. The verbal altercation escalated to a physical altercation, resulting in physical intervention and a client injury. A CPS investigation supports this case for physical abuse.

Violation:

2. On 03/28/22 a staff acted outside of the scope of behavior management training and placed a client in a choke hold during a physical intervention. Video coverage supports this violation. A CPS investigation supported this case for physical abuse.

Copper Hills Initial Response to Violation 1:

- On 1/02/22 staff Redacted - PII was inappropriate in his verbal interactions with a student causing the escalation of an incident. Redacted - PII did not follow verbal de-escalation techniques that are taught at Copper Hills Youth Center . The student was placed in a restraint due to his physical assault on staff *(multiple punches to staffs face)*.
  On 1/02/22 Redacted - PII received corrective counseling and was placed on administrative leave and remained on administrative leave till DHS employee gave permission for him to return on March 3 2022.
- Upon hire and in continuing education *(prior to the incident)* Redacted - PII was educated by Copper Hills on *(Training is attached to this email)*:
  - The Utah State Code of Conduct
  - Verbal De-escalation
  - Intervention Model *(Progressive Intervention / least restrictive intervention)*

Copper Hills Initial Response to Violation 2:

- On 3/28/22 *(Date of incident)* Copper Hills identified that the staff had acted inappropriately placing a student in a choke hold at which point we placed the staff on administrative leave and reported out to CPS. Staff was placed on administrative leave till CPS findings were concluded. On May 3 2022 Redacted - PII substantiated findings of physical abuse *(choke hold)* at which point CHYC immediately terminated Redacted - PII
- Upon hire and in continuing education *(prior to the incident)* staff Redacted - PII had been trained on: *(All training documentation is attached to this email)*
  - Utah State Code of Conduct
  - Verbal De-escalation

- Intervention Model *(Progressive Intervention / least restrictive intervention)*
- Handle with Care

Continued Response / Plan of Action:
Every incident involving aggression or restraint will be reviewed by the Program Director and any departure of technique from protocol will be immediately addressed with the involved staff in the form of training and a corrective counseling that will be placed in their training file. Progressive counseling/management will take place ranging from preventative counseling to termination based upon the level of actions by Copper Hills employee(s).

R501-19-4. Requirement for Intermediate Secure Treatment.

(2) Intermediate secure treatment programs serving youth shall maintain a staff-to-client ratio of no less than one staff to every five clients.

Violation(s) associated with Section R501-19-4:

3. During client interviews, administration interviews, review of daily shift roster, and camera review, CHYC was out of ratio on multiple occasions between 03/01/22-04/30/22. Lack of maintaining staff-to-client ratio has contributed to critical incidents, including client sexual misconduct and client injuries.

Response: Due to employment shortages and covid over the last year Copper Hills has experienced staffing issues. This was presented to licensor in the 2021 licensure renewal. Approximately 6 months out of 12, during 2021, administration worked 7 days a week to assure that the facility was safe. We have since implemented a number of initiatives/changes to improve our staffing to insure safety, these actions are listed below.

We have also put together an internal performance improvement plan which we have worked half way through that has to date proven to be successful. *(See under proposed future plan of action.)*

Action Taken over the last year of licensure to ensure staffing ratios:

- Hiring rate for line staff was increased from $14.50 an hour to $16.00 dollars an hour.
- Weekend shifts moved from 2.35 differential an hour to a $5.00 an hour differential.
- An internal CAP was placed at 100 to 105 student census that was connected to staffing needs for a 5 month time frame.
- A staffing meeting is held once a week *(Wednesdays)* and scheduled staffing patterns are reviewed. Staffing incentives are approved and communicated at this point ranging from 150 dollars a shift to 250 dollars a shift.
- Implemented a Referral Bonus of 1,000 for working professionals and 200 dollars for milieu staff.
- Sign on bonus for working professionals of 1,000.
- Clinician's pay scale was increased approximately 5k a year.

Plan of Action in response to violation with R501-19-4:

1. A protocol will be written regarding ratios and implementation of systems and guidelines that help the program accomplish and manage the 1:5 ratio.
    a. All staff will be trained on this protocol and adherence to the protocol will be reviewed daily by the Program Directors, Risk Manager and CEO. Addressed in the protocol will be: Protocol has been written and in-serviced
        i. Program Managers falling into the unit ratio when staff call off.
        ii. Flexing unit numbers, assuring that unit census is completed in a way that supports the 1:5 ratio.
        iii. Using the Senior on / Program Manager with students that require intervention to avoid splitting staff and falling out of ratio.
2. Move Recreational Therapy to the swing shift to offer stronger structured programming i.e. Recreational Therapy groups.
    a. 3 to 4 fulltime recreational therapists will be in rotation with milieu/residential staff in the ratio running organized group therapy.
        i. Hire two fulltime teachers to add art and life skills classes to the a.m. shift which will allow Rec Therapists to move their shifts to a 12: - 8:p.m. shift. *(Students begin bedtime preparation at 8: p.m.)*
            1. *2 teacher positions have been opened, director of plant operations is working on classrooms.*
            2. *Schedules for RT have been written, waiting for teachers to be hired to implement new academic schedules and move RT to the evening.*
3. Retention / Training Initiatives - CHYC will continue to do the following to strengthen retention with MHA's (line staff).
    a. Hire a milieu trainer that audits and trains line staff on findings.
        i. Taking place
    b. Increase training with new hires from 2 weeks to 4 weeks.
        i. Taking place
    c. Increase new hire check in's form monthly to bi-weekly to get their concerns and training needs.
        i. Taking place
    d. Increase staff involvement in students treatment i.e. attendance in treatment team, RT/Milieu outings and Team meetings.
        i. Taking place as of a week ago.
    e. Regular work in a staff development plan. *("Mastery Program")*
        i. Half way completed, will have complete and implemented by 8/31/22

Retention and Training Committee Initiatives

1. CONNECTION – Form a relationship of trust.

- **Increased Check ins / interviews** *(Touches)* ***Completed and taking place since beginning of June***
  - 2 weeks, 4 weeks, 6 weeks, 8 weeks, 10 weeks, 12 weeks
- **Team Meetings by Area / Shift** *(Gives the team an opportunity to bond, do housekeeping and train)*
  - ***Completed and implemented as of 7/11/22***
- **RT / Activity outings –** Get the MHT's out with the students on activities. Get MHT's involved in RT, process groups and co-facilitating.
  - ***Currently reworking the RT Program / Schedules***

2. TRAINING – Take out ambiguity and anxiety from the job.

- **Redefine Milieu Training** – *(Create the golden thread that holds the new hires hand from day 1 through day 90.)*
  - **Training Handbooks**
    - Lay out onboarding and competencies according to week in trainings
      - ***Rewritten and implemented***
  - **Milieu Trainer Responsibilities** *(Have the milieu trainer own new hires till they are CONNECTED to their immediate supervisor.)*
    - ***Hired and Training since June 1st***
      - NEO
      - Health stream
      - Shadow Shifts
        - Training Handbooks & Training Meetings
          - Week 1 NEO week, Week 2 trainings, Week 3 trainings, Week 4 trainings
          - In class training takes place prior to the shift and debriefing takes place toward the end of the shift.
  - **Mastery Program** – Mirrors the new hire training program for the first two steps. Mastery is based in job protocols and responsibilities.
    - ***In Progress, completed through Team Lead. Will be completed by the end of July.***

i. MHT
ii. Core Staff
iii. Team Lead
iv. Area Manager
v. Senior On

3. VALUE – Tie employees into the job by giving them a sense of accomplishment, value in their job. Allow them to be a part of the students change process as a MHT.

- Define job duties with the students.
- Treatment team duties

R501-1-24. Program Policy and Procedure Requirements.
(1) A program shall develop, implement, and comply with policies and procedures sufficient to ensure client health and safety and meet the needs of the client population served.

R495-876-5. Provider Code of Conduct.
(1) Providers and provider staff:
(e) shall maintain the health and safety of clients in each program service and activity;
(k) shall provide services and supervision that is commensurate with the skills, abilities, behaviors, and needs of each client;
Violation(s) associated with Section R501-1-24 and R495-876-5:
Multiple client interviews disclosed and video reviews support that, on multiple occasions, clients enter and exit other clients' bedrooms. Staff acted outside of their training, did not follow Copper Hills guidelines, and failed to intervene. The staff's lack of action contributed to multiple critical incidents occurring, including sexual misconduct incidents, physical altercations between clients, and client injuries.

Copper Hills initial response to violations with Section R501- and R495-8765:

- Wrote protocols regarding Staff to student supervision and not allowing students to enter other students bedrooms and in-serviced all Grave staff.
- Wrote "Community Guidelines", made posters and mounted them behind plexi on every unit. This is trained with staff and has been added to our new hire training manual.
- Implemented a monthly training with Grave shift to address housekeeping items and trending issues discovered in routine grave camera reviews.
- A Grave Handbook was written with the expectation for staff supervision during Grave. Included in this handbook and its competencies is the expectation that staff should not allow students to access other students bedrooms.
    - This handbook was trained with all current Grave staff.

Plan of Action:

- Copper Hills will write a protocol regarding student supervision giving clear guidelines for students entrance into other student's rooms that are not their own.
    - Completed and in-serviced.
- Heightened interventions will be defined for non-compliance by students to this protocol. Roll out of the new protocol will be reinforced by larger rewards to help ensure success with adherence by the students.
- The Protocol will be written and all staff and students will be in-serviced on the protocol by 8/5/22.
- Documented camera reviews / auditing will be done weekly to ensure adherence to the protocol.

State of Utah
SPENCER J. COX
Governor
DEIDRE M. HENDERSON
Lieutenant Governor

Department of Human Services
TRACY S. GRUBER
Executive Director
NATE CHECKETTS
Deputy Director
DAVID LITVACK
Deputy Director

July 08, 2022

Copper Hill Youth Center
[redacted] Executive Director
[redacted]
West Jordan, UT [redacted]

RE: **Corrective Action Plan Required**

The office may consider the chronicity, severity, and pervasiveness of violations when determining whether to simply provide notification of violation(s) with no follow-up requirement or request a corrective action plan or apply a formal penalty to the program. In an effort to assist your program in compliance with Licensing Rules/Statutes and in accordance with R501-1-12 (outlined below), the Office of Licensing is requesting a Corrective Action Plan (CAP) in regards to the following Administrative Rule violations:

- **R501-1-27. Client Rights.**
  (1) Clients have the right to:

(a) be treated with dignity;
(b) be free from potential harm or acts of violence;
(c) be free from potential harm or acts of violence;
(d) be free from abuse, neglect, mistreatment, exploitation, unusual or unnecessary consequences, and fraud;

R501-1 Definitions
(28) "Physical mistreatment" means conduct that results in pain, injury, or death. For a notation violation involving physical mistreatment, there must be culpability on the part of the program or its staff. Ie: staff acting outside policy or training and causing pain, injury or death.

- **R495-876-5. Provider Code of Conduct.**
  (1) Providers and provider staff:
  (c) may not abuse, neglect, harm, exploit, mistreat, or act in a way that compromises the health and safety of clients through acts or omissions, by encouraging others to act, or by failing to deter others from acting;

  Violation(s) associated with Sections R501-1-27 and R495-876-5:

  1. On 01/02/22 multiple staff interviews disclosed and video coverage supported that staff acted outside the scope of behavior management training and Copper Hills Policy and Procedure. The staff engaged in a verbal altercation with a client and failed to use de-escalation techniques. The verbal altercation escalated to a physical altercation, resulting in physical intervention and a client injury. A CPS investigation supports this case for physical abuse.

  2. On 03/28/22 a staff acted outside of the scope of behavior management training and placed a client in a choke hold during a physical intervention. Video coverage supports this violation. A CPS investigation supported this case for physical abuse.

- **R501-19-4. Requirement for Intermediate Secure Treatment.**
  (2) Intermediate secure treatment programs serving youth shall maintain a staff-to-client ratio of no less than one staff to every five clients.

  Violation(s) associated with Section R501-19-4:

  3. During client interviews, administration interviews, review of daily shift roster, and camera review, CHYC was out of ratio on multiple occasions between 03/01/22-04/30/22. Lack of maintaining staff-to-client ratio has contributed to critical incidents, including client sexual misconduct and client injuries.

- **R501-1-24. Program Policy and Procedure Requirements.**
  (1) A program shall develop, implement, and comply with policies and procedures sufficient to ensure client health and safety and meet the needs of the client population served.

  R495-876-5. Provider Code of Conduct.
  (1) Providers and provider staff:
  (e) shall maintain the health and safety of clients in each program service and activity;
  (k) shall provide services and supervision that is commensurate with the skills, abilities, behaviors, and needs of each client;

  Violation(s) associated with Section R501-1-24 and R495-876-5:

4. Multiple client interviews disclosed and video reviews support that, on multiple occasions, clients enter and exit other clients' bedrooms. Staff acted outside of their training, did not follow Copper Hills guidelines, and failed to intervene. The staff's lack of action contributed to multiple critical incidents occuring, including sexual misconduct incidents, physical altercations between clients, and client injuries.

R501-1-12. License Violations.
(4) When the office issues a request for a corrective action plan, a licensee shall submit a written corrective action plan to the office within ten business days from the date of the request and the corrective action plan shall include:
(a) a statement of each violation identified by the office;
(b) a detailed description of how the licensee will correct each violation and prevent an additional violation;
(c) the date by which the licensee will achieve compliance with administrative rule and statute; and
(d) describe the involvement of each program owner and director, including each foster parent, if involving a licensed or certified foster home.
(5) The office shall review corrective action plans submitted to the office and either inform the licensee that the corrective action plan is approved or inform the licensee that the corrective action plan is not approved and provide an explanation.
(6) If a corrective action plan is not approved, the office may permit a licensee to amend and resubmit its corrective action plan within five additional business days.
(7) A notification of violation or a request for a corrective action plan is not a penalty.
(8) A program may choose to refuse the notification of violation or corrective action plan process and preserve the program's appeal rights by instead requesting a penalty.
(9) The office may issue a penalty for a violation if the licensee fails to submit and comply with an approved corrective action plan.

Thank you for your cooperation in this process, we look forward to working together with you to achieve a compliant program status for you, your employees, and the clients you serve.

Sincerely,

[redacted]
Licensing Investigator
Department of Human Services/Office of Licensing
[redacted]
Salt Lake City, Utah [redacted]

[redacted]
Licensing Investigator
Department of Human Services/Office of Licensing

[redacted]
Salt Lake City, Utah [redacted]

Cc:

[redacted]
Licensing Specialist
Department of Human Services/Office of Licensing
[redacted]
Salt Lake City, Utah [redacted]

[redacted]
Investigations Manager
Department of Human Services/Office of Licensing
[redacted]
Salt Lake City, Utah [redacted]

UHS-FINHELP-00009926 [Redacted]

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of
Health and Social Services

DIVISION OF BEHAVIORAL HEALTH
Anchorage Regional Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

October 11, 2019

Copper Hills Youth Center
[redacted]
West Jordan Utah [redacted]

Attention: Utilization Review

As you are aware, the Code of Federal Regulations (42 CFR 456.600-614) requires State Medicaid Agencies to conduct reviews of inpatient psychiatric facilities on an annual basis.

Copper Hills was reviewed on 9/30/2019 to 10/3/2019, and conducted by [redacted] RN IV and [redacted] MHC III. State of Alaska Department of Health and Social Services (DHSS) representatives from Division of Behavioral Health (DBH).

TYPE OF REVIEW
Annual

REPORT
Enclosed is the **Site Review Summary of Findings** report dated 10/11/2019. This document contains a description and history of your organization, purpose and process of the site review, a summary of Behavioral Health findings and recommendations. This report also contains detailed information pertaining to the medical necessity clinical chart review conducted by Behavioral Health staff.

This report is also available without Medicaid numbers. This non-confidential version is submitted to your licensing organization.

Plan of Improvement
Plan of improvement (POI) is required as a result due to deficit found during the site/chart review process. Your facility must take corrective action based on the recommendations of the review team (42 CFR 456.613). If a POI is requested, is expected to respond in writing to DBH by November 15, 2019.

Address: State of Alaska
Attention:
Department of Health and Social Services

[redacted]
Anchorage, AK [redacted]

Fax: [redacted]

If you have any questions in regards to areas for improvement identified in the HSS integrated site review report please contact [redacted] DBH Medicaid Section Manager / Tribal Liaison at [redacted]

The Alaska site review team thanks the staff at Copper Hills for their hospitality, flexibility and willingness to accommodate our requests while on site.

Sincerely,

[redacted]
DBH Medicaid Section Manager / Tribal Liaison
Division of Behavioral Health

CC: Utah State Licensing
Copper Hills CEO

State of Alaska Department of Health and Social Services
Division of Behavioral Health
Site Review Summary of Findings

Provider: Copper Hills Youth Center
Provider ID: 1006504

Start Date of Review: 9/30/2019
End Date of Review: 10/3/2019

Lead Reviewer:
[redacted] Medicaid Program Specialist V, Medicaid Services Sections& Tribal Program Manager

Other Reviewers:
[redacted] RN BSN
[redacted] LPC

Date of Report: 10/11/2019

Number of Charts Reviewed: 14

ORGANIZATIONAL DESCRIPTION AND HISTORY

Copper Hills is licensed to treat up to 197 youth, 12-17 years of age.

---Administrative staff typically keep the census below 110 youth.

Copper Hills is accredited by the Joint Commission, Northwest Accreditation Commission, and is licensed by the Utah Department of Human Services.

Each unit has access to a large out door area.

Facility has added doors between the bedroom hallway and the main living area.

Bunk beds are being replaced with pedestal style beds.

The program has been rebuilding itself.
---Units are rewarded for "safest" unit and "clean" unit weekly.
---Staff are nominated to receive awards.
---Facility continues to move forward with positive reinforcement and de-escalation techniques to help decrease the use of restraint and seclusion.
---When needed additional training is provided.

Copper Hills has a general behavioral health program which is divided up between males and females and cognitive level of functioning.

The program also provides substance abuse treatment.
Copper Hills has 2 units for their Autism Spectrum Disorder (ASD) Asperger's program which are divided by level of functioning.

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Staff employed in these units receive specialized training.
The ASD program is designed for individuals with Asperger's Syndrome or High Functioning Autism and continues develop.

The program has implemented a therapeutic recreation program which is integrated into overall treatment.
---This provides recreation activities on and off campus for the youth.
---There is a low ropes course which allows youth to work as a team and provides the opportunity to learn problem solving skills.
---The recreation therapy program is working more in collaboration with a new physical education teacher to offer more options for youth.
---The facility also offers animal assisted therapy programs.
---Facility has created a basketball team to compete with a sister facility. The focus will also be on having appropriate interactions with one another especially during competitions i.e. no bullying.

The facility has a full education department which provides special educational services and regular education to students.

SITE REVIEW PURPOSE AND PROCESS

Per 42 CFR 456.606 site reviews are required to be performed yearly.

FINDINGS

Plan of Care: ***42 CFR 441.155(b)(1); 42 CFR 441.155 b(2); 42 CFR 456.609;7 AAC 140.410 (a)(3); 42 CFR 441.155(b)(3); 42 CFR 441.155 (c)(2); 42 CFR 441.156; 7 AAC 140.405(b)(5); 7 AAC 140.410 (a)(4); 7 AAC 140.410 (a)(6)***

The plans of care for thirteen (13) recipients at Copper Hills were reviewed one (1) additional client admitted during the site review. The initial and master treatment plans of care are part of their electronic health record and are developed for each recipient with the signature page scanned into the electronic health record.
All thirteen (13) plans of care were based upon an initial psychiatric evaluation after admission to Copper Hills. The initial evaluations yielded psychiatric diagnoses and any updates were noted in the electronic health record.

All thirteen (13) plans of care were developed by a team of professionals, as evidenced by signatures from the recipient, the parent/guardian, clinician, social worker, psychiatrist and director of nursing on the initial treatment plan and subsequent master treatment plans except for the brand new admission. Documentation of the involvement of the required teams in the development of the plan of care was inconsistent and all thirteen (13) charts had missing documentation of the required team members. This was discussed with leadership and it was noted with leadership this has been a problem in previous site reviews. A plan of improvement will be required for this. It was noted the signatures often lacked the credentials of the person signing the signature page.

All thirteen (13) plans of care prescribed an integrated program of therapies, activities and experiences to include individual therapy, group therapy, family therapy, recreation therapy, treatment plan reviews, milieu skills development, educational skills, health and wellness and

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medication management, designed to meet treatment objectives.

Five (5) of thirteen (13) plans of care included discharge plans on the plan of care that mentioned a discharge date, anticipated aftercare providers and living arrangements for recipients. Eight (8) charts plans of care were missing some detail required in discharge planning. This was discussed with the leadership team. A plan of improvement will be required for this deficiency.

Ten (10) plans of care had review dates outside of the every thirty (30) day time frame required by Federal regulations. This has been an ongoing problem for the facility. It was discussed with leadership and the care coordinators and the care coordinators were working on a solution to have the plans of care completed within the thirty (30) day requirement. A plan of improvement will be required for the deficiency.

It was discussed with leadership the onsite family therapy policy. The acting clinical director was given information regarding the new policy and the requirements laid out in the policy of documenting the onsite family therapy in the plan of care.

Progress Notes: ***42 CFR 456.610 (a); 42 CFR 456.610 (b)(1); 42 CFR 456.610 (c); 42 CFR 456.610 (d)***
Individual, family, group, and rec therapy progress notes were reviewed and found to be satisfactory. Psychotherapy was meeting the requirements of one (1) individual one (1) family therapy, and one (1) group once a week. Progress notes, in general, described the types of services provided, their duration, how they related back to the treatment plan, what progress had been made along with signatures and credentials for the respective service providers.

Psychiatric staff assess youth monthly. Psychiatric staff documentation is reflective of current laboratory findings, any changes of physical condition of the youth, side effects of the medications, the reasons for medication use, adjustments, discontinuances, and clinical progress of the youth.
Nursing staff assess youth upon admission and complete monthly summary for Treatment Team review. RNs also document behavioral and medical issues by exception. The notes are readable, easily understood, accurate, and concise. The notes document specific interventions and interactions and provide clear documentation of care, follow up, and outcomes.
Random audit of Medication Administration Records (MARs) was found to be lacking initials to indicate that scheduled medication was administered in six (6) of fourteen (14) reviewed records . Additionally, administered PRN medications were missing the follow-up comments in twelve (12) of fourteen (14) reviewed records. The effectiveness of the PRN medications needs to be assessed and documented within one (1) hour of medication administration. There is an expectation to document observations regarding the effect of the PRN medication using the information specific to the client that would indicate that there has been a desired effect, some effect, or no effect (i.e., behavioral changes, vital sign measurement, client's report).
Alaska Department of Health and Social Services requires medication monitoring when a youth is in RPTF care and on psychotropic medications. Monitoring for atypical antipsychotics includes monthly monitoring of Body Mass Index (BMI) and biannual laboratory monitoring for fasting glucose levels and fasting lipid level. The height, weight, and BMI of each student are recorded on admission.
Nine (9) of fourteen (14) reviewed records were missing monthly BMI documentation.
All clients are screened for nutritional needs and referred for a nutritional assessment when indicated. Dietary needs are addressed in the Treatment Plan and re-assessed on regular basis.

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The facility does not use Medication Consent forms for previously prescribed medication at the time of admission. Registered Nurses (RNs) complete Medication Reconciliation form at the time of admission and obtain verbal consent from the parent/guardian prior to any medication administration for each student. However, verbal consents for psychotropic medications documented on Medication Reconciliation form does not meet criteria for Medication Consent and does not contain all elements required by the State of Alaska. These elements include justification for use, risk / side effects, benefits and alternate treatment. Medication Consents for new scheduled and over the counter (OTC) medications do not contain all elements required by the State of Alaska as well. The noted above deficiencies were also identified during the previous site reviews in 2016, 2017 and 2018.
The facility was provided on-site technical assistance with an explanation of CMS regulations and State of Alaska Policies regarding Medication Consent. The copy of the State policy "Use of psychiatric medications for children in out of home care or receiving medication through Medicaid" was provided. It was evident during 2019 site review that this issue has not been resolved..

Restraint and Seclusion: ***42 CFR 483.350 through 42 CFR 483.376***

The facility utilizes physical restraints to manage behavioral crises that rise to the level of potential for self-harm or harm to others. Per leadership reports seclusions are rarely used at the program.
The majority of reviewed documentation of restraint events were found to be out of compliance with Center for Medicare & Medicaid Services (CMS) regulations due to multiple Emergency Safety Intervention (ESI) events having missing documentation of staff's observations of youth every 5 minutes as required by 42 CFR 483.362 (a); q 5 minutes documentation did not cover entire event of used ESI intervention; inaccurate/inconsistent time of holds throughout ESI documentation; 1 hour face-to face assessments were not completed within required 1 hour time frame; missing time of 1 hour face-to-face assessment; missing time of release from hold; missing order on ESI documentation for physical restraint.
The facility was provided on-site technical assistance with an explanation of CMS regulations regarding Seclusion and Restraints events and required documentation.
There was no indication during the review that restraints are inappropriately used.
There is evidence in reviewed records the parent and youth had been notified of the facility's philosophy for the use of seclusion and restraint.

Youth Interview Findings: ***42 CFR 456.608(a)(1)***

14 youth interviewed
Youth reported knowing why they are in treatment
Overall youth reported getting along with their peers.
It was reported the youth get along with staff members and some favorite staff were mentioned.
Youth reported knowing their treatment goals. They had an opportunity to be involved in deciding what goes into their treatment plans and felt they were making progress in meeting treatment goals.
Things learned were:
-Coping skills, coloring, journaling
-Being calm
-Self-harm and suicide are not the answers
-How to figure it out to be safe
-Not getting angry, be truthful, dating in treatment is stupid
-express needs, communicate before acting, and control thoughts of self-harm

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-life gets better
-patience, deal with situations
-it is easier to communicate with parents than previously thought
-follow directions
Youth knew their medications and most could tell why they were taking them
Phone calls to family were enough. One OCS student reported not having contact with OCS case worker
8 youth had been placed in a restraint or seclusion which they indicated was needed
-3 youth reported not discussing the incident with their treatment team members.
Youth knew the grievance policy and some had filed one and it was discussed with them
All youth reported feeling safe and had no safety concerns.

Parent Interviews:

Eight (8) of eleven (11) non-custody parents/ guardians were interviewed regarding the facilities engagement with them on restraint/seclusion use and grievance process.
Three (3) parents were unable to be reached.
The majority of interviewed parents indicated they were informed of the facility's policy on restraints and seclusions and it was presented in a manner which was easy to understand. Some of the parents could not recall if they had been notified.
Six (6) interviewed parents reported their youth had been placed in a hold or secluded.
All parents indicated they had been contacted after the incident most of the time and were able to provide input to the treatment team afterwards.
The majority of interviewed parents were aware of the grievance process at the facility.
The majority of interviewed parents identified no concerns regarding their child's safety at the facility and made positive comments about the program and the communication with the facility. One (1) parent expressed some concerns about "Morning staff does not give kids enough time to process and being punitive." One (1) parent did not agree with diagnosis of their child and expressed frustration their child could only talk to a psychiatrist once a month during treatment reviews.

QUALITY OF CARE

CHYC is trauma-based program that is grounded in basic principles of a number of trauma-related models and facility-wide understanding of trauma- informed care. There is a program wide effort to help youth build positive relationships with staff and their peers. Organizational leadership identified several areas in which they are in the process of implementing change that should bring into alignment all departments in the collaboration of care.
One of the changes was creating a Clinical Program Manager position, a master level clinician that works in collaboration with Director of Nursing Department (DON) to develop most effective ways to manage the milieu of the units.
The facility holds monthly "All staff meetings" that provides continuous education on trauma-informed care, behavioral management, patient safety and infection control topics.
The facility has closed circuit video monitoring (CCVM) for the environment of care with the exception of private spaces like bedrooms and bathrooms. The facility is utilizing CCVM for effective risk management and review of behavioral crisis events as a teaching tool.
Nursing Department Clinical department would benefit from developing an audit process to address documentation deficiencies identified during this site review.

It was noted on various documents scanned into the electronic health record staff were not

signing notes and documents with credentials. This was discussed with the leadership team.

Copper Hills will be instituting a new electronic health record. The previous electronic health record company was not able to meet the requirements they had promised to the facility.

PLA□ OF IMPROVEMENT (POI)
Provide a POI that addresses how you will correct the following deficiency/s:

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 483.350 through 42 CFR 483.376
Findings: The majority of reviewed documentation of seclusion and restraint events were found to be out of compliance with Center for Medicare & Medicaid Services (CMS) regulations.

Please provide Plan of Improvement (POI) that identifies how your organization will ensure that documentation of restraint and seclusion events are in compliance with CMS regulations.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 456.610(c)
Findings: The facility does not use Medication Consent forms for previously prescribed medications at the time of admission. Medication Consents for scheduled medications prescribed at the facility and over the counter (OTC) medications do not contain all elements required by the State of Alaska.

Please provide Plan of Improvement (POI) that identifies how your organization will provide Medication Consent for previously prescribed medications, scheduled medications prescribed at the facility and over the counter medications that have the risks, benefits and alternative therapies reviewed with parent/guardian.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 456.610(c)
Findings: Nine (9) of fourteen (14) reviewed records were missing monthly BMI documentation.

Please provide a Plan of Improvement (POI) that identifies how your organization will ensure that BMI documentation completed monthly.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 456.610(c)
Findings: Medication Administration Records (MARs) were found to be lacking initials to indicate that scheduled medication was administered in six (6) of fourteen (14) reviewed records. Administered PRN medications were missing the follow-up comments in twelve (12) of fourteen (14) reviewed records.

Please provide a Plan Of Improvement (POI) that identifies how your organization will

ensure timely
documentation of medication administration and required follow-up.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(b)(2)
Findings:
Plans of care did not consistently have the required documentation of the required members in the development of the plan of care.

Please provide a POI that identifies how your organization will ensure timely and consistent documentation of the involvement of the required team members.

Please provide to the Division of Behavioral Health on the 15th of each month beginning November 15th, 2019 for 6 months concluding April 15, 2020 an audit of your plans of care indicating this regulation has been met.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(b)(5) and 7 AAC 140.410(6)
Findings:
Plans of care did consistently document specific discharge providers on each plan of care from admission to discharge.

Please provide a POI that identifies how your organization will ensure documentation of specific discharge providers on each plan of care.

Please provide to the Division of Behavioral Health on the 15th of each month beginning November 15th, 2019 for 6 months concluding April 15, 2020 an audit of your plans of care indicating this regulation has been met.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(c)
Findings:
Plans of care were not completed consistently every 30 days.

Please provide a POI that identifies how your organization will comply with this regulation to have plans of care completed within 30 days.

Please provide to the Division of Behavioral Health on the 15th of each month beginning November 15th, 2019 for 6 months concluding April 15, 2020 an audit of your plans of care indicating this regulation has been met.

Submit POI by: 11/15/2019

Mail To:
State of Alaska

Department of Health and Social Services
Division of Behavioral Health
Attn:
[redacted] Medicaid Program Specialist V, Medicaid Services Sections& Tribal Program Manag
[redacted]
Anchorage, AK [redacted]

Or
E- Mail To: [redacted]@alaska.gov
Or
Fax POI To: [redacted]attention
[redacted] Medicaid Program Specialist V, Medicaid Services Sections& Tribal Program Manag

Summary of Chart Review Findings

42 CFR 441.155(a) and 456.180

14 out of 14 chart(s) met this requirement.

42 CFR 441.155(b)(1)

14 out of 14 chart(s) met this requirement.

42 CFR 441.155(b)(3)

14 out of 14 chart(s) met this requirement.

42 CFR 441.155(b)(2)

1 out of 14 chart(s) met this requirement.

KB 0600947658	Inconsistent documentation of required team members 4/11, 5/9, 6/6, 7/1, 8/1, 9/5.
CC 0601090639	Inconsistent documentation of required team members 5/1, 6/11, 7/9, 8/13, 9/10
PF 2004947028	9/4 missing parent/guardian
KK 0601238457	Inconsistent documentation of required team members 6/14, 6/25, 7/9, 8/13, 9/10
IM 0601063913	Inconsistent documentation of required team members 3/14, 4/1, 5/9, 6/13, 7/1, 8/1, 9/5
JM 0601082594	Inconsistent documentation of required team members 11/8, 12/13, 1/10, 2/14, 3/14, 4/11, 5/9, 6/13, 7/11
AS 0601371518	Inconsistent documentation of required team members 1/31, 2/7, 3/7, 4/4, 5/2, 6/6, 8/4,
JU 2004989548	Inconsistent documentation of required team members 8/27, 9/4
TW 0601019636	Inconsistent documentation of required team members 7/2, 8/6, 7/2
JW 0601348720	Inconsistent documentation of required team members 4/17, 5/16, 6/20, 7/18, 8/15, 9/19
AA 0601100822	Inconsistent documentation of required team members 2/12, 3/12, 4/10, 5/8, 6/11, 7/9, 8/13, 9/10
JC 0601085787	Inconsistent documentation of required team members 8/27
CF 0601112196	Inconsistent documentation of required team members 7/29, 8/20, 9/17

42 CFR 441.155(b)(4)

14 out of 14 chart(s) met this requirement.

42 CFR 441.155(b)(5) and 7 AAC 140.410(6)

5 out of 14 chart(s) met this requirement.

KB 0600947658	Inconsistent documentation of specific discharge providers
CC 0601090639	Inconsistent documentation of specific discharge providers
KK 0601238457	Initial plan of care no specific discharge providers
JM 0601082594	No specific discharge providers identified from admit until January
AS 0601371518	3/7 plan of care missing specific discharge providers
JU 2004989548	Initial plan of care and master plan of care missing specific discharge providers
JW 0601348720	Not consistently reviewed every 30 days
JC 0601085787	No specific discharge providers identified
CF 0601112196	No specific discharge providers identified

42 CFR 441.155(c)

3 out of 14 chart(s) met this requirement.

KB 0600947658	Not consistently reviewed every 30 days
CC 0601090639	Not consistently reviewed every 30 days
KK 0601238457	Not consistently reviewed every 30 days
IM 0601063913	Not consistently reviewed every 30 days
JM 0601082594	Not consistently reviewed every 30 days
AS 0601371518	Not consistently reviewed every 30 days
TW 0601019636	Not consistently reviewed every 30 days
JW 0601348720	Not consistently reviewed every 30 days
AA 0601100822	Not consistently reviewed every 30 days
JC 0601085787	Missing plan of care for September
CF 0601112196	Not consistently reviewed every 30 days

42 CFR 441.156 and 7 AAC 140.405(d)

14 out of 14 chart(s) met this requirement.

42 CFR 456.609(a)(b)(c)(d)

14 out of 14 chart(s) met this requirement.

42 CFR 456.610(a)

14 out of 14 chart(s) met this requirement.

42 CFR 456.610(b)(1)

14 out of 14 chart(s) met this requirement.

42 CFR 456.610(c)

1 out of 14 chart(s) met this requirement.

KB 0600947658	Missing BMI documentation for September, August, June and May 2019. Missing PRN follow-up on 4/22/19, 4/23/19, 6/19/19.
CC 0601090639	Missing BMI documentation for September and August 2019. Missing PRN follow-up on 5/2/19, 8/30/19, 9/17/19.
PF 2004947028	Missing PRN follow-up on 9/15/19.
KK 0601238457	MAR lacks sign off for scheduled medication on 7/19/19, 8/2/19.
IM 0601063913	Missing BMI documentation for July, April and February 2019. Missing PRN follow-up on 9/10/19, 9/26/19, 9/28/19, 8/12/19, 8/10/19, 4/26/19,10/15/18, 12/11/18, 12/13/18, 12/23/18.
JM 0601082594	Missing BMI documentation for April, March and February 2019. Missing PRN follow-up on 7/19/19, 6/28/19 6/26/19, 6/17/19, 6/11/19, 5/7/19, 4/25/19, 4/24/19, 4/10/19, 4/5/19, 3/26/19, 3/6/19, 11/18/18.
AS 0601371518	Missing BMI documentation for August, May, April, March and February 2019. MAR lacks sign off for scheduled medication on 6/20/19. MARs for scheduled and PRN medications for week of 7/7/19 are not found in the records. Missing PRN follow-up on 1/23/19, 2/5/19, 2/6/19, 2/7/19, 2/27/19, 3/7/19, 5/15/19, 6/17/19, 7/3/19, 7/4/19, 8/13/19.
JU 2004989548	MAR lacks sign off for medication provided on 8/27/19. Missing PRN follow-up on 8/31/19, 9/2/19, 9/9/19, 9/10/19, 9/12/19.
TW 0601019636	Missing BMI documentation for August, July, June, May, April, February 2019 and September 2018. MAR lacks sign off for scheduled medication on 5/1/19, 5/7/19, 5/19/19, 6/18/19, 7/7/19, 7/8/19, 10/8/18, 12/10/18, 12/11/18. Missing PRN follow-up on 2/15/19, 3/12/19, 4/16/19, 4/18/19, 7/2/19, 7/9/19, 12/24/18.
JW 0601348720	Missing BMI documentation for July and May 2019. MAR lacks sign off for medication provided on 5/15/19, 5/16/19, 9/20/19. Missing PRN follow-up on 4/18/19, 7/23/19, 8/27/19, 8/28/19.
AA 0601100822	Missing BMI documentation for September, August and April 2019. MAR lacks sign off for medication provided on 2/20/19, 6/28/19, 8/23/19. Missing PRN follow-up on 1/25/19, 1/26/19, 3/24/19, 3/30/19, 4/10/19, 4/11/19, 4/19/19.
JC 0601085787	Missing PRN follow-up on 8/23/19, 8/24/19, 9/8/19.
CF 0601112196	Missing BMI documentation for September and August 2019.

	Missing PRN follow-up on 9/5/19, 8/2/19, 7/31/19, 7/29/19.

42 CFR 456.610(d)

14 out of 14 chart(s) met this requirement.

42 CFR 456.610(e)

14 out of 14 chart(s) met this requirement.

42 CFR 483.350 through 42 CFR 483.376

6 out of 14 chart(s) met this requirement.

IM 0601063913	Missing q 5 min documentation on 8/27/19. Q 5 min documentation does not cover entire event on 5/28/19. 1 hour face-to-face assessment 8 min pass due on 8/27/19. Inaccurate time of hold on 10/28/18 throughout ESI documentation.
JM 0601082594	Missing q 5 min documentation on 12/1/18, 10,28/19. Q 5 min documentation does not cover entire event on 5/1/19, 11/28/18. 1 hour face-to-face assessment 10 min pass due on 11/2/18. Inaccurate time of hold on 4/25/19 throughout ESI documentation.
AS 0601371518	Missing q 5 min documentation on 5/28/19, 6/4/19, 6/7/19. Q 5 min documentation does not cover entire event on 5/13/19, 5/15/19. Missing time of 1 hour face-to-face assessment on 4/18/19, 5/15/19. 1 hour face-to-face assessment 2 min pass due on 5/28/19. Inaccurate time of hold throughout ESI documentation on 5/12/19, 5/15/19, 6/7/19, 6/7/19, 8/3/19, 8/21/19.
JU 2004989548	Missing q 5 min documentation on 10/1/19, 10/2/19. 1 hour face-to-face assessment 30 min pass due on 9/27/19. Inaccurate time of hold throughout ESI documentation on 9/25/19.
TW 0601019636	Missing q 5 min documentation on 10/19/18, 12/13/19, 7/25/19. 1 hour face-to-face assessment 10 min pass due on 12/13/18. Inaccurate time of hold throughout ESI documentation on 10/12/18, 10/19/18, 4/16/19, 6/3/19, 7/25/19.
JW 0601348720	Missing q 5 min documentation on 5/19/19, 9/30/19. 1 hour face-to-face assessment 1 hour and 5 min pass due on 5/14/19 and 4 min pass due on 8/16/19. Inaccurate time of hold throughout ESI documentation on 5/15/19, 5/19/19, 7/17/19, 8/16/19, 9/30/19. No date/time of release from hold on 9/30/19.
JC 0601085787	Missing q 5 min documentation on 8/26/19, 8/27/18. Incorrect time of release on 9/29/19 hold.
CF 0601112196	Missing q 5 min documentation on 7/31/19, 8/2/19, 8/7/19,

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	8/8/19, 8/31/19, 9/9/19, 9/25/19. 1 hour face-to-face assessment 15 min pass due on 8/2/19. Inaccurate time of hold throughout ESI documentation on 7/20/19, 8/21/19. Missing order on ESI documentation for hold on 8/11/19.

It should be noted that the actions described in this report, or the plan of improvement, do not limit any administrative, civil, or criminal liability of the provider either for conduct which is the subject of this report, or the plan of improvement, or other instances of provider misconduct, or noncompliance with Behavioral Health or the Alaska Medicaid Program.

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey
2019

Finding	Corrective Action	Staff Responsible Date Due
42 CFR 183.350 through 42 CFR 483.376 The majority of reviewed documentation of seclusion and restraint events were found to be out of compliance with CMS regulations. **Identify how your organization will ensure that documentation of restraint and seclusion events are in compliance with CMS regulations.**	• Q-5 observation will occur for all restraints noting start and stop times. • Charge Nurses will audit all restraint packets the day of documentation/restraint and signed off for accuracy and completeness. • Nurses will be trained to do face to face assessment from the start time of the restraint. • Nurses will be trained to obtain a separate order for seclusions if both a restraint and seclusion happen during the crisis	• DON/ADON will audit restraint packets the following business day to assure charge nurses are auditing and the packets are complete. • Nurses will have a staff meeting on 10/24/19 for restraint documentation including when the face-to-face assessment is due and obtaining separate orders for seclusion and restraints and completing Q-5 check for every restraint/seclusion.
42 CFR 456.610 © The facility does not use Medication Consent forms for previously prescribed medications at the time of admission. Medication consent forms for scheduled medications prescribed at the facility and over the counter (OTC) medications do not contain all elements required by the State of Alaska. **Provide a Plan of Improvement that identifies how your organization will provide Medication Consent for previously prescribed medications, scheduled medications prescribed at the facility and over the counter medications that have the**	• The OTC consent form will be re-created to list the medication, dose, side effects, benefits/risks and alternative therapies. • Nursing will notify guardians of physician admitting orders, obtain verbal consent as noted in electronic medical record by two licensed nurses and offer to send US mail service Copper Hills medication teaching and consent form.	• DON will have new admission consent forms with required elements by December 1, 2019.

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey
2019

risk, benefits, and alternative therapies reviewed with parent/guardian. **42 CFR 456.610(c)** Nine out of fourteen reviewed records were missing monthly BMI documentation. **Provide a POI that identifies how your organization will ensure that BMI documentation is completed monthly.**	• Nurses are completing a treatment review bi-monthly to include monitoring BMI at least once monthly beginning in November 2019	• DON/ADON will audit treatment reviews weekly to assure the treatment plans are complete, including assessment of BMI at least once monthly-Will add to the nurse meeting and trained by 10/24/19
42 CFR 456.610 (c) Medication Administration Records were found to be lacking initials to indicate that scheduled medication was administered in (6) out of (14) records. Administered PRN medications were missing the follow-up comments in (12) of (14) reviewed records. **Provide with a Plan of Improvement that identifies how your organization will ensure timely documentation of medication administration administered and required follow-up.**	• Charge nurses will audit MARs daily for scheduled medications and missing signatures • Charge Nurses will audit MARs daily for PRN documentation and one hour follow-up • Charge Nurses will audit MAR's daily for first dose education and follow-up. • This will begin in November 2019	• DON/ADON will audit MARs weekly to assure the treatment plans are complete-Will add to the nurse meeting and trained by 10/24/19 • DON/ADON will meet individually with each nurse and monitor how each nurse is completing medication pass-will have completed by November 15, 2019
42 CFR 441.115 (b) (2)	• Each member of the treatment team will	• The Director of Clinical services will audit each

COPPER HILLS YOUTH CENTER

Corrective Action Plan
Alaska Department of Health and Social Services Survey
2019

Plans of care did not consistently have the required documentation of the required members of the plan of care **Provide a POI that identifies how your organization will ensure timely and consistent documentation of the involvement of the required team members.** **Provide the division of Behavioral Health on the 15th of each month beginning November 15th, 2019 for 6 months concluding April 15th, 2020 an audit of your plans of care indicating this regulation has been met.**	electronically sign the treatment plan every treatment meeting.	treatment plan and report to Governing Board monthly for compliance rate.
42 CFR 441.155(b)(5) and 7 AAC 140.410(6) Plans of care did not consistently document specific discharge providers on each plan of care from admission to discharge **Provide a POI that identifies how your organization will ensure documentation of specific discharge providers on each plan of care** **Provide the division of Behavioral Health on the 15th of each month beginning November 15th, 2019 for 6 months concluding April 15th, 2020 an**	• Therapists will note two potential discharge resources noting specific resources for each resident in the discharge section of the treatment plan.	• The Director of Clinical services will audit each treatment plan and report to Governing Board monthly for compliance rate.



Corrective Action Plan
Alaska Department of Health and Social Services Survey
2019

audit of your plans of care indicating this regulation has been met.		
42 CFR 441.115(c) Plans of care were not completed consistently every 30 days **Provide a POI that identifies how your organization will comply with this regulation to have plans of care completed with 30 days.** **Provide the division of Behavioral Health on the 15th of each month beginning November 15th, 2019 for 6 months concluding April 15th, 2020 an audit of your plans of care indicating this regulation has been met.**	• Treatment review will be completed on the first and third week of every month.	• Utilization Management will schedule all Alaska residents to have a treatment review. The Utilization Manager will sign attesting the review occurred. • The Director of Business Support Services will report compliance rate to Governing Board monthly.

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of Health and Social Services

DIVISION OF BEHAVIORAL HEALTH
Anchorage Regional Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

November 19, 2019

Copper Hills Youth Center
[redacted]
West Jordan, UT [redacted]

Dear: [redacted]
Fax: [redacted]

Re: Plan Of Improvement (POI)

The State of Alaska Division of Behavioral Health has received your POI. You may be contacted to ensure compliance. Behavioral Health looks forward to a continued partnership with your agency to ensure fulfillment of state and federal regulation.

Sincerely,

[redacted]
Medicaid Program Specialist V, Medicaid Services Sections& Tribal Program Manager
Division of Behavioral Health

UHS-FINHELP-00009946 [Redacted]

The Joint Commission

Final Accreditation Report

Kids Behavioral Health of Utah Inc

[redacted]

West Jordan, UT [redacted]

Organization Identification Number: [redacted]

60-day Evidence of Standards Compliance Submitted: 3/25/2020

ESC Programs Reviewed

Behavioral Health

Final Report: Posted 3/28/2020

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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	3/25/2020	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.02.05	Compliant
CTS.03.01.03	Compliant
CTS.03.01.09	Compliant
CTS.04.03.33	Compliant
HRM.01.06.01	Compliant
LS.02.01.30	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
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.03.01.03	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.03.01.03	6	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 provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.
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.
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.
LS.02.01.30	19	The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. 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.	Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.



Final Accreditation Report

Kids Behavioral Health of Utah Inc

[redacted]

West Jordan, UT [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 1/28/2020 - 1/31/2020

Program Surveyed
Behavioral Health

Final Report: Posted 1/31/2020

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Executive Summary

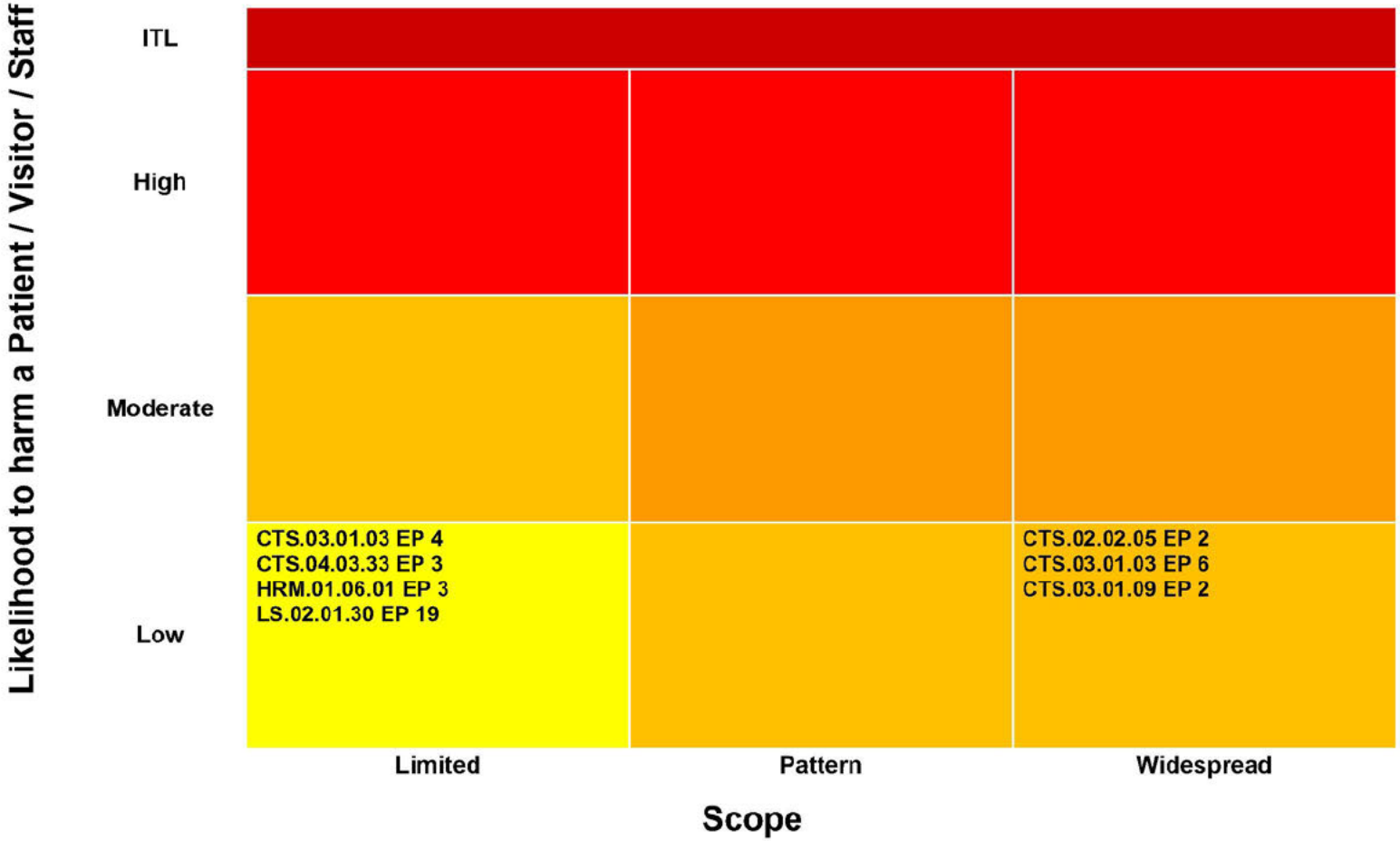
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health	01/28/2020 - 01/31/2020	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	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.02.02.05	2	Low / Widespread	✓
CTS.03.01.03	4	Low / Limited	✓
	6	Low / Widespread	✓
CTS.03.01.09	2	Low / Widespread	✓
CTS.04.03.33	3	Low / Limited	✓
HRM.01.06.01	3	Low / Limited	✓
LS.02.01.30	19	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.02.02.05	2	Low Widespread	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 Record Review at Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . It was observed the residential facility's current assessments screened for trauma, abuse, and neglect, however, they did not screen for exploitation. This was verified by the Director of Clinical Services and Director of Nursing.
CTS.03.01.03	4	Low Limited	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 Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . It was observed that the treatment plan of a 15-year-old female had not been reviewed/revised to include restraints as an intervention within 24 hours of the client being placed in a 14 minute hold as the organization's policy required. This was verified by the Director of Clinical Services and the Director of Nursing.
CTS.03.01.03	6	Low Widespread	The organization provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.	1). Observed in Record Review at Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . In 8 of 8 patient records reviewed, it was observed that the treatment plans did not include interventions for all members of the interdisciplinary treatment team. Specifically, the treatment plans did not include interventions for the psychiatrist or nurse. This was verified by the Director of Clinical Services and the Director of Nursing.
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 Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . Although the residential facility had selected numerous outcome measurement tools they were using to monitor the individual's progress in treatment, they had not begun using this information to evaluate and/or modify the goals and objectives of the individual's treatment plan. This was verified by the Director of Clinical 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 Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . While touring the kitchen, opened soy milk and almond milk cartons available to be served to clients were observed to be lacking a date that they were opened. The Food Service staff reported their procedure was to discard the milk after it had been open for seven days, however, without a documented open date staff would be unable to determine when it should be discarded.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
HRM.01.06.01	3	Low Limited	The organization conducts an initial assessment of staff competence. This assessment is documented.	1). Observed in HR File Review at Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . It was observed that a full initial competency had not been completed following the promotion of an employee. Specifically, a floor nurse was promoted to the Assistant Director of Nursing/Infection Control Nurse. There were job descriptions and completed competencies observed for the Infection Control Nurse and from when the employee was a floor nurse, however, there was not an initial competency for the role of Assistant Director of Nursing.
LS.02.01.30	19	Low Limited	Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.	1). Observed in Building Tour at Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . While touring the residential facility, numerous ceiling tiles were observed to be stained, broken, or penetrated. Specifically, two ceiling tiles located in the Riser Room on the hallway of the education building/gym were observed to be stained; one ceiling tile located in the hallway outside of the library was observed to have a visible crack through the center of it; and one ceiling tile located in the nurses station by the pharmacy was observed to have a hole in it from a sprinkler head that had been re-located.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

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
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.03.01.03	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.03.01.03	6	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 provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.
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.
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.
LS.02.01.30	19	The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. 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.	Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.

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.

UHS-FINHELP-00009962 [Redacted]



Final Accreditation Report

Kids Behavioral Health of Utah Inc

[redacted]

West Jordan, UT [redacted]

Organization Identification Number: [redacted]

Unannounced Full Event: 1/10/2023 - 1/13/2023

Program Surveyed

Behavioral Health Care and Human Services

Final Report: Posted 1/16/2023

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Executive Summary

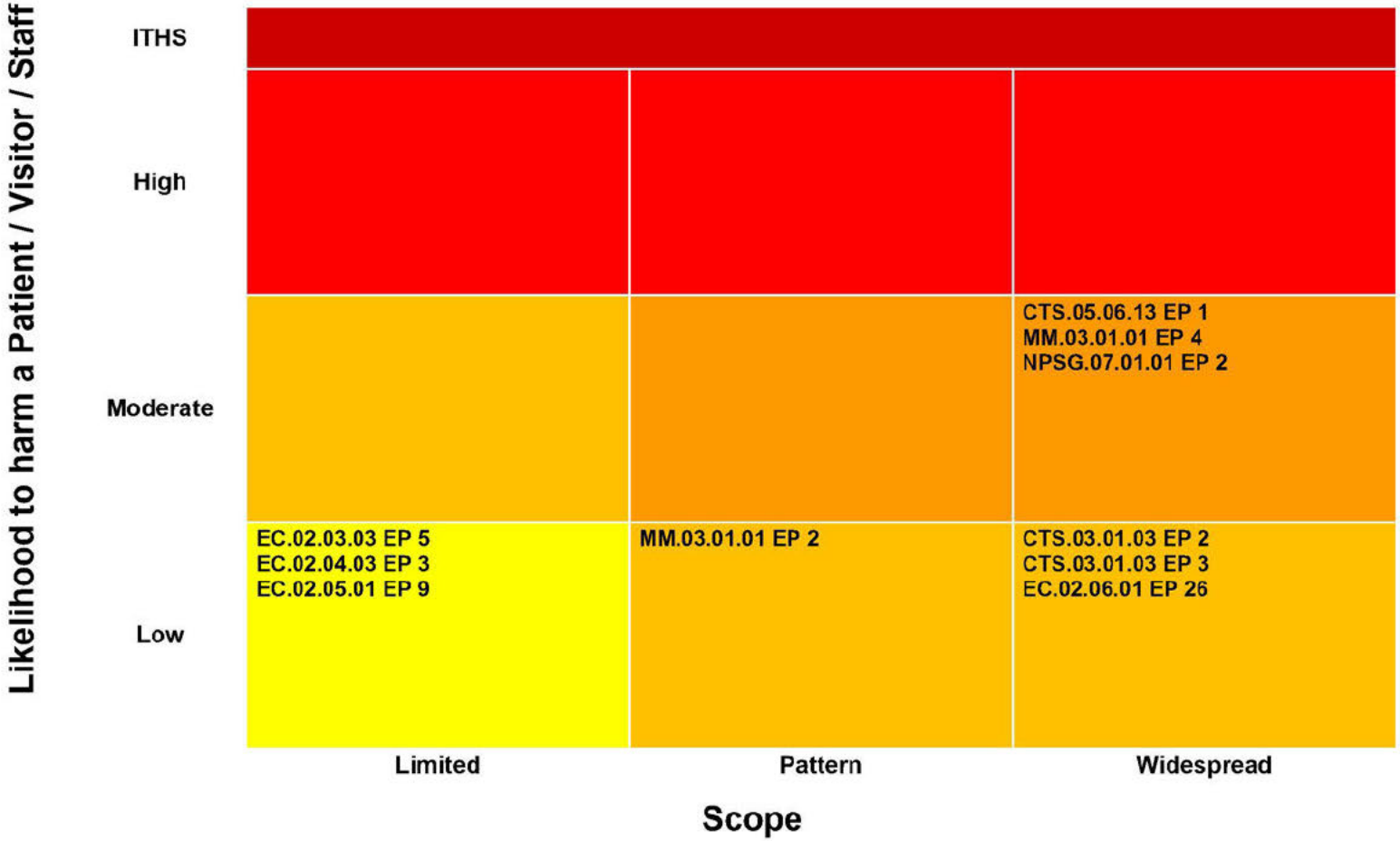
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	01/10/2023 - 01/13/2023	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards 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.03.01.03	2	Low / Widespread	✓
	3	Low / Widespread	✓
CTS.05.06.13	1	Moderate / Widespread	✓
EC.02.03.03	5	Low / Limited	✓
EC.02.04.03	3	Low / Limited	✓
EC.02.05.01	9	Low / Limited	✓
EC.02.06.01	26	Low / Widespread	✓
MM.03.01.01	2	Low / Pattern	✓
	4	Moderate / Widespread	✓
NPSG.07.01.01	2	Moderate / Widespread	✓

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.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/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 Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . In 6 of 6 resident records reviewed, , goals on the treatment plan do not capture the words or intent about what the patient desires to accomplish in treatment, this would also help individualize goals to that student. This was observed by the Director of Clinical Operations.
CTS.03.01.03	3	Low Widespread	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 Kids Behavioral Health of Utah Inc. [redacted] West Jordan, UT) site . In 6 of 6 patient records reviewed, the treatment plan objectives for these patient's did not contain measurable steps that would determine progress toward identified goals. This was discussed with and affirmed by the Director of Clinical Operations.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.05.06.13	1	Moderate Widespread	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 a 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 Record Review at Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . In 4 of 4 patient records reviewed, - The verbal order received by a nurse to apply a restraint were never authenticated by MD who gave the order, however, in two of the records the orders were present but were out of the 24 hour time frame according to their policy, this was observed by the Director of Clinical Operations.
EC.02.03.03	5	Low Limited	The organization critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire.	1) Observed in Emergency Management Session at Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . The organization did have a form for their fire drills, but did not have a written process to critique, and plan for improvement, this was also evident to the Director of Plant Operations. The organization had updated their initial forms to add these sections on it.
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 Medication Management Tracer at Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . A procedure was not being followed to test the AED and there were not logs of being checked. This was verified by the Director of Nursing. There has been a process put in place to check the AED's daily and is being monitored.
EC.02.05.01	9	Low Limited	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 Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . During the building tour the main Emergency Shut off was not labeled. This could create a hazard if the power needed to be shut off in an emergency situation and the staff did not know where the shut off was. This was verified by the Director of Plant Operations and a sign was made and placed on the shut off prior to the end of the survey.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
EC.02.06.01	26	Low Widespread	The organization keeps furnishings and equipment safe and in good repair.	1) Observed in Building Tour at Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . During the building tour, 2 of the bedrooms observed there was rust corrosion on the shower heads. This was confirmed by the Director of Plan Operations. Prior to the end of the survey the shower heads had been cleaned and new ones had been ordered.
MM.03.01.01	2	Low Pattern	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 Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . The medication refrigerators in the med room did not have documented temperature checks on weekends Another refrigerator that stored meds was only being checked sporadically. The organization has put in place a system to be able to monitor this more accurately prior to the end of the survey.
MM.03.01.01	4	Moderate Widespread	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 Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . During the tour of the medication room on the lower level, it was observed the controlled medications did not have two signatures logged for counting the meds to avoid diversion. The DON confirmed this observation.
NPSG.07.01.01	2	Moderate Widespread	Set goals for improving compliance with hand hygiene guidelines. Note: This element of performance applies only to organizations that provide physical care. (See also IC.03.01.01, EP 1)	1) Observed in Medication Management Tracer at Kids Behavioral Health of Utah Inc. [redacted]West Jordan, UT) site . During the observance of med pass on the lower level nurses station, the nurse doing the med passes did not implement hand hygiene during or between each student, this was validated 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 & Addendum Text
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 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.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 a 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

The Joint Commission

Standard	EP	Standard Text	EP & Addendum Text
			licensed practitioners (for example, registered nurses, licensed social workers) if permitted by state law and by the organization.
EC.02.03.03	5	The organization conducts fire drills.	The organization critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire.
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.02.05.01	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.
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.
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.
NPSG.07.01.01	2	Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the current World Health Organization (WHO) hand hygiene guidelines. Note: This standard applies only to organizations that provide physical care.	Set goals for improving compliance with hand hygiene guidelines. Note: This element of performance applies only to organizations that provide physical care. (See also IC.03.01.01, EP 1)

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

Kids Behavioral Health of Utah Inc
[redacted]
West Jordan, UT [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 3/9/2023

ESC Programs Reviewed
Behavioral Health Care and Human Services

Final Report: Posted 3/9/2023

The Joint Commission
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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	3/9/2023	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.03.01.03	Compliant
CTS.05.06.13	Compliant
EC.02.03.03	Compliant
EC.02.04.03	Compliant
EC.02.05.01	Compliant
EC.02.06.01	Compliant
MM.03.01.01	Compliant
NPSG.07.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

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UHS-FINHELP-00010014 [Redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT A recertification survey visit was conducted on March 24 through 25, 2021. The purpose of this visit was to determine compliance with the requirements of 42 CFR, Part 441.184, Subpart D Emergency Preparedness regulations for Medicare and Medicaid participating providers and suppliers. The Foundations Behavioral Health/Perseverance facility is in compliance with the requirements of 42 CFR, Part 441.184, Subpart D Emergency Preparedness regulations for Medicare and Medicaid participating providers and suppliers.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

CONFIDENTIAL UHS-FINHELP-00010014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0000	INITIAL COMMENT A recertification survey visit was conducted on March 24 through 25, 2021. The purpose of this visit was to determine compliance with the requirements of 42 CFR, Part 483, Subpart G regulations for Psychiatric Residential Treatment Facilities for residents under the age of 21. The census at the time of the visit was 13, and the sample consisted of six residents.	N 0000		
N 0145		N 0145		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	**03/25/2021**

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0145	Continued from page 1 483.358(f) ORDERS FOR USE OF RESTRAINT OR SECLUSION Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This REQUIREMENT is not met as evidenced by:	N 0145	1. Following the recertification validation audit for Perseverance Hall on 3/25/2021, Foundations Behavioral Health leadership team members met to review the findings, policy and standards and develop a plan of action specific to the Face to Face assessment requirements. The meeting was facilitated by the Director of Compliance and in collaboration with the facility Interim CEO. In order to assure ongoing compliance with face to face assessments, data will continue to be reviewed bi-weekly during Executive Leadership Meeting, led by the CEO and Hospital Administrator. 2. Training on the elements of restrictive interventions in accordance with policy and standard was initiated on 3/26/2021 by RN Leadership Staff led by the Chief Nursing Officer. This training focused on elements of the Face to Face assessment completion requirements to be completed post intervention within 1 hour from	Completion Date: **04/09/2021** Status: **APPROVED** Date: **04/13/2021**

CONFIDENTIAL UHS-FINHELP-00010016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0145	Continued from page 2	N 0145	initiation of the restrictive intervention. Nursing Staff providing care within Perseverance Hall and within all other accredited PRTF programs within the facility, received in person instruction on these three elements, with training initiated on 3/26/2021 and will be completed on or before 4/13/2021. For those staff members that were not able to be trained due to unavailability, training will be required before their next worked shift. 3. Given the oversight and management required by the RN in restrictive interventions, a separate formal training was developed by RN leadership led by the Chief Nursing Officer, initiated on 4/5/2021 to be concluded on or before 4/13/2021 via HealthStream, the facility's web-based training portal. Training was specific to those RNs providing care within Perseverance Hall as well as within other accredited PRTF programs within the facility. Educational materials focused on face to face assessment completion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0145	Continued from page 3	N 0145	requirements to be completed post intervention within 1 hour from initiation of the restrictive intervention. For those RNs that were not able to complete the formal training due to unavailability, training will be required before their next worked shift. 4. Initiated on 3/26/2021, RN Supervisors, led by the Chief Nursing Officer, are now notified by unit RNs each time a restrictive intervention is initiated applicable to Perseverance Hall as well as all other PRTF programs within the facility. This live, real-time notification allows for supervisory support and oversight in properly completing the Face to Face assessment according to policy and standard. RN supervisory oversight remains current and ongoing. Deficiencies noted during this review process shall be brought to the attention of the Chief Nursing Officer for appropriate follow up, including disciplinary action as warranted. Information and data collected by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0145	Continued from page 4	N 0145	the RN Supervisors to the Chief Nursing Officers on face to face assessment documentation compliance will be collected, reviewed and analyzed monthly using an overall percentage of compliance. Data will be presented monthly to Performance Improvement and Medical Executive Committee and quarterly update to the Board of Governors. 5. As an additional measure of monitoring and sustainability, 100% of all restrictive interventions for Perseverance Hall and all PRTF facility programs for the next 3 months shall be reviewed by the facility compliance team, led by the Director of Compliance. Data points on compliance with the face to face assessment requirements. The use of data related to compliance with the Face to Face assessment requirements will be collected monthly using overall percent compliance and graphical depictions for trending and tracking purposes. Should sustainability in the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0145	Continued from page 5	N 0145	aforementioned areas of focus be above 90% compliance following 3 months of 100% reviews, consideration will be given to reduction in the sample size from 100% to 50%. Data will be presented monthly to Performance Improvement and Medical Executive Committee and quarterly update to the Board of Governors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0145	Continued from page 6 Based on a review of facility documents and interview with administrative staff, the facility failed to ensure that within one hour of the initiation of the emergency safety intervention a physician or other licensed practitioner trained in the use of emergency safety interventions (ESI) and permitted by the state and the facility to assess the physical and psychological well-being of residents, must conduct a face-to-face assessment of the physical and psychological well-being of the Resident. This practice is specific to Resident #1 and #3. Findings include: A review of the records for Resident #1 and #3 on 03/24/2021 and 03/25/2021 between 9:00 AM and 11:00 AM revealed the following; Resident #1 A review of the record of Resident #1 revealed that she had been restrained on 01/30/2021. This incident was documented on an restrictive	N 0145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0145	Continued from page 7 intervention order packet. This restrictive intervention order packet revealed that the ESI was initiated at 11:45 AM and discontinued at 12:00 PM. Continued review of this restrictive intervention order packet revealed that the one hour assessment of the physical and psychological well-being was conducted at 11:30 AM, 15 minutes prior to the start of this restraint. Resident #3 A review of the record of Resident #3 revealed that she had been restrained on 10/26/2020. This incident was documented on an restrictive intervention order packet. This restrictive intervention order packet revealed that the ESI was initiated at 5:32 PM and discontinued at 5:50 PM. Continued review of this restrictive intervention order packet revealed that the one hour assessment of the physical and psychological well-being was conducted at 6:15PM beyond the one hour assessment time period, from initiation of the restraint.	N 0145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0145	Continued from page 8 Interview with the Director of Compliance & Physician Relations on 03/25/2021 at approximately 10:00 AM confirmed the that the above mentioned one hour assessments were not conducted within one hours of the initiation of the restraint. either conducted before the restraint and/or conducted late.	N 0145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0145	Continued from page 9	N 0145		
N 0188		N 0188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	**03/25/2021**

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0188	Continued from page 10 483.370(a) POST INTERVENTION DEBRIEFINGS 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. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident ard staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion. This REQUIREMENT is not met as evidenced by:	N 0188	1. Following the recertification validation audit for Perseverance Hall on 3/25/2021, Foundations Behavioral Health leadership team members met to review the findings, policy and standards and develop a plan of action specific to patient debriefings. The meeting was facilitated by the Director of Compliance and in collaboration with the facility Interim CEO. In order to assure compliance with staff and patient debriefings, data will continue to be reviewed bi-weekly during Executive Leadership Meeting, led by the CEO and Hospital Administrator. 2. Training on the elements of restrictive interventions in accordance with policy and standard was initiated on 3/26/2021 by RN Leadership Staff led by the Chief Nursing Officer. This training included patient debriefing requirements including timeliness within 24 hours after the restraint episode, rather than during restraint episode. Mental Health Technicians	Completion Date: **04/09/2021** Status: **APPROVED** Date: **04/13/2021**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0188	Continued from page 11	N 0188	and Nursing staff members providing care within Perseverance Hall and within other accredited PRTF programs within the facility, received in person instruction on patient debriefing with training initiated on 3/26/2021 and will be completed on or before 4/13/2021. For those staff members that were not able to be trained due to unavailability, training will be required before their next worked shift. 3. Given the oversight and management required by the RN in restrictive interventions, a separate formal training was developed by RN leadership led by the Chief Nursing Officer, initiated on 4/5/2021 to be concluded on or before 4/13/2021 via HealthStream, the facility's web-based training portal. Training was specific to those RNs providing care within Perseverance Hall as well as within other accredited PRTF programs within the facility. Educational materials focused on policy and standard for patient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0188	Continued from page 12	N 0188	debriefing requirements including timeliness within 24 hours after the restraint episode, rather than during restraint episode. For those RNs that were not able to be trained due to unavailability, training will be required before their next worked shift. 4. Initiated on 3/26/2021, RN Supervisors, led by the Chief Nursing Officer, are now notified by unit RNs each time a restrictive intervention is initiated applicable to Perseverance Hall as well as all other PRTF programs within the facility. This live, real-time notification allows for supervisory support and oversight in properly completing the patient debriefing in accordance with policy and standard. Supervisory oversight remains current and ongoing. Deficiencies noted during this review process shall be brought to the attention of the Chief Nursing Officer for appropriate follow up, including disciplinary action as warranted. Information and data collected by the RN Supervisors to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0188	Continued from page 13	N 0188	the Chief Nursing Officers on compliance with patient debriefings will be collected, reviewed and analyzed monthly using an overall percentage of compliance. Data will be presented monthly to Performance Improvement and Medical Executive Committee and quarterly update to the Board of Governors. 5. As an additional measure of monitoring and sustainability, 100% of all restrictive interventions for Perseverance Hall and all PRTF facility programs for the next 3 months shall be reviewed by the facility compliance team, led by the Director of Compliance. The use of data specific to patient debriefing compliance will be collected monthly using overall percent compliance and graphical depictions for trending and tracking purposes. Should sustainability in patient debriefings be above 90% compliance following 3 months of 100% reviews, consideration will be given to reduction in the sample size from	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0188	Continued from page 14	N 0188	100% to 50%. Data will be presented monthly to Performance Improvement and Medical Executive Committee and quarterly update to the Board of Governors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0188	Continued from page 15 Based on record reviews and interview with administrative staff the facility failed to ensure that within 24 hours after the use of restraint, staff involved in an emergency safety intervention and the resident must have a face to face discussion. This practice is specific to Resident #1, and #5. Findings include: A review of the records for Resident #1 and #5 was completed on 03/24/2021, between 9:00 AM and 11:00 AM, and revealed the following: Resident #1 Resident #1 was restrained on 12/11/2020. This incident was documented on a restrictive intervention order packet which documents all aspects of an ESI. The restrictive intervention order packet indicates that the ESI was initiated at 7:00 PM and discontinued at 7:10 PM. The client debriefing listed all the staff involved in the ESI. However the debriefing occurred on 12/11/2020 at	N 0188		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
N 0188	Continued from page 16 7:00 PM, the exact time the ESI was initiated. Resident #1 was restrained on 1/22/2021. The restrictive intervention order packet indicates that the ESI was initiated at 5:45 PM and discontinued at 6:00 PM. The client debriefing listed all the staff involved in the ESI. However, the debriefing occurred on 1/22/2021 at 6:45 PM, the exact time the ESI was initiated. Resident #1 was restrained on 01/30/2021. This incident was documented on a restrictive intervention order packet which documents all aspects of an ESI. The restrictive intervention order packet indicates that the ESI was initiated at 11:45 AM and discontinued at 12:00 PM. The client debriefing listed all the staff involved in the ESI. However the debriefing occurred on 01/30/2021 at 11:30 AM, 15 minutes before the initiation of the restraint. Resident #5	N 0188		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0188	Continued from page 17 Resident #5 was restrained on 12/29/2020. This incident was documented on a restrictive order packet which documents all aspects of an ESI. The restrictive intervention order packet indicates that the ESI was initiated at 8:06 PM and discontinued at 8:11 PM. The client debriefing listed all the staff involved in the ESI. However, the debriefing occurred on 12/29/2020 at 8:07 PM, which was during the time Resident #5 was in the restraint. Interview with the Director of Compliance & Physician Relations on 03/25/2021, at approximately 10:30 AM, confirmed that per facility policy, the debriefings for Resident #1 and #5 should have occurred after the resident was released from the restraint, not before and/or during the restraint.	N 0188		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	[redacted]	A. BLDG: 00 B. WING:	03/25/2021

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOUNDATIONS BEHAVIORAL HEALTH - PERSEVERANCE STATE LICENSE NUMBER: [redacted]	[redacted] **DOYLESTOWN, PA** [redacted]

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N 0188	Continued from page 18	N 0188		

UHS-FINHELP-00010075 [Redacted]

New York State Office of Children and Family Services
Agency Name: Universal Health dba Foundations Behavioral Health **Report Date: 11/15/2022 Draft X Final**

Program Name: Universal Health Services of Doylestown, LLC dba Foundations Behavioral Health	**Review Dates**: 11/1/2022 – 11/2/2021 **Report Date**: 11/15/2022
OCFS Reviewers: [redacted] RRO [redacted] RRO [redacted] RRO	**Locations:** [redacted] Doylestown, PA [redacted] [redacted] Chalfont, PA [redacted] **Name of Agency:** Foundations Behavioral Health **Corporate Address:** [redacted] Doylestown, PA [redacted] **Programs:** • Adolescent Inpatient Psychiatric Acute Care • Autism Spectrum Disorders and Neurodevelopmental Inpatient Psychiatric Disorders • Intensive Behavioral Health Services • Residential Treatment Facility • LifeWorks Schools – ASD Academy, Diagnostic Program

	Level of Care: Institutional based, Psychiatric Residential Treatment Facility

Background:

The New York State Office of Children and Family Services (OCFS) is responsible for providing oversight and support to agencies providing foster care services to children and their families. As required by "Billy's Law" (Chapter 392 0f 2005), which called for increased oversight of out-of-state residential facilities, the New York State Office of Children and Family Service's Child Welfare and Community Services (CWCS) conducts periodic reviews of out of state agencies where New York State foster care youth are placed by Local Departments of Social Services (LDSS).

OCFS's analysis consisted of case file reviews of the New York LDSS youth currently in residential placement at Universal Health Services of Doylestown LLC dba Foundations Behavioral Health (FBH), and interviews with staff and residents. Of note, all NYS LDSS youth residing at FBH were either interviewed or an interview was attempted by OCFS staff. The following report represents OCFS findings of the desk review conducted for FBH.

Methodology:

Upon arrival at FBH, OCFS staff participated in an entrance conference with FBH administrators, [redacted], [redacted], and [redacted] During this time, OCFS staff were provided some general information about the residential programs operated by FBH. For the purpose of this review, residential programs at FBH with New York youth utilize a trauma informed, evidence-based intervention in an RTF setting. Agency administrative staff also provided OCFS with information on medical, educational, and psychological services available to youth that reside at FBH as well as the quality assurance and reporting procedures in place.

OCFS staff assessed practice at the residential program operated by FBH. OCFS concentrated the assessment on the following areas: *Safety Assessments, Risk Assessments, Stability of Placement& Level of Care (LOC) Assessment, Permanency Planning Goal (PPG) & Efforts to Achieve PPG,*

*Visiting with Parents/Discharge Resource & Siblings, Preserving Connections, Relationship of Child in Care with Parents, Needs and Services of Child and Parents/Discharge Resource, Child and Parents Involvement in Case Planning, Case Work Contacts (child and parents/discharge resource), Educational Needs, Physical Needs, Medical Needs, Mental Health Needs, Documentation, Policy and Procedure, Fire Safety and Statewide Information System Review for Accuracy (CONNECTIONS). A*ssociated with each area of review were a series of questions designed to identify strengths and overall comments. Information was gathered through interviews with youth and staff, and case record and CONNECTIONS reviews. The CONNECTIONS review was limited to one year (9/1/2021 – 9/30/2022). This was designated as the period- under-review (PUR).

Following the period of information gathering, the review teams presented and prioritized their findings through a phone conference report-out. During this process, agency administrative staff had the opportunity to listen to the information, ask clarifying questions, and participate in the identification of themes. The attached report summarizes the findings and themes.

Program Description:

Foundations Behavioral Health

Foundations Behavioral Health provides innovative and comprehensive behavioral, psychiatric, educational, and community services to children, adolescents and young adults diagnosed with an Autism Spectrum Diagnosis and/or Developmental Disability. As an Autism Spectrum Disorders Center for Excellence, they offer specialized care for ASD students who've struggled to find the kind of specialized care that will help them live their full potential. The Residential Treatment Program serves individuals with significant complex psychiatric and behavioral disorders.

Populations Served

FBH supports and provides services to children, youth, and young adults diagnosed with Emotional Disturbances, Autism Spectrum Disorder, Asperger, Pervasive Developmental Disorder, Learning Disabilities, Intellectual Disabilities.

Program Profile:

Capacity: Determination Hall- 12; Resiliency Hall -12
NYS LDSS youth reviewed: 1
Gender Served: male and female
Age Range Served: 12-21
Age at Admission: license for 8 years old but generally admit 12 years old
Staffing Ratio: 1:8

Case Review & Oversight Topics

Risk & Safety Assessment and Management

Identified Strengths:

Risk and safety assessments were conducted as required and concerns were not noted during the period under review. The staff interviewed reported feeling safe at Foundations Behavioral Health (FBH) and also reported that they believe the children are safe in the care of the staff at Foundations Behavioral Health. The safety of the children in the program was identified as one of the program strengths.

The youth was interviewed via video conference due to being in quarantine. The youth was engaged in conversation and noted that she felt safe in care. The youths' Behavioral and Safety Plans, as well as the NYS CONNECTIONS Safety and Risk documentation, reflected the youth to be safe in placement and the level of risk is appropriately managed and consistent with case circumstances.

Staff interviewed noted that the youth has a history of being extremely aggressive coupled with sexual harmful behaviors. Staff noted that they make every effort to ensure a restraint is the last measure used and is only conducted to ensure safety. The team noted that they attempt to process with the youth after incidents with focus on support. A behavior analyst regularly works with the youth for additional support and treatment.

Staff and supervisors debrief on the youth's behavior and any challenges prior to and following a work shift. Safety is assessed through direct contact with the youth and by the feedback from clinicians, direct care staff, and educational staffand during reviews of treatment plans and daily case briefing.

FBH does not have a no restraint policy. The focus youth has been in 34 restraints in the past six month. The NYS Justice Center received 6 reports regarding the youth, two of which have been designated abuse/neglect. One investigation remains open with the Justice Center, the investigation completed by FBH was extremely comprehensive and resulted in staff termination.

The youth reported understanding the reason for the restraints and did not report any related injuries. A de-escalation team at FBH utilizes a Crisis Intervention Model, handle with care to respond to youth in crisis and there is a post hold assessment process.

Improvement Opportunity:

No recommendations

Stability of Placement & LOC Assessment

Identified Strengths:

Based on the review of documentation and interviews with staff and youth, it was determined the focus youth remains stable in her placement. The youth has been in placement at FBH for more than 12 months. There are no changes in foster care placements, and the placements are in the best interests of the youth. It was noted by the [redacted] County that they would like to bring the youth back to NYS for placement at a specialized facility under OMH or OPWDD oversight (a referral has been made to Deveraux). This writer did note that an OPWDD assessment would be prudent. The county noted in an interview that the child is already deemed eligible.

Improvement Opportunity:

No recommendations

Permanency Planning Goal (PPG) & Efforts to Achieve PPG

Identified Strengths:

The appropriate Permanency Planning Goals (PPG) have been established for the focus youth. Interviews and case documentation show that the goal of APPLA is appropriate for the youth as the youth will need a long-term care facility under the OMH or OPWDD umbrella. Referrals have been made and the LDSS is awaiting a determination.

Improvement Opportunity:

No recommendation

Visiting with Parents/Discharge Resource & Siblings

Identified Strengths:

FBH made concerted efforts to facilitate frequent quality visits between the youth and family however distance and her mental health has been a great barrier for the mother. Mother is inconsistent in her attendance, phone contact, and follow through. The agency offers weekly family sessions, but the mother has been inconsistent with attendance. This writer attempted to contact mother multiple times but was unsuccessful. The child does have some contact with the sibling who resides with the mother, but this also remains a challenge and is minimal. It should be noted that FBH is making effort to ensure communication remains but there are barriers in place. There was an in person visit on 4/25/22 however, the visit did not go well as the mother struggled with rules of programming and became escalated.

Improvement Opportunity:

Work with [redacted] DSS in an effort to support visitation and increase contact with mother and brother.

Preserving Connections:

Identified Strengths:

Case documentation and interviews with staff reflected FBH made concerted efforts to promote and preserve the youth connections with the parent. FBH also creates and maintains the youth's other meaningful connections by gathering information from families regarding cultural norms, religious beliefs and dietary needs during the intake process. When circumstances permit, FBH preserve the continuity of relationships that the youths had before entry into care.

Improvement Opportunity:

No recommendations

Relationship of Child in Care with Parents:

Identified Strengths:
FBH makes concerted efforts to promote and support positive relationships between the youth and their parents. Clinical staff meet with youth individually on a weekly basis and facilitate weekly family sessions. The family sessions were mostly virtual and were inconsistent. Family therapy is a significant component of residential care.
Improvement Opportunity:
No recommendations

Needs and Services of Child and Parents/Discharge Resource:

Identified Strengths:
FBH makes concerted efforts to assess the needs of the youth and parents and provide services to achieve case goals. The information gathered contributes to a plan that addresses behavioral, education, medical, clinical, safety planning needs. Components of the youths' Master Treatment Plan is shared with the appropriate staff working directly with the individual youth. The NYS CONNECTIONS service plans are reviewed and revised every 6 months. FBH identified the appropriate needs and services that would promote the achievement of permanency. This writer did note an assessment for OPWDD services would be appropriate, when talking to the county it was determined the youth is eligible. The county did note that they had concerns about the length of time in care, but did not have a place for the youth to discharge to at this time.
Improvement Opportunity:
No recommendations

Child and Parents Involvement in Case Planning:

Identified Strengths:
FBH made concerted efforts to involve the youth in case planning as developmentally appropriate. The agency also made concerted efforts to involve the mother in the case, but it was noted that her involvement was sporadic.

Improvement Opportunity:

No recommendations

Case Work Contacts (child and parents/discharge resource):

Identified Strengths:

FBH maintains a very detailed record on the youth. Progress notes are well documented and completed daily. The county did note that they would like more frequent communication from the agency. In person caseworker visits were noted on quarterly basis 4/25/22, 6/29/22 and 8/30/22. The agency has also offered virtual visits in addition to the in-person visits.

Improvement Opportunity:

It was noted by the county that there has been issues with communication from FBH. The area of concern was around consents for medical care when the target youth went to the hospital. This writer did see a newly revised form to address said concern. It was also noted that the overall communication from FBH was not frequent enough.

Educational Needs:

Identified Strengths:

FBH offers a co-ed residential school, the LifeWorks schools. The focus youth is receiving educational services; however, school has been a challenge for the focus youth. Inconsistent attendance due to lack of engagement and behavioral concerns have been a theme throughout the past year. The youths IEP was recently updated.

Direct care staff accompany the youth to school and are available in the classroom to support the educators. The staff are kept informed of the youth's needs and support the youth in the activities of daily living. Vocational and Independent Living skills taught in school are reinforced by direct care staff and clinical staff. The agency continues to work with the focus youth on basic life skills as developmentally appropriate.

Improvement Opportunity: No recommendations

Physical Needs:

Identified Strengths: The focus youth was up to date on all exams having her last physical on 6/22/22, her last dental on 5/3/22 and her last vision exam on 7/19/22. Nursing is available 24/7 on the campus.
Improvement Opportunity: No recommendations

Mental Health Needs:

Identified Strengths:

FBH follows a Trauma Informed Model of Care. FBH has a Psychiatric hospital on campus with full complement of medical staff available to address short and long-term mental health crisis. All youth undergo a comprehensive formal clinical assessment at intake and are reevaluated throughout their time in care. A Mental Health Technician works 1:1 with assigned youth and there is daily communication between staff regarding theyouth's behavior. Clinical staff receive group supervision every 2 weeks, with a participation in seminars on clinical topics. FBH has a monthly multidisciplinary treatment team that develop individualized treatment plans for each youth in residence. The treatment plans reflect the youths' current needs and circumstances and include lifestyletraining. Youth are provided group and individual therapy as part of their residential services. Youth are prescribed medication for their mental health and is managed by medical staff. Medication logs were reviewed to ensure consistency in medication administration. Case documentation and staff interviews reflect the youths' mental health needs are being met. The Clinical staff and Mental Health Technicians interviewed had detailed knowledge of the youths' family challenges, progress, successes, and circumstances.

Improvement Opportunity:

No recommendations

Documentation:

Identified Strengths:

FBH staff maintain thorough, detailed up to date documentation. The review of Health and Safety Assessments, and Behavioral and SafetyPlans, reflected information was current and adjustments were made when necessary.

The documentation in CONNECTIONS was reviewed to assess the appropriateness of timely, concise, and accurate case notes as an adequate indicator of the resident's progress. Information regarding the youth and family was communicated by FBH staff to the LDSS Manager. The LDSS Manager entered the information in CONNECTIONS. Progress notes, as well as other NYS required documentation were reviewed during the period under review. The FASP was noted to be late, but documentation was sent to the LDSS in a timely manner.

Improvement Opportunity:

The FASP on the focus youth needs to be completed. (LDSS)

Policy and Procedures:

Identified Strengths:

There have been no content changes made to the policies around restraints, incident reporting, investigations of abuse or significant incidents, and staff training since the last desk review in 2021. The agency is not a Qualified Residential Treatment Program. FBH's policies and procedures continue to be comprehensive, clear and concise. An organizational chart was provided and reviewed. Policies also include internal reporting system related to incidents and therapeutic holds that led up to, during and debriefing after. FBH continue to utilize the Handle with Care Crisis Intervention and Prevention Model. Direct care staff receive Handle with Care Crisis Intervention Model training every 6 months, and First Aid/CPR every 2 years. The staff continue to participate in annual training on, Health and Safety, CPS Mandated Reporting, and other Trauma Informed Model of Care topics relevant to their assigned tasks. Clinical training also supports the maintenance of their clinical licenses and certificates. FBH has a formal policy regarding cases involving children that are absence without consent. The crisis unit works with youth who are out of program/AWOC. The FBH medical staff continue to store the medication and manage the administration of the medication. FBH's patient and family handbook had not changed. It provides comprehensive information on programming, visiting policy, expectations, patient rights, as well as detail guidance on grievance procedures. Staff interviewed described a concern regarding high Direct Care and clinical employee turnover. This was not an observation shared by all staff interviewed. FBH is in compliance with all PA licensing as evident by their active license and their most recent relicensing survey.

Improvement Opportunity:

No recommendations

Fire Safety:

Identified Strengths:

1. Over all the buildings were found to be clean well maintained.
2. Central kitchen area was clean and well organized.
3. The exterior grounds and the exterior of the buildings were found to be well groomed and in good repair.
4. Required inspections of fire protection equipment, local fire inspectors/fire department reports, and heating systems, Health Department were all on file and reviewed, all documents were found to be completed and up to date.
5. A review of the fire drill logs indicated that fire drills are conducted each building.
6. Emergency disaster plans were reviewed they were noted to be very detailed and easy to navigate.
7. During the walkthrough of the grounds and buildings certain findings when it was possible were addressed within the same day or were completed prior to review ending.

Area of Improvements:

1. Add safety choking signs in areas where residents eat.
2. Label mechanical, sprinkler, and electrical doors.
3. Add signage to the cabinets or walls identifying the fire extinguisher's location areas.

Statewide Information System Review for Accuracy (CONNECTIONS):

Youth Identifying information was reviewed and is accurate.

Conclusion

The New York State Office of Children and Family Services would like to thank the FBH staff and the individuals you serve for the courtesy and cooperation given to us during the review. If you or any member of FBH agency staff have any questions, please do not hesitate to contact my office. We look forward to working with you as you continue to provide quality services to New York State's youth.

UHS-FINHELP-00010088 [Redacted]

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK
The Office of Special Education
Special Education Quality Assurance
Nondistrict Unit
[redacted] Albany, NY [redacted]
Tel: [redacted] Fax: [redacted]
www.p12.nysed.gov/specialed

[redacted] Peekskill, NY [redacted]
Tel: [redacted] Fax: [redacted]

July 5, 2019

Dr. [redacted]
Chief Executive Officer
Foundations Behavioral Health
[redacted]
Doylestown, PA [redacted]

Dear Dr. [redacted]

Enclosed is the status report for the 2017-18 school year Special Education Quality Assurance Comprehensive Residential Review with No CSE. The Foundations Behavioral Health has completed all corrective actions in the Compliance Assurance Plan, as indicated in the enclosed status report. As a result, all identified compliance issues are now resolved.

You may contact me at the above number if you have any questions.

Sincerely,

[redacted]
Regional Associate

Enclosure

c: [redacted]

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July 05, 2019 Compliance Assurance Plan Status Report
Foundations Behavioral Health Comprehensive Residential Review with No CSE 2017-18
Final Report Issued March 27, 2019

Citation	Required Corrective Action	Accepted Date
200.15(e)(3)	The School will develop written procedures for the supervision of employees and volunteers who have the potential for contact with students in residential care. Such procedures must include the method by which staff and volunteers will be made aware of the identity of all supervisors, including designated on-site supervisors.	07/05/2019
	Verification of Compliance	
	The RA will verify the School has written procedures which include the method by which staff and volunteers will be made aware of the identity of all supervisors, including designated on-site supervisors.	

Citation	Required Corrective Action	Accepted Date
200.15(e)(4)	The School will develop written procedures for the supervision of employees and volunteers who have the potential for contact with students in residential care. Such procedures must include a provision of written supervisory guidelines to employees and volunteers.	07/05/2019
	Verification of Compliance	
	The RA will verify the School has written procedures which include a provision of written supervisory guidelines to employees and volunteers.	

UHS-FINHELP-00010089

Appendix 104.

Citation	Required Corrective Action	Accepted Date
200.15(e)(5)	The School will develop written procedures for the supervision of employees and volunteers who have the potential for contact with students in residential care. Such procedures must include that there will be periodic observations by supervisors of employees and volunteers in interaction with students.	07/05/2019
	Verification of Compliance	
	The RA will verify the School has written procedures which include periodic observations by supervisors of employees and volunteers in interaction with students.	

Citation	Required Corrective Action	Accepted Date
200.15(e)(6)	The School will develop written procedures for the supervision of employees and volunteers who have the potential for contact with students in residential care. Such procedures shall include that there will be periodic supervisory conferences for employees and volunteers.	07/05/2019
	Verification of Compliance	
	The RA will verify the School has written procedures which include periodic supervisory conferences for employees and volunteers.	

Citation	Required Corrective Action	Accepted Date
200.15(f)(2)(iv)(b)	The School will develop written policies that supervisors will provide increased training and/or increased supervision to volunteers and staff pertinent to the prevention and remediation of abuse, neglect and significant incidents.	07/05/2019
	Verification of Compliance	
	The RA will verify written policies include supervisors will provide increased training and/or increased supervision to volunteers and staff pertinent to the prevention and remediation of abuse, neglect and significant incidents.	

Citation	Required Corrective Action	Accepted Date
200.15(f)(2)(iv)(c)	The School will develop written policies for temporary removal of the student(s) from a program and reassignment of the student(s) within the facility, as an emergency measure, if it is determined that there is a risk to the health or safety of such student(s) in remaining in that program. The policy must include that whenever a student is removed from a special education program or service specified in his or her individualized education program, such action shall be immediately reported to the commissioner or his designee and referred to the appropriate committee on special education for review.	07/05/2019
	Verification of Compliance	
	The RA will verify written policies include (1) temporary removal of the student(s) from a program and reassignment of the student(s) within the facility, as an emergency measure, if it is determined that there is a risk to the health or safety of such student(s) in remaining in that program, and (2) whenever a student is removed from a special education program or service specified in his or her individualized education program, such action shall be immediately reported to the commissioner or his designee and referred to the appropriate committee on special education for review.	

Citation	Required Corrective Action	Accepted Date
200.15(f)(2)(iv)(d)	The School will develop written policies for the provision of counseling to the student(s) involved in the report and any other students, as appropriate.	07/05/2019
	Verification of Compliance	
	The RA will verify written policies include the provision of counseling to the student(s) involved in the report and any other students, as appropriate.	

Citation	Required Corrective Action	Accepted Date
200.15(f)(3)(i)	The School will develop written policies that they will take appropriate action to support a request for information from the Justice Center, its representative or designee, and/or the State Education Department when such requests are made in accordance with law and regulation.	07/05/2019
	Verification of Compliance	
	The RA will verify written policies include the School will take appropriate action to support a request for information from the Justice Center, its representative or designee, and/or the State Education Department when such requests are made in accordance with law and regulation.	

Citation	Required Corrective Action	Accepted Date
200.15(j)(1)(i)	The school will submit a written plan to provide instruction to all students in techniques and procedures which will enable such students to advocate for and protect themselves from reportable incidents which shall be appropriate for the age, individual needs and particular circumstances of students.	07/05/2019
	Verification of Compliance	
	The RA will verify the written plan provides instruction to all students in techniques and procedures which will enable such students to advocate for and protect themselves from reportable incidents and is appropriate for the age, individual needs and particular circumstances of students.	

Citation	Required Corrective Action	Accepted Date
200.15(j)(1)(ii)	The school will submit a written plan to provide instruction to all students in techniques and procedures which will enable such students to advocate for and protect themselves from reportable incidents which shall be provided at different times throughout the year in a manner which will ensure that all students receive such instruction.	07/05/2019
	Verification of Compliance	
	The RA will verify the written plan provides instruction to all students in techniques and procedures which will enable such students to advocate for and protect themselves from reportable incidents and will be provided at different times throughout the year in a manner which will ensure that all students receive such instruction.	

Citation	Required Corrective Action	Accepted Date
200.22(b)(4)(i)	Foundations Behavioral Health (School) will submit revised BIPs for students 1, 2, 3, 4, 6, 13, 14, 15,16, 17, 18, 19, 20, 21, 22, 23, 24, which include the baseline measure of the problem behavior, including the frequency, duration, intensity and/or latency of the targeted behaviors. Such baseline should, to the extent practicable, include data taken across activities, settings, people and times of the day. The School will also submit revised BIPs for students 3 and 6, which include the duration or intensity of the targeted behaviors.	07/05/2019
	Verification of Compliance	
	The RA will verify that BIPs for students 1, 2, 3, 4, 6, 13, 14, 15,16, 17, 18, 19, 20, 21, 22, 23, 24 include the baseline measure of the problem behavior, including the frequency, duration, intensity and/or latency of the targeted behaviors, and, to the extent practicable, include data taken across activities, settings, people and times of the day. The RA will verify the BIPs for students 3 and 6 include the duration or intensity of the targeted behaviors.	

Citation	Required Corrective Action	Accepted Date
200.22(b)(4)(iii)	The School will submit revised BIPs for students (1, 2, 3, 4, 6, 8, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24), which must include a schedule to measure the effectiveness of the interventions, including frequency, duration and intensity of the targeted behaviors at scheduled intervals.	07/05/2019
	Verification of Compliance	
	The RA will ensure the BIPs for students (1, 2, 3, 4, 6, 8, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24) include a schedule to measure the effectiveness of the interventions, including frequency, duration and intensity of the targeted behaviors at scheduled intervals.	

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Citation	Required Corrective Action	Accepted Date
200.22(b)(5)	The School will submit BIPs for 19 NYS students (1, 2, 3, 4, 6, 8, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24) to include regular progress monitoring of the frequency, duration and intensity of the behavioral interventions at scheduled intervals, as specified in the behavioral intervention plan and on the student's IEP. The School will submit progress monitoring reports and evidence that the results of the progress monitoring have been documented and reported to the students' parents and to the CSEs.	07/05/2019
	Verification of Compliance	
	The RA will ensure the BIPs for 19 NYS students (1, 2, 3, 4, 6, 8, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24) include regular progress monitoring of the frequency, duration and intensity of the behavioral interventions at scheduled intervals, as specified in the behavioral intervention plan and on the student's IEP. The RA will verify the results of the progress monitoring have been documented and reported to the students' parents and to the CSEs.	

Citation	Required Corrective Action	Accepted Date
200.22(d)(4)	The School will revise its form to include whether or not a student has a BIP. The School will submit all completed emergency intervention forms for any NYS students for the time period of April, May and June, 2019 which will include a statement as to whether the student has a current behavioral intervention plan.	07/05/2019
	Verification of Compliance	
	The RA will verify that the School's revised emergency intervention form includes the missing required component of a statement as to whether the student has a current behavioral intervention plan.	

UHS-FINHELP-00010095

UHS-FINHELP-00010096 [Redacted]

NEW YORK STATE | **Office of Children and Family Services**

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Commissioner

January 16, 2020

[redacted]
Director of Compliance
Foundations Behavioral Health
[redacted]
Doylestown, PA [redacted]

Dear Ms. [redacted]

Enclosed please find the final report regarding the out-of-state agency review conducted by the New York State Office of Children and Family Services. The report reflects the findings identified by the review team.

It has been a pleasure to work with you and FBH staff during the onsite review process. We thank you for the courtesies shown to our staff during this time. Please contact me at [redacted] or [redacted] with any questions or if we can be of assistance.

Sincerely,

[redacted]
Executive Deputy Director, NYC Regional Office

Cc: [redacted] Associate Commissioner, OCFS
[redacted] Associate Commissioner, OCFS
[redacted] Director Regional Operations, OCFS

New York State Office of Children and Family Services
Agency Name: Universal Health dba Foundations Behavioral Health
Report Date: 1/16/2020

Program Name: **Universal Health Services of Doylestown, LLC dba Foundations Behavioral Health**	**Review Date:** **November 6, 2019** **Report Date:** **December 17, 2019**
OCFS Reviewers: [redacted] NYCRO [redacted] NYCRO [redacted] NYCRO [redacted] NYCRO	**Location:** [redacted] **Doylestown, PA** [redacted] [redacted] **Chalfont, PA** [redacted] **Name of Agency:** **Foundations Behavioral Health** **Corporate Address:** [redacted] **Doylestown, PA** [redacted] **Programs:** • Acute Psychiatric Hospital Program • Neurodevelopmental Acute Psychiatric Hospital Program • Psychiatric Residential Treatment Program • Foundations Intensive Residential Support & Treatment • Partial Hospitalization Program • Behavioral Health Rehabilitation Services Program

	• LifeWorks Schools – ASD Academy, Diagnostic Program
	Level of Care: Institution

Background:

The New York State Office of Children and Family Services (OCFS) is responsible for providing oversight and support to agencies providing foster care services to children and their families. As required by "Billy's Law" (Chapter 392 0f 2005), which called for increased oversight of out-of-state residential facilities, the New York State Office of Children and Family Service's Child Welfare and Community Services (CWCS) conducts periodic reviews of out of state agencies where New York State foster care youth are placed by Local Departments of Social Services (LDSS).

OCFS's analysis consisted of case file reviews of the New York LDSS youth currently in residential placement at Foundations Behavioral Health, on site observations, interviews with staff and residents. Of note, all LDSS youth residing at Foundations Behavioral Health (FBH) were either interviewed or observed and interacted with OCFS staff. The following report represents OCFS findings of the review conducted at Foundations Behavioral Health (FBH) Residential Treatment Program.

Methodology:

Upon arrival at FBH, OCFS staff participated in an entrance conference with [redacted] Assistant Hospital Administrator, [redacted] PsyD, Director of Residential Clinical Services, [redacted] Assistant Director of Compliance, [redacted] Chief Nursing Officer, [redacted] Director of Admissions, and [redacted] Executive Director of Education Services at the administration building. During this time, OCFS staff were provided some general information about the residential program(s) operated by FBH. For the purpose of this review, FBH residential program(s) are: Determination, Empowerment and Perseverance residences. Agency administrative staff also provided OCFS with information on medical, educational and psychological services available to youth that reside at FBH as well as the quality assurance and reporting procedures in place.

OCFS staff assessed practice at the programs operated by FBH. OCFS concentrated the assessment on the following areas: Services Assessment, Planning and Provision; Foster Care Visits-Frequency and Quality; Documentation; Safety and Quality of Daily Living, Frequency and Quality of Casework Contacts, Safety Assessments, Risk Assessments and Youth Well Being-Needs Assessed and Met. Associated with each area of review were a series of questions designed to identify strengths and overall comments. Information was gathered through interviews with youth, staff, direct observation of staff and youth, case record and CONNECTIONS reviews, and a physical plant walkthrough. The Connections review was limited to the 12 months immediately prior to dates of the on-site review. This was designated as the period-under-review (PUR).

Following the period of information gathering, the review teams presented and prioritized their findings through an exit conference report-out. During this process, agency administrative staff had the opportunity to listen to the information, ask clarifying questions, and participate in the identification of themes. The attached report summarizes the findings and themes.

Program Description:

Foundations Behavioral Health

Foundations Behavioral Health provides innovative behavioral health treatment and academic services to children, adolescents, and young adults diagnosed with an Autism Spectrum Diagnosis and/or Developmental Disability. Residential treatment serves individuals with significant complex psychiatric and behavioral disorders.

Populations Served
Autism Spectrum Disorder, Emotional Disturbance, Learning disabilities, Intellectual Disabilities, Multiple Disabilities

Program Profile:
Capacity: 62
NYS LDSS youth: 3
Gender Served: M/F
Age Range Served: 8 - 21
Age at Admission: 8 - 21
Staff/Pupil Ratio: Residential 1:8, Academic varies based on IEP

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Oversight Topics

Service Assessment, Planning, and Provision

Identified Strengths:

To determine whether necessary services were identified and provided to achieve case goals and adequately address the issues relevant to the Agency's involvement with the family.

- Pre-placement, intake representatives visit families in NY and obtain information from collaterals to assists in assessments and planning for the youth.
- At intake a comprehensive clinical assessment is completed, and assessments completed at regular intervals.
- Assessments of each youth are well documented and up to date.

Comments:

Record review identified extensive and thorough assessment of youth's history of placements, family dynamics, permanency goals, previously documented service needs and service provision. FBH schedules a pre-admission conference with parents for their perspective on the needs of their youth and district staff to map out planning responsibilities related to provision of services, residential stay and permanency reviews. Each youth's file contains information regarding any previous placements and pre-admission interview and assessment of the youth. Information gathered assists FBH in developing individual plans addressing behavioral, education, medical, clinical, safety planning and service needs.

Foster Care Visits-Frequency and Quality

Identified Strengths:

To determine whether concerted efforts have been made to make certain that visits between the child and his or her mother, father, siblings and alternative discharge resource are of sufficient frequency and quality to promote continuity in the child's relationship(s) and to facilitate permanency for the child.

- Foundations Behavioral Health encourages family engagement and its strength is in this area is accomplished by staying connected with family through ZOOM video conferencing, clinicians being available to families in providing cell phone numbers and providing once a month stay at local hotels for family visits.

- Monthly family therapy sessions and family team meetings are accessed through ZOOM platform.
- NYS LDSS provide transportation services for families and youth to facilitate visitation by directly transporting youth and families or arranging transportation.

Comments:

NYS districts, Oneida and Sullivan, have challenges related foster care visits.

Sullivan county should assess whether home visits would be possible to supplement the visits [redacted] family is able to make. There are issues with the mother's health and stability of the family's living situation that impact the frequency of visits.

Visits for the Oneida County youth is also impacted by the mother's health and her ability to tolerate the long-distance travel. The district is identifying possible therapeutic foster home in NY as recommended by FBH for a step down in [redacted]s placement. A closer placement to [redacted]s home would impact the frequency and quality of visitation.

Documentation

Identified Strengths:

To determine if the Agency has appropriately documented all case activities.

- Foundations Behavioral Health staff/clinicians maintain thorough, detailed up to date documentation. Behavioral plans are adjusted at team meetings when warranted, and when a meeting is convened after an incident.
- Educational assessments are documented in each youth's file and provided at regular intervals as required by individual IEPs.
- FBH staff follow a medical model which includes documenting observation rounds every 15 minutes during each shift.
- Policies that include internal reporting system related to incidents and therapeutic holds that led up to, during and debriefing after.
- Interdisciplinary meetings every Monday.
- Review of clinician case notes, casework/collateral contacts, communication with education, up to date assessments and incident reports with follow up
- Oneida county includes treatment plan updates from FBH in progress in Connections as well as detailed FASP and Permanency Hearing reports.

Comments:

FBH maintains detailed case notes of casework contacts in provision of services of the youth placed in their program. Onondaga and Sullivan counties provide little to no detail in Connections related to casework contacts. Much of the information will be a cursory sentence that a casework contact has occurred with no detail regarding progress in the treatment plan, safety and well-being of youth from their district. Both district staff visit youth on FBH's campus but provide little detail of the activities engaged in during visits.

Safety and Quality of Daily Living

Identified Strengths:

- Youth interviewed reported feeling safe at Foundations Behavioral Health. All were observed to be clean and appropriately dressed.
- Staff interviewed and those participating during the entrance conference report feeling safe in the program which is attributed to the organizational culture and comprehensive procedures, protocols and professional development. Although many staff roles are dictated by their experience and education there is an unspoken tenet that everyone is responsible for maintaining safety of the physical space as well as youth in their care and each other. A nurse and mental health technician (MHT) who were interviewed reported their commitment in working at FBH and the MHT of working additional shifts to maintain required staff coverage.
- All staff participate in on-going training in various topics that targets issues of safety and development and intellectual challenges of placed youth. Also, staff are trained in the nationally recognized program for verbal de-escalation and therapeutic holds, Handle with Care.
- FBH practices cultural responsiveness during intake as they gather information from families regarding cultural norms, religious beliefs and dietary needs. FBH also provides activities for youth related to their identified culture. A highlight of the year involves a passport activity where youth can experience food, art, and music by learning of different cultures by visiting through FBH passports.
- Psychiatric hospital on campus with full complement of medical staff available to address short and long-term mental health crisis. Nurses are available 24-7 for medication administration through a mobile unit and a nurse staffed at LifeWorks school.
- Pediatric services provided on campus all days of the week.
- Medications are sent to FBH form local pharmacy
- Contracted services for dental exams every 6-months and yearly vision care.
- Nursing staff arrange for appointments with specialist when needed.

- FBH provides training to local emergency services regarding children and what to expect from youth on the Autism Spectrum.
- Monthly meetings are held by the Safety Committee to discuss safety issues and concerns that lead to policy development. The committee is attended by director of plant operations, director of HR, director of nursing and nursing staff, senior and assistant hospital administrators, 2 outside community members, and FBH's CEO is invited.
- Treatment team meetings attended by treatment team that includes psychiatrist, physician, nurses and medication technicians.
- Motion sensors installed in bedrooms as an alert for when youth are moving around and/or leaving their bedrooms during the overnight hours.
- Extensive activities allowing for wrap-around programs in the community in fostering life skills.

Comments:

A review of the medication dispensing protocols, recreational activities, structure of the program, tour of the campus, off-site housing and interviews with youth and staff attest that the environment is safe and Foundations Behavioral Health provide a high quality of life for the youth in their care.

Frequency and Quality of Casework Contacts

Identified Strengths:

To determine whether concerted efforts have been made to maintain casework contacts of sufficient frequency and quality to address issues to achieve case goals as well as meeting minimal standards.

- Review of case files revealed numerous face-to-face contacts between youth and agency staff. Contacts by school staff (Board Certified Behavior Analyst), Mental Health Technicians (line staff) and clinicians are documented in case files. In addition, monthly telephone contacts between NYS caseworkers and Foundations Behavioral Health staff were documented.

Comments:

Notes in case records are up to date and detail frequency and quality of casework contacts.

There's an improvement opportunity for NYS district workers (Onondaga, Sullivan) in updating Connections in terms of timeliness and detailing case activities.

Safety Assessments

Identified Strengths:

To determine whether the Agency has adequately assessed and addressed the safety concerns relating to the child(ren) in their own homes or while in foster care.

- Safety assessments are completed and updated timely. FBH begins safety planning for each youth during intake by eliciting information from youth's family and previous placements.
- FBH utilizes a de-escalation team to respond to youth in crisis which also includes a debrief with youth and staff after each episode.
- Clinicians with input from direct line staff and educational staff revise behavioral plans (safety plans) tailored to the youth as needed.
- Review of CONNECTIONS notes, incident reports and safety plans

Comments:

Safety assessments were completed and updated as needed.

Risk Assessments

Identified Strengths:

To determine whether the agency made concerted efforts to assess and address the risk concerns relating to the child(ren) in their homes or while in foster care.

- According to case record reviews and review of Connections notes, risk assessment for each youth were appropriate and consistent with case circumstances.
- FBH continually assess risk during review of treatment plans and feedback from direct care and educational staff.

Comments:

An improvement opportunity exists for Onondaga and Sullivan counties in documenting participation in risk assessments, review of treatment plans and incident reports. There is little documentation in progress notes detailing treatment plans.

Youth Well-Being - Needs Assessed and Met

Identified Strengths:

To determine if the child in foster care is in an appropriate, quality and stable placement and that any changes in placement that occurred were in the best interest of the child and consistent with achieving the child's permanency goals.

- FBH provides any opportunities on campus and in the community for youth to participate in recreational activities as well as to practice life management skills.
- RTF unit, Empowerment House, located a short distance off campus that allows for greater community integration for those youth who achieve behavioral and safety criteria.
- FBH is successful in moderating youth's behaviors because of their programming where other placements have failed. Evidenced by reduced incidents for youth since intake. Placement of youth at FBH is appropriate and stable.
- FBH boasts less than 12% staff turnover. Stable caregivers positively impact well-being of the youth in their care.
- FBH provides housing for out-of-state families at a local hotel where they can stay with their child. An itinerary is developed for the family to engage in normalizing activities during their visit.

Comments:

Despite efforts made by FBH for visiting families, visitation for the NYS placed youth is limited.
[redacted]s parent wants to surrender her parental rights and has health issues that prevent her from visiting often. Concurrent goal of return to parent and adoption been established in the last year. Oneida county that placed [redacted] is evaluating a therapeutic foster home in NY upon FBH's recommendation for a placement step down.
[redacted]s parent has moved from New York to Florida to Texas and back to New York and her visits have reduced from twice a month to about once every 6-months.
None of the 3 youth, who have high needs, have alternate resources identified. The concern is for long-term stability should current goals disrupt.

Policy and Procedures

Identified Strengths:

- Medication management is handled by FBH's medical staff. Policies, procedures and logs observed during visit were safe and appropriate.
- Fire drill procedures were in accordance with observed documentation of drill times and drill locations.
- Incident reporting procedures are detailed and appropriate for the population.
- FBH utilizes Handle with Care crisis intervention and prevention model that includes use of de-escalation techniques and a therapeutic hold when de-escalation fails.
- FBH has a comprehensive training plan for staff the includes yearly training in their crisis intervention model, health and safety and other relevant topics.
- FBH's patient and family handbook provides comprehensive information on programming, visiting policy, expectations, patient rights, as well as detail guidance on grievance procedures.
- To assess and provide Agency policies for clarity and consistency.
- FBH has a clear policy describing missing/AWOL (elopement) procedures.

Comments: FBH's policies and procedures are comprehensive, clear and concise.

Physical Plant

Identified Strengths: To assess the interior and exterior grounds for any safety hazards. • OCFS conducted walkthroughs of two residence units, Determination, Empowerment and Perseverance residences. All three residence units were found to be clean, well maintained and in good repair. • OCFS staff observed the exterior grounds and the exterior of buildings to be well groomed without hazards. • The school building, Life Works, underwent a major project in the last few years and is bright, welcoming with state-of-the art equipment.
Comments: The walkthrough of the buildings and grounds showed the interior and exterior were in good repair without hazards. The Empowerment House is particularly well maintained with rooms decorated for youth's individuality and has a home-like atmosphere. FBH should consider providing carbon monoxide detectors on all levels of the residence halls as recommended by OCFS Fire Safety staff.

Conclusion

The New York State Office of Children and Family Services would like to thank FBH and FBH staff and the individuals you serve for the courtesy and cooperation to us during the review. If you or any member of FBH agency staff have any questions, please do not hesitate to contact my office. We look forward to working with you as you continue to provide quality services to New York State's youth.

UHS-FINHELP-00010163 [Redacted]

Foundations Behavioral Health				
Doc #	**Inspections**	**Date**	**Findings**	**Status of Corrective Action**
1	PA Bureau of Program Integrity	8/31/2022	Documentation of MCO and community involvement in meetings, physicians orders for therapeutic passes and departure/return date/time, diets need to be ordered every 30 days.	Completed
2	PA Dept of Health - Determination	4/7/2021	A resident is seen by a physician or other licensed practitioner within 1 hour of the initiation of the emergency safety intervention; Post intervention debriefings - 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 and documentation.	Completed
3	PA Dept of Health - Integrity	6/5/2019	Requires semiannual training for crisis management.	Completed
4	PA Dept of Health - Empowerment	4/9/2021	Survey not completed because building had no residents at the time.	N/A
5	PA Dept of Health - Empowerment	10/28/2021	No deficiences	N/A
6	PA Dept of Health - Perseverance	3/24/2021	A resident is seen by a physician or other licensed practitioner within 1 hour of the initiation of the emergency safety intervention; Post intervention debriefings - 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 and documentation.	Completed
7	PA Dept of Health - Resiliency	8/6/2021	Lack of reporting of serious occurences to both the State Medicaid agency and the state designated protection and advocacy system.	Completed
8	PA Dept of Human Services - OCYF	3/23/2022	Copies of the ISPs, revisions to the ISP and monthly documentation of progress shall be provided to the child if the child is over 14 years of age, the parent/guardian and, if applicable, the contracting agency and persons who participated in the development and revisions to the ISP.	Completed
9	PA Dept of Human Services - OCYF	3/7/2023	No deficiences. As of 5/31/23 surveyor was unable to provide final report due to surveyor system issues.	Completed
10	PA Dept of Human Services - OCYF	6/11/2019	Discontinued medication was not disposed.	Completed

11	PA Dept of Human Services - OCYF	6/19/2018	Grievance procedure was not posted in the facility. One in three children did not receive a dental examination semiannually. One in three children did not have a health and safety assessment completed/signed. One child was missing a signature of who administered a medication.	Completed
12	PA Dept of Human Services - OCYF	9/24/2020	No citations	N/A
13	PA Dept of Human Services - OCYF	4/22/2021	Each staff person will complete First Aid and CPR training at least every year.	Completed
14	The Joint Commission - Behavioral	9/3/2019	The organization: Screens all individuals served for physical pain, their nutritional status; identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation; Has a plan for care, treatment, or services; Maintains fire safety equipment and fire safety building features; Manages risks associated with its utility systems; Provides and maintains fire alarm systems; Provides and maintains systems for extinguishing fires; Safely prepares medications for administration; reduce the risk for suicide.	Completed
15	The Joint Commission - Behavioral	8/17/2022	The organization: identifies individuals who may have experianced trauma, abuse, neglect, or explotation; Has a plan for care, threatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served; Has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served; Provides and maintains systems fir extingishing fires, Reduce the risk for suicide.	Completed
16	Maryland DHS	1/8/2018	No deficiences	N/A
17	Maryland DHS	4/9/2018	No deficiences	N/A
18	Maryland DHS	4/24/2020	No deficiences	N/A
19	NY State OCFS	11/1/2022	No citations, suggestions made as part of report without required follow up.	N/A
20	OSHA	5/11/2021	No deficiences in final report.	N/A

21	NY Board of Education	7/11/2019	The school will develop written procedures for the supervision of employees and volunteers who have the potential for contact with students in residential care. School will develop written procedures for the supervision of employees and volunteers who have potential for contact with students in residential care. Supervisors must provide increased training /supervision to prevent remediation of abuse, neglect, and significant incidents. School will develop written policies for temporary removal or the student from a program and reassignment of the student as an emergency measure. School will developwritten policie for the provision of counseling to students involved in the report. The school will develope written policies that they will take appropriate action to support a request for information from the Justice Center or State Education when requests are made in accordance with the law. School will submit a written plan to provide instruction to all students in techniques and procedures which enable students to advocate and protect themselves from reportable incidents. The school will submit revised BIPs for students to include frequency, duration, intensity, and latency of the targeted behaviors. Revised BIPs should also include a schedule to measure the effectiveness of the interventions. BIPs schould include regular progress monitoring of frequency, duration, and intensity of behavioral interventions at scheduled intervals. The school will revise its form to include whether or not a student has a BIP.	Completed
22	NY OCYF	11/1/2022	No deficiences	Completed
23	NY OCFS	11/6/2019	No citations	Completed
24	NY OCFS	10/20/2020	No citations	Completed
25	PA OMHSAS	3/30/2023	No deficiencies. Reported they would not provide a final report.	N/A

UHS-FINHELP-00010166 [Redacted]

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Final Accreditation Report

UHS of Doylestown, LLC
[redacted]
Doylestown, PA [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 8/15/2022 - 8/17/2022

Programs Surveyed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 8/19/2022

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	08/15/2022 - 08/17/2022	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
Behavioral Health Care and Human Services	08/16/2022 - 08/17/2022	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

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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.02.02.05	3	Moderate / Pattern	✓
CTS.03.01.03	1	Low / Pattern	✓
	2	Low / Pattern	✓
LS.02.01.35	5	Low / Limited	✓
NPSG.15.01.01	3	High / Limited	✓
	4	High / Limited	✓
	5	Moderate / Limited	✓

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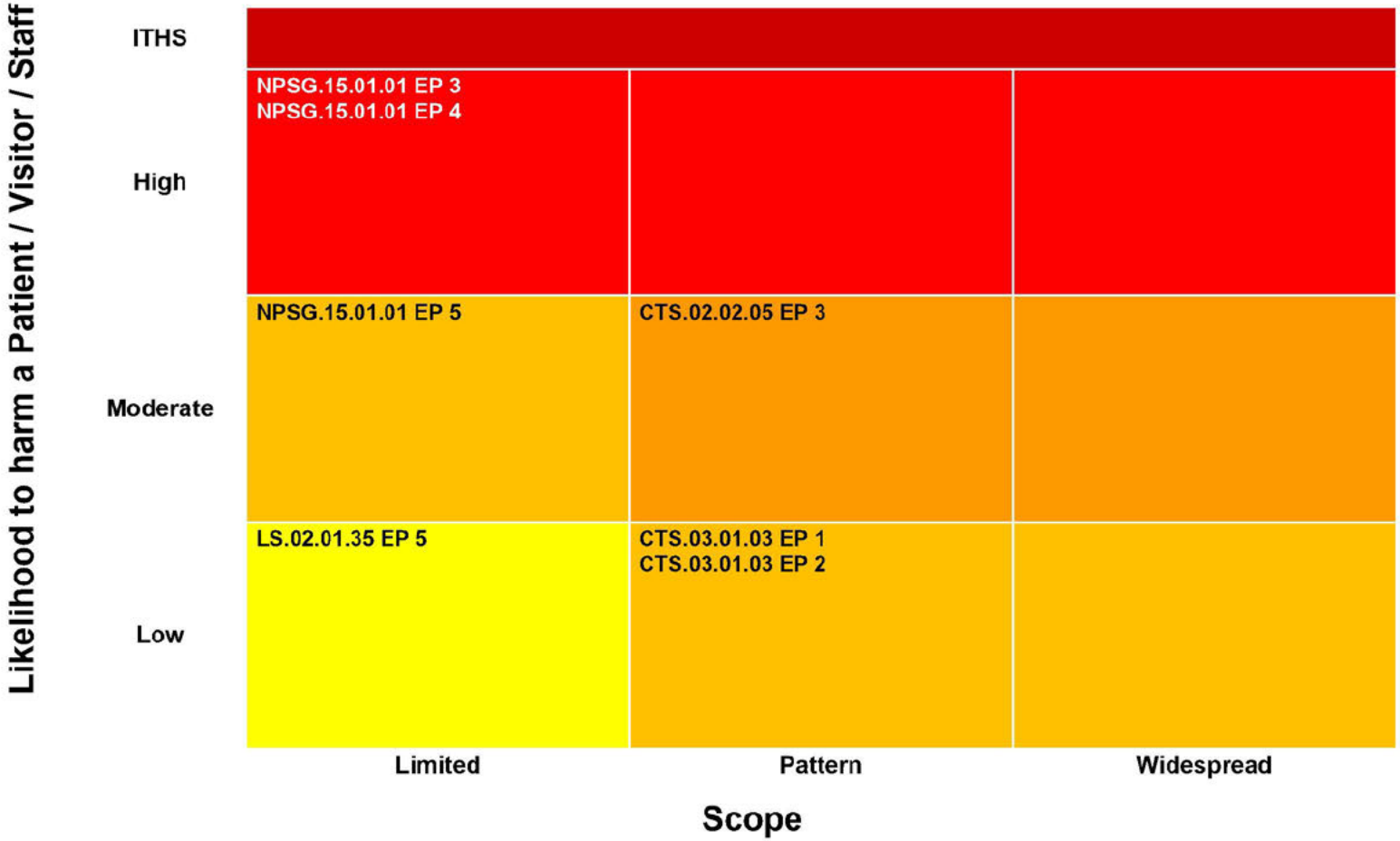
SAFER™ Matrix
Program: Behavioral Health Care and Human Services



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Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.02.05	3	Moderate Pattern	The organization assesses the individual who may have experienced trauma, abuse, neglect, or exploitation or refers the individual for such assessment.	1) Observed in Individual Tracer at UHS of Doylestown, LLC ([redacted] PA) site . In 2 out of 2 patient records reviewed who had experienced trauma, abuse and/or neglect, there was no trauma assessment completed or a referral for such an assessment. There as no process in place to conduct a trauma assessment or to provide a referral for a trauma assessment. This was confirmed by the Director of Clinical Services.
CTS.03.01.03	1	Low Pattern	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 UHS of Doylestown, LLC ([redacted] PA) site . In 2 out of 2 client records reviewed, all of the assessed needs and goals of the patient were not included in the treatment plan, deferred or referred out to another provider. For example, in 2 records reviewed with reported trauma and/or neglect, trauma and neglect were not included in the treatment plan, deferred or referred out to another provider. This was confirmed by the Director of Clinical Services.
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 UHS of Doylestown, LLC ([redacted] PA) site . In 2 out of 2 patient records reviewed, the goals on the treatment plan were not in the patient's own words or in words that represent the patient. For example, goals included "Controlling anger" and "Independent living skills". This was confirmed by the Director of Clinical Services.

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Standard	EP	SAFER™ Placement	EP Text	Observation
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 UHS of Doylestown, LLC ([redacted] PA) site . In the Empowerment residential home, there was a sprinkler, including the escutcheon plate that had rust on it. The entire sprinkler was replaced onsite during the survey. 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
NPSG.15.01.01	3	High Limited	Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.	1) Observed in Individual Tracer at UHS of Doylestown LLC ([redacted] Doylestown, PA) site . In one residential patient record reviewed who had a positive suicide risk screening using the Columbia C-SSRS Recent Screener version, there was no suicide risk assessment conducted. The screener used included plan and intent, however there was no information obtained about risk factors, self-harm behaviors and protective factors. In the screener, the patient reported having a current plan with intent. This was confirmed by the Director of Clinical Services.
NPSG.15.01.01	4	High Limited	Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.	1) Observed in Individual Tracer at UHS of Doylestown LLC ([redacted] Doylestown, PA) site . In one residential patient record reviewed, the overall level of suicide risk was not documented. It was documented that the patient had "increased risk" for suicide and therefore was placed on suicide precautions, including 15 minute checks, placed in a paper scrubs and daily suicide risk screening was to be conducted. The screener reported current suicidal ideation with a plan and intent, however the patient was not placed on a 1:1. This was confirmed by the Director of Clinical Services and the Director of Nursing.
NPSG.15.01.01	5	Moderate 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 UHS of Doylestown LLC ([redacted] Doylestown, PA) site . The suicide risk policy entitled "Assessment of Suicide and Suicide Risk Management-Residential" policyStat ID 12126374, effective 07/2022 did not address the monitoring of patients served who are at high risk for suicide, including placing anyone determined to be at high risk on a 1:1. The policy also did not include that if a patient screens positive for suicide risk, then a suicide risk assessment is completed. This was confirmed by the Director of Clinical Services.

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Redacted

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP & Addendum Text
CTS.02.02.05	3	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation.	The organization assesses the individual who may have experienced trauma, abuse, neglect, or exploitation or refers the individual for such assessment.
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

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Standard	EP	Standard Text	EP & Addendum Text
			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.
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)
NPSG.15.01.01	3	Reduce the risk for suicide.	Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.
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.
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

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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.

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Final Accreditation Report

UHS of Doylestown, LLC
[redacted]
Doylestown, PA [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 10/18/2022

ESC Programs Reviewed
Hospital
Behavioral Health Care and Human Services

Final Report: Posted 10/24/2022

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Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	10/18/2022	No Requirements for Improvement	None	None
Behavioral Health Care and Human Services	10/18/2022	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.03.01.03	Compliant
LS.02.01.35	Compliant
NPSG.15.01.01	Compliant

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Redacted

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP & Addendum Text
CTS.02.02.05	3	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation.	The organization assesses the individual who may have experienced trauma, abuse, neglect, or exploitation or refers the individual for such assessment.
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

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Standard	EP	Standard Text	EP & Addendum Text
			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.
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)
NPSG.15.01.01	3	Reduce the risk for suicide.	Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.
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.
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

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-00010185 [Redacted]



Final Accreditation Report

UHS of Doylestown, LLC
[redacted]
Doylestown, PA [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 11/20/2019

ESC Programs Reviewed
Hospital
Behavioral Health

Final Report: Posted 11/27/2019

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Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	11/20/2019	No Requirements for Improvement	None	None
Behavioral Health	11/20/2019	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.01.09	Compliant
CTS.02.01.11	Compliant
CTS.02.02.05	Compliant
CTS.03.01.03	Compliant
EC.02.03.05	Compliant
EC.02.05.01	Compliant
LS.02.01.34	Compliant
LS.02.01.35	Compliant
MM.05.01.07	Compliant
NPSG.15.01.01	Compliant

The Joint Commission

Redacted

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.01.09	1	The organization screens all individuals served for physical pain.	The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)
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.03.01.03	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, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01)

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Standard	EP	Standard Text	EP Text
			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.
EC.02.03.05	15	The organization maintains fire safety equipment and fire safety building features. Note: This standard does not require organizations to have the types of fire safety equipment and building features described in the elements of performance of this standard. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.
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.
LS.02.01.34	9	The organization provides and maintains fire alarm systems. 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.	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)
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.	Sprinkler heads 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.05.01.07	2	The organization safely prepares medications for administration. Note: This standard is applicable only to organizations that prepare medications for administration.	For organizations that prepare medications for administration: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for medication preparation. Note: Sterile technique (also called aseptic technique) refers to practices

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Standard	EP	Standard Text	EP Text
			that are designed to minimize exposure to germs and maintain sterility of the medication through the use of "no touch" procedures; the use of sterile gloves, supplies, and instruments (for example, needles and syringes); and the use of a sterile field. In contrast, clean technique refers to practices designed to reduce exposure to germs, and include the use of hand washing, clean instruments, and a clean environment. Clean technique does not require the use of sterile technique or sterile supplies. The technique used for medication preparation depends on the need for sterility (for example, intravenous solutions) versus cleanliness (for example, oral products).
NPSG.15.01.01	2	Reduce the risk for suicide.	Screen all individuals served for suicidal ideation using a validated screening tool.



Final Accreditation Report

UHS of Doylestown, LLC
[redacted]
Doylestown, PA [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 9/4/2019 - 9/6/2019

Programs Surveyed
Hospital
Behavioral Health

Final Report: Posted 9/12/2019

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	09/04/2019 - 09/06/2019	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	09/04/2019 - 09/05/2019	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.02.01.09	1	Low / Pattern	✓
CTS.02.01.11	1	Low / Widespread	✓
CTS.02.02.05	2	Low / Pattern	✓
CTS.03.01.03	2	Low / Pattern	✓
EC.02.03.05	15	Low / Limited	✓
EC.02.05.01	9	Low / Pattern	✓
LS.02.01.34	9	Low / Limited	✓
LS.02.01.35	5	Low / Limited	✓
MM.05.01.07	2	Low / Pattern	✓
NPSG.15.01.01	2	Moderate / Pattern	✓

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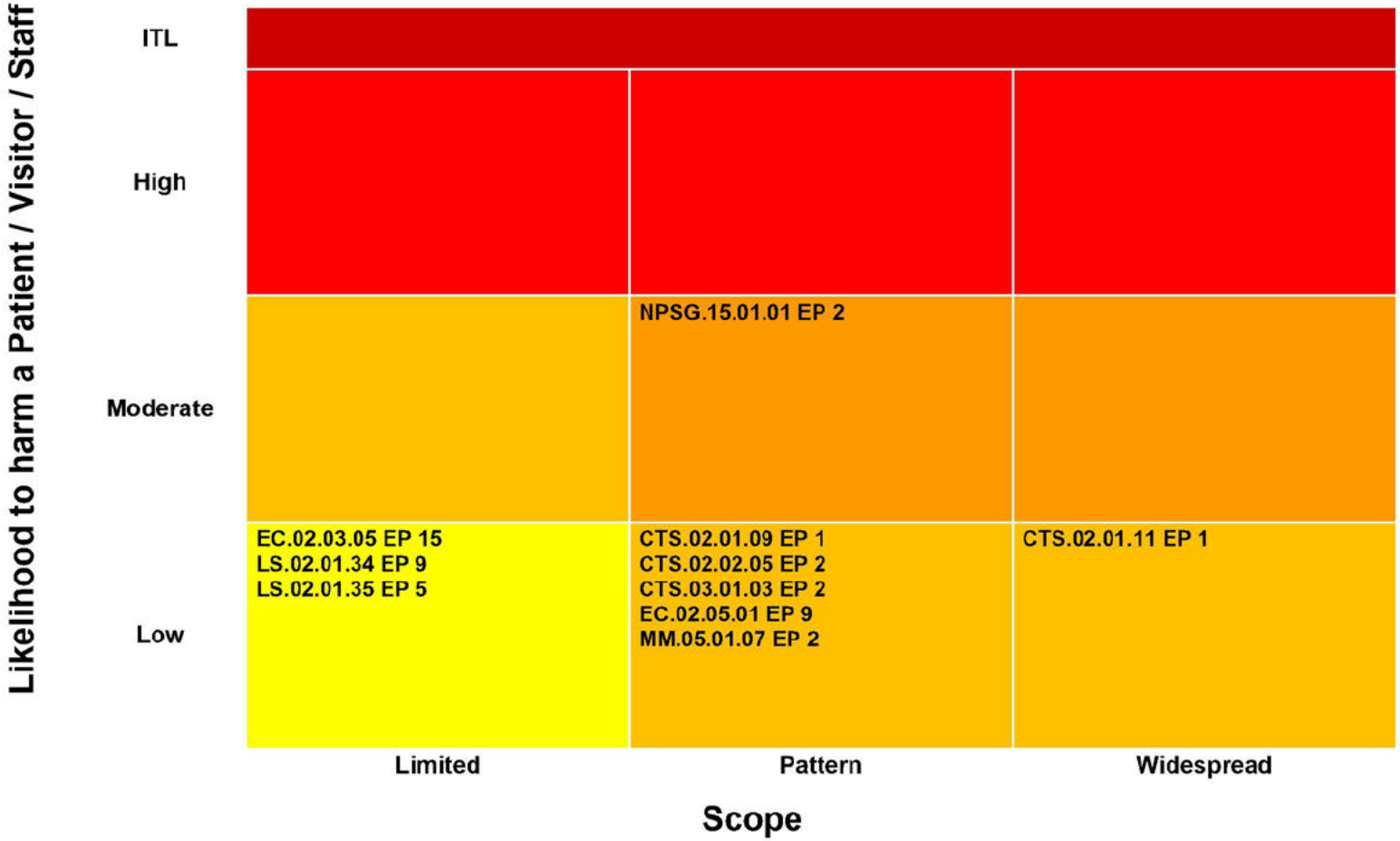
SAFER™ Matrix
Program: Behavioral Health



The Joint Commission
Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.09	1	Low Pattern	The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)	1). Observed in Individual Tracer at UHS of Doylestown LLC [redacted] Doylestown, PA) site . The assessment completed for the WRAP program does not include a screen for physical pain.
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 UHS of Doylestown LLC [redacted] Doylestown, PA) site . The nutrition screen observed in the Residential Program tracers asks about weight loss of ten pounds or more in the last three months and not weight gain.
				2). Observed in Individual Tracer at UHS of Doylestown LLC [redacted] Doylestown, PA) site . The assessment completed for the WRAP program does not include a screen of the individual's nutrition status.
CTS.02.02.05	2	Low Pattern	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 UHS of Doylestown LLC [redacted] Doylestown, PA) site . The assessment completed for the WRAP program includes a section where the Psychologist generally addresses the individual's history of trauma. It does not specifically identify individuals served who may have experienced abuse, neglect or exploitation.
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, 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,	1). Observed in Individual Tracer at UHS of Doylestown LLC [redacted] Doylestown, PA) site . The care plan goals reviewed during the WRAP program tracer were written as clinical formulations and did not capture the words and ideas of the individual served.

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Standard	EP		EP Text	Observation
			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.	
EC.02.03.05	15	Low Limited	At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.	1). Observed in Building Tour at UHS of Doylestown LLC [redacted] Doylestown, PA) site . During the building tour of the Integrity House residential program it was observed that the portable fire extinguisher in the kitchen had not been inspected in August. .
EC.02.05.01	9	Low Pattern	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 Competency Session at UHS of Doylestown LLC [redacted] PA) site . The electrical panels at the Empowerment Residential program were not fully labeled to enable a partial shut down.
LS.02.01.34	9	Low Limited	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)	1). Observed in Building Tour at UHS of Doylestown LLC [redacted] PA) site . In Bedroom #1 at the Empowerment Residential program a half inch opening around a pipe leading into the ceiling tile was observed.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
LS.02.01.35	5	Low Limited	Sprinkler heads 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 UHS of Doylestown LLC [redacted] PA) site . In Bedroom #1 at the Empowerment Residential program, the sprinkler escucheon plate was observed to have some corroding and a gap between it and the ceiling tile. The plate was not flush with the ceiling tile.This

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Standard	EP		EP Text	Observation
				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.05.01.07	2	Low Pattern	For organizations that prepare medications for administration: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for medication preparation. Note: Sterile technique (also called aseptic technique) refers to practices that are designed to minimize exposure to germs and maintain sterility of the medication through the use of "no touch" procedures; the use of sterile gloves, supplies, and instruments (for example, needles and syringes); and the use of a sterile field. In contrast, clean technique refers to practices designed to reduce exposure to germs, and include the use of hand washing, clean instruments, and a clean environment. Clean technique does not require the use of sterile technique or sterile supplies. The technique used for medication preparation depends on the need for sterility (for example, intravenous solutions) versus cleanliness (for example, oral products).	1). Observed in Medication Management Tracer at UHS of Doylestown LLC [redacted] Doylestown, PA) site . The medication passes observed for residential clients were conducted in the school nurse's office on a cabinet that is not functionally separate from administrative functions.
NPSG.15.01.01	2	Moderate Pattern	Screen all individuals served for suicidal ideation using a validated screening tool.	1). Observed in Individual Tracer at UHS of Doylestown LLC [redacted] Doylestown, PA) site . The WRAP program assesses for suicidal ideation within the mental status exam done at admission but does not use a validated screening tool.

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Redacted

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.01.09	1	The organization screens all individuals served for physical pain.	The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)
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.03.01.03	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, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01)

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Standard	EP	Standard Text	EP Text
			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.
EC.02.03.05	15	The organization maintains fire safety equipment and fire safety building features. Note: This standard does not require organizations to have the types of fire safety equipment and building features described in the elements of performance of this standard. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.
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.
LS.02.01.34	9	The organization provides and maintains fire alarm systems. 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.	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)
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.	Sprinkler heads 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.05.01.07	2	The organization safely prepares medications for administration. Note: This standard is applicable only to organizations that prepare medications for administration.	For organizations that prepare medications for administration: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for medication preparation. Note: Sterile technique (also called aseptic technique) refers to practices

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Standard	EP	Standard Text	EP Text
			that are designed to minimize exposure to germs and maintain sterility of the medication through the use of "no touch" procedures; the use of sterile gloves, supplies, and instruments (for example, needles and syringes); and the use of a sterile field. In contrast, clean technique refers to practices designed to reduce exposure to germs, and include the use of hand washing, clean instruments, and a clean environment. Clean technique does not require the use of sterile technique or sterile supplies. The technique used for medication preparation depends on the need for sterility (for example, intravenous solutions) versus cleanliness (for example, oral products).
NPSG.15.01.01	2	Reduce the risk for suicide.	Screen all individuals served for suicidal ideation using a validated screening tool.

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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.

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-00010213 [Redacted]

12VAC35-46-70
Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substances Abuse Services (12VAC5-115)

This regulations was not met as evidenced by:
See OHR citation

Action to be taken:
See responses provided by Harbor Point Behavioral Health Center in regards to the Office of Human Rights Citations below.

Compliance Date:
06-27-2022

12VAC35-115-50. C. (3a) – In services provided in residential and inpatient settings, each individual has the right to 3. Live in a humane, safe, sanitary environment that gives each individual, as a minimum: 3a. Reasonable privacy and private storage space.

This regulation was not met as evidenced by:
An unannounced visit was complete to this provider where several Human Rights violations were noted such as clogged toilets, vents that were covered with heavy dust, mold on shower curtains, uncleaned bathroom, hole in a wall, peeling paint, bread that had expired and soap scum build-up.

Providers Response/Corrective Action Taken:
On March 15, 2022, the Director of Plant Operations ordered eleven patient room doors from Beach Door, five of which were broken by a resident during one incident. When ordering, the Director of Plant Operations ordered additional doors to maintain in inventory for future replacement needs. The Director of Plant Operations received notice from Beach Door, noting delay in shipment on May 17, 2022. Again, on June 9, 2022, the Director of Plant Operations was notified by Beach Door in a delay in shipment. The patient room doors were delivered to Harbor Point Behavioral Health Center on June 16, 2022, beginning installation on June 17, 2022. Installation is expected to be complete on or before June 27, 2022. On March 25, 2022, the Associate Administrator, in conjunction with the Program Managers, reassigned patient rooms to ensure each resident was assigned to a room with a working patient room door.

Person Responsible:
Director of Plant Operations

Monitoring System:
The Director of Plant Operations maintains oversight of facility work orders, noting damages in patient room doors and/or patient bathroom doors that would interfere with the patient's right to reasonable privacy and private storage space. The Director of Plant Operations creates the work schedule for the maintenance department, elevating the door replacement to top priority for completion. The Director of Plant Operations maintains inventory of replacement doors and orders monthly to maintain stock of doors for immediate replacement. The Director of Plant Operation will notify the Associate Administrator of an inability to replace doors. The Associate Administrator, in conjunction with the Program Managers, will

reassign the patient to a room with workable doors. All work orders, to include damage to doors and replacement of doors, is reported monthly to the Environment of Care Committee, to include date of damage and date of repair.

The Director of Plant Operations maintains oversight of facility work orders, including damage to structure such as holes in the wall, peeling paint, etc. The Director of Plant Operations creates the work schedule for the maintenance department, assigning maintenance staff to repair damages in order of severity. All work orders, to include damage to facility structure, is reported monthly to the Environment of Care Committee, noting date of damage and date of repair.

Compliance Date:
06-27-2022

12VAC35-115-50. C. (3b) – In services provided in residential and inpatient settings, each individual has the right to 3. Live in a humane, safe, sanitary environment that gives each individual, as a minimum: 3b. An adequate number of private operating toilets, skinks, showers, and tubs that are designed to accommodate individuals' physical needs.

This regulation was not met as evidenced by:
An unannounced visit was complete to this provider where several Human Rights violations were noted such as clogged toilets, vents that were covered with heavy dust, mold on shower curtains, uncleaned bathroom, hole in a wall, peeling paint, bread that had expired and soap scum build-up.

Providers Response/Corrective Action Taken:
On March 25, 2022, Housekeeping Staff, with oversight from the Director of Plant Operations and the Environmental Services Manager, completed a deep clean of all patient bathrooms and community bathrooms, focusing on those identified as having mold, soap-scum build-up and concerns with overall cleanliness. On March 25, 2022, the Director of Plant Operations contacted Jani-King, cleaning company, who arrived to the facility on the same date, conducting an assessment, providing a verbal response that the areas identified were residue and soap scum build-up, not mold. The Director of Plant Operations is developing a contract for annual cleaning for possible mold and soap scum build-up. Harbor Point Behavioral Health Center utilizes a hospital grade, high-pressure steam spray cleaning system to disinfect and sanitize all surfaces of patient bathrooms and community bathrooms on a monthly basis, in addition to daily chemical cleaning of patient bathrooms and community bathrooms. The Director of Plant Operations will secure an external vendor to disinfect patient bathrooms and community bathrooms, focusing on mold and soap scum build-up, on a bi-annual basis.

Person Responsible:
Director of Plant Operations
Environmental Services Manager

Monitoring System:

The Environmental Services Manager maintains oversight of the daily and monthly cleaning schedule, including but not limited to mold in the bathrooms and/or shower curtains, soap scum build-up, and overall cleanliness. The Environmental Services Manager develops the facility cleaning assignments,

maintaining oversight of completion and conducting fidelity checks for compliance of the Housekeeping staff.

The Director of Plant Operations maintains oversight of facility work orders, including but not limited to clogged toilets. The Director of Plant Operations creates the work schedule for the maintenance department, assigning maintenance staff to repair damages in order of severity. All work orders, to include clogged toilets, as well as, daily, monthly and bi-annual cleaning compliance is reported monthly to the Environment of Care Committee, noting date of facility damage, date of repair and facility cleaning compliance.

Compliance Date:
06-27-2022

12VAC35-115-50. C. (3e) – In services provided in residential and inpatient settings, each individual has the right to 3. Live in a humane, safe, sanitary environment that gives each individual, as a minimum: 3e. Clean air, free of bad odors.

This regulation was not met as evidenced by:
An unannounced visit was complete to this provider where several Human Rights violations were noted such as clogged toilets, vents that were covered with heavy dust, mold on shower curtains, uncleaned bathroom, hole in a wall, peeling paint, bread that had expired and soap scum build-up.

Providers Response/Corrective Action Taken:
Following the Office of Human Rights unannounced visit, the Director of Plant Operations ordered a vacuum specifically designed to clean vents. On April 21, 2022, Maintenance Staff, with oversight from the Director of Plant Operations, began a deep clean of facility vents, removing heavy dust accumulated from the return registers. The Director of Plant Operations implemented a quarterly vent cleaning schedule to clean and remove heavy dust. In addition, Housekeeping Staff maintains daily oversight of vents, immediately notifying Maintenance Staff if heavy dust build-up is observed, allowing for the cleaning of the vent, permitting quality air circulation.

Person Responsible:
Director of Plant Operations
Environmental Services Manager

Monitoring System:
The Director of Plant Operations maintains oversight of facility work orders and schedules, ensuring quarterly completion of facility vents, removing heavy dust accumulated from the return registers, permitting clean air and removal of bad odors. All routine orders, to include cleaning vents, is reported monthly to the Environment of Care Committee, noting date of damage and date of repair.

Compliance Date:
04-27-2022

Providers Response/Corrective Action Taken:
Though not cited in a specific standard, Nutritional Services Policy 009: Food Product Storage was revised

on May 12, 2022. The Dietary Manager developed a checklist of compliance with food rotation on a daily basis. Weekly, the Dietary Manager, or designee, will audit the checklist for compliance. All bread products contain a "Received" date on the package. The Dietary Department will use red "Use First" stickers to identify older products, ensuring quality according to the date and condition of the product. The Dietary Manager completed training with 100% of the Dietary Staff on June 16, 2022, focusing on quality assurance during meal preparation. In addition, Dietary Staff will complete the Portsmouth Food Handlers training course yearly.

Person Responsible:
Dietary Manager
Director of Plant Operations

Monitoring System:
Weekly, the Dietary Manager, or designee, will audit the food rotation checklist for compliance. The Dietary Manager collects and aggregates data, submitting report information to the Director of Plant Operations for inclusion in the in monthly Environment of Care meeting. Upon discovery of deficiencies and/or non-compliance, the Dietary Manager will complete retraining and/or corrective action as appropriate.

Compliance Date:
06-12-2022

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-14-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115).	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: See OHR citation.		
12VAC35-115-50. C. (3a) - In services provided in residential and inpatient settings, each individual has the right to: 3. Live in a humane, safe, sanitary environment that gives each individual, at a minimum: 3a. Reasonable privacy and private storage space;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: Incident date: 3.25.22 • An unannounced visit was completed to this provider where several Human Rights violations were noted such as clogged toilets vents that were covered with heavy dust, mold on shower curtains, uncleaned bathrooms, hole in a wall, peeling paint, bread that had expired and soap scum build up.		

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-14-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-115-50. C. (3b) - In services provided in residential and inpatient settings, each individual has the right to: 3. Live in a humane, safe, sanitary environment that gives each individual, at a minimum: 3b. An adequate number of private, operating toilets, sinks, showers, and tubs that are designed to accommodate individuals' physical needs;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: Incident date: 3.25.22 • An unannounced visit was completed to this provider where several Human Rights violations were noted such as clogged toilets vents that were covered with heavy dust, mold on shower curtains, uncleaned bathrooms, hole in a wall, peeling paint, bread that had expired and soap scum build up.		
12VAC35-115-50. C. (3e) - In services provided in residential and inpatient settings, each individual has the right to: 3. Live in a humane, safe, sanitary environment that gives each individual, at a minimum: 3e. Clean air, free of bad odors;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: Incident date: 3.25.22 • An unannounced visit was completed to this provider where several Human Rights violations were noted such as clogged toilets vents that were covered with heavy dust, mold on shower curtains, uncleaned bathrooms, hole in a wall, peeling paint, bread that had expired and soap scum build up.		

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-14-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

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] Review Specialist | (Signature of Organization Representative) | Date

Due Date: 06/27/2022

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010220 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **01-06-2020**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	12VAC35-115-50 Dignity B;2 which states: In receiving services, each individual has the right to; be protected from harm including abuse, neglect and exploitation. This regulation was NOT met as evidenced by the following: Employee 1 made an error in giving individual 1 the wrong medication cup. An internal investigation was completed. It was determined corrective action measures will be required to include training on reinforcing policy and procedures.	1. The Director of Nursing, in conjunction with the Nurse Manager, provided preventive corrective action and counseling, to include re-education related to the responsibility of the nurse to ensure that the five rights to medication administration are adhered to: the correct resident receives the medication, the right medication is administered to the resident, the medication is administered at the correct time, the correct dose of medication is administered to the patient as ordered, and the correct route is utilized when administering the medication to the resident. 2. The Director of Nursing, or designee, will continue to retrain staff, provide corrective action and/or terminate based on the results of medication administration errors and findings. 3. The facility will continue to investigate all internal allegations of abuse, neglect and/or exploitation, including all medication errors and variances. If substantiated, Harbor Point Behavioral Health Center (HPBHC) will continue to notify Virginia Department of Behavioral Health and Developmental Services (DBHDS) via the Comprehensive Human Rights Information System (CHRIS). Responsible Person: Director of Nursing Risk Manager Chief Executive Officer Monitoring System: Director of Nursing will continuously monitor the medication administration process to ensure a safe and therapeutic outcome for all residents	4/10/2020

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **01-06-2020**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			served in compliance with 12VAC35-115-50 – Dignity, reporting all substantiated and unsubstantiated incidents to DBHDS via CHRIS. RECEIVED 4.27.20 APPROVED	

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] (Signature of Organization Representative) Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010222 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-80. B. - Submit corrective action for all violations	N	Harbor Point Behavioral Health 12VAC35-46-80. Written corrective action plans. B. The provider shall submit to the department and implement a written corrective action plan for each regulation for which the provider is found to be in noncompliance. This regulation was NOT MET as evidenced by: Provider was previously cited for late reporting on CAP dated 12/2/2020. Provider submitted a CAP dated 12/7/2020, which included an acceptable corrective action (s). **This corrective action(s) was not implemented, as evidenced by provider receiving a second citation for late reporting in a two year time period.	PR: Corrective Action Taken: 1. The Risk Manager/Performance Improvement Director, or designee, will collaborate with facility leaders and develop and submit a corrective action plan suitable for each regulation for which the facility is found to be in noncompliance to the Virginia Department of Behavioral Health and Developmental Services (DBHDS). 2. The Risk Manager/Performance Improvement Director, or designee, in conjunction with the Chief Executive Officer, will maintain oversight of submitted correction actions plans, ensuring compliance with submitted action steps, continuously reviewing the facility's obligation to adhere to the agreed upon plan of action. Person Responsible: Risk Manager/Performance Improvement Director Chief Executive Officer Monitoring System: The Risk Manager/Performance Improvement Director audits 100% of written corrective action plans to ensure compliance with 12VAC35-46-80 – Written corrective action plan, noting "the provider shall submit to the department and implement a written corrective action plan for each regulation for which the provider found to be in noncompliance". OLR: CAP NOT ACCEPTED (3/1/2021) In addition to the above, provider response needs to include the following: 1. Plan that has been or will be implemented to ensure all corrective actions have been returned	2/19/2021

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			within the required timeframe. PR: (3/5/2021) Addendum: Upon receipt of a citation from the Department of Behavioral Health and Developmental Services (DBHDS), the Risk Manager/Performance Improvement Director will collaborate with appropriate disciplines, developing a corrective action plan. The Risk Manager will ensure the correction action plan has been implemented by the planned completion date and ensure the corrective action plan is returned to DBHDS within the required time frame. Person Responsible: Risk Manager/Performance Improvement Director Chief Executive Officer Monitoring System: The Risk Manager/Performance Improvement Director audits 100% of written corrective action plans to ensure compliance with 12VAC35-46-80 – Written corrective action plan, noting "the provider shall submit to the department and implement a written corrective action plan for each regulation for which the provider found to be in noncompliance". OLR: Accepted (3/8/2021)	
12VAC35-46-1070. C. - Report serious illness or injury w/in 24 hours to regulator	NS	Harbor Point Behavioral Health 12VAC35-46-1070. Serious incident reports. C. The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include:	PR: Corrective Action Taken: 1. The Risk Manager/Performance Improvement Director completed a training with Senior Leaders and Managers, as well as, medical staff	2/15/2021

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; and 6. The name of the person to whom the report was made. This regulation was NOT MET (SYSTEMIC) as evidenced by: 1. Review of CHRIS Case #20200086 reveal a discovery date and time 12/19/2020 8:02:00 PM for this incident of but the provider did not notify the department using the department's web-based reporting application until 12/21/2020 5:59:00 AM . The entry was made 9.95 hours past the 24- hour reporting timeframe as required by regulation. 2. Review of CHRIS Case #20200100 reveal a discovery date and time 12/30/2020 8:05:00 AM for this incident of but the provider did not notify the department using the department's web-based reporting application until 1/3/2021 10:20:00 AM . The entry was made 74.25 hours past the 24- hour reporting timeframe as required by regulation. *Note: Provider was previously cited for late reporting on CAP dated 12/2/2020. As this is provider's second citation in two years, the provider has demonstrated systemic noncompliance.	on completing an internal incident report at the time of incident or injury and/or time of discovery of incident or injury, to include residents testing positive for COVID-19. Upon completion of the internal incident the staff will submit the form to the nursing department for review and notification of the substitute decision maker. The nursing department will submit the completed internal incident report to the Risk Manager, or designee, in person or by placing the form is the designated area in the mail room. 2.The Risk Manager/Performance Improvement Director re-educated Senior Leaders and Managers, as well as, medical staff on submitting all serious incidents, including but not limited to residents testing positive for COVID-19, serious injury requiring medical attention and an unplanned emergency room or urgent care facility visit, when not used in lieu of primary care, into the Comprehensive Human Rights Information System (CHRIS) for the Department of Behavioral Health and Developmental Services. (DBHDS). 3. The Risk Manager/Performance Improvement Director re-trained and re-educated Senior Leaders and Mangers, as well as, medical staff on the 24-hour notification of serious illness and injury, to include residents testing positive for COVID-19. The Risk Manager/Performance Director reviewed the requirement of entering the date and time the incident occurred, a description of the incident, the action taken as a result of the incident, the name of the person who completed the report, the name of the person who made the report to the placing agency and the parent/guardian, as well as, the	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			name of the person to whom the report was made. Person Responsible: Risk Manager/Performance Improvement Director Chief Executive Officer Monitoring System: The Risk Manager/Performance Improvement Director audits 100% of internal incident reports to ensure all required cases have been submitted to CHIRS in compliance with 12VAC35-46-1070 – Serious incident reports, noting the provider shall notify the department "within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. OLR: CAP NOT ACCCEPTED (3/1/2021) In addition to the above, provider response needs to include the following: 1. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). 2. Staff by title who serves as back up to enter incidents into CHRIS when the designated person is out including nights, weekends, and holidays. 3. Staff by title who will be providing CHRIS training for back up staff. 4. Date backups were/will be trained/reeducated on entering information into CHRIS including deadlines. 5. Dates back up staff received their own Delta login ID and password. 6. Description of process implemented to forward reportable incidents to designated person who enters into CHRIS within the required timeframe	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			to include nights, weekends, and holidays. Be sure to list staff by title only. PR: (3/5/2021) Addendum: On February 15, 2021 the Risk Manager/Performance Improvement Director re-trained and re-educated those staff responsible for entering incidents into the CHRIS system. Those staff/back-up to the Risk Manager/Performance Improvement Director include the Director of Nursing, Nurse Manager, Infection Control Nurse, Program Managers x3, Director of Education, Director of Clinical Services, Clinical Liaison and Director of Admissions. Each staff identified to enter incidents into the CHRIS system have their own Delta login. Monday through Friday the Risk Manager/Performance Improvement Director or Risk Assistant enters cases into the CHRIS system. For nights, weekends and holidays, each staff identified participate in a rotation schedule, entering incidents into the CHRIS system. The rotation schedule is called Administrator-on-Call (AOC) which is assigned Monday – Sunday. In the absence of the Risk Manager/Performance Improvement Director or Risk Assistance, Monday through Friday, the assigned AOC will enter incidents into the CHRIS system. In addition to the training provided on February	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			15, 2021, the Risk Manager/Performance Improvement Director or Risk Assistant will ensure the assigned AOC staff, designated to enter incidents into CHIRS for the upcoming weekend, have an active Delta login. At that time, the designated staff member receives re-education on the requirement for 24 hour notification of serious illness and injury, to include residents testing positive for COVID-19. To elaborate in #1 above, an internal incident report is complete by the staff witnessing an incident or who first becomes aware of an incident. Upon completion of the internal incident the staff will submit the form to the nursing department for review and notification of the substitute decision maker. The nursing department will submit the completed internal incident report to the Risk Manager's mailbox by placing the form in the designated area in the mail room. The Risk Manage/Performance Improvement Director or AOC will retrieve the completed incident reports from the Risk Manager mailbox, reviewing each and entering those meeting criteria into the CHRIS system. This process is complete Monday – Sunday, to include nights, weekends and holidays. The incident reports are returned to the Risk Manger's mailbox, collected by the Risk /Performance Improvement Director on the following business day for review and auditing. Person Responsible: Risk Manager/Performance Improvement Director Chief Executive Officer Monitoring System:	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The Risk Manager/Performance Improvement Director audits 100% of internal incident reports to ensure all required cases have been submitted to CHIRS in compliance with 12VAC35-46-1070 – Serious incident reports, noting the provider shall notify the department "within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Addendum: The Risk Manager/Performance Improvement Director audits this Monday for incidents entered Saturday and Sunday. The Risk Manager/Performance Improvement Director audits this Tuesday through Friday for incidents entered the prior day. The Risk Manager/Performance Improvement Director compiles a monthly data report which is presented to Quality Council on a monthly basis. OLR: Accepted (3/8/2021)	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **02-12-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
"**The response to the citation was determined CAP NOT ACCEPTED. Please respond no later than March 15, 2021.**
Thanks
[redacted] **MPA**

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], Licensing Application Specialist	(Signature of Organization Representative)	Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010230 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-15-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	12VAC35-115-230. Provider Requirements for Reporting: A.2. - allegations must be reported "within 24 hours of receipt of the allegation." Per the Office of Human Rights request, this regulation was not met as evidenced by: The provider failed to comply evidenced by documentation in CHRIS for case 20190055. The CHRIS entry documents the allegation being reported to the provider on 3/9/19. The allegations were not reported to the Office of Human Rights until 3/12/19, 3 days after the allegation should have been reported.	1. Risk Manager/Performance Improvement Director developed a training manual for Senior Leaders and Managers when entering abuse, neglect, etc. allegations and incidents into the Comprehensive Human Rights Information System (CHRIS), the electronic human rights and reporting system for the Department of Behavioral Health and Developmental Services (DBHDS). 2. Risk Manager /Performance Improvement Director developed a training manual for Senior Leaders and Managers when entering serious injury incidents into CHRIS. 3. Risk Manager/Performance Improvement Director attended the DBHDS CHRIS training, reviewing training materials and expectations with Senior Leaders and Managers responsible for submitting CHRIS cases. 4. [redacted] Human Rights Advocate with DBHDS, to conduct an in-person training for Harbor Point Behavioral Health Center (HPBHC) Senior Leaders and Managers. Training to include all required elements for submitting incidents to CHRIS, to include reporting within 24-hours of receipt of the allegation. Note, training was rescheduled from May 2, 2019. Responsible Person: Risk Manager/Performance Improvement Director Chief Executive Officer Monitoring System: The Risk Manager/Performance Improvement Director audits 100% of internal incidents to	5/23/2019

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-15-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			ensure all required cases have been submitted to CHRIS in compliance with 12VAC35-115-230 – Provider Requirements for Reporting: A-.2. – Allegations must be reported "within 24 hours of receipt of the allegation". Re-trainings and/or corrective actions administered for noncompliance of DBHDS regulation. APPROVED 7.1.19	

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] (Signature of Organization Representative) Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010232 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-17-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	Harbor Point Behavioral Health Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115). Human Rights Regulations: 12VAC35-115-50. Dignity. B.2. which states: In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation. This regulation was NOT MET as evidenced by: According to the provider's investigative findings, Employee #1 denied saying to Individual #1, "I will slap the sh*t out of you, I don't care. I will slap the sh*t out of you if you keep trying to bite me." However, Employee #1 did admittedly say to Individual #1 that Employee #1 would, "box" Individual #1 while Individual #1 was biting Employee #1 during a behavioral intervention with Individual #1. According to the provider, Employee #1's admitted actions are not consistent with the provider's internal policy regarding therapeutic communication.	Provider Response: 1. Risk Manager/Performance Improvement Director, in collaboration with Senior Leaders, continuously reviews the Patient Abuse, Neglect and Exploitation – Reporting and Investigating policy, along with 12VAC35-115-50 Resident's Rights to include the right to be treated with dignity as a human being and be protected from abuse, neglect and exploitation. This training occurs with 100% of staff, at minimum, at hire and yearly thereafter. 2. The facility conducted an internal investigation for abuse and neglect. Risk Manager will continue to investigate all internal and external allegations of abuse, neglect and/or exploitation. If substantiated, Harbor Point Behavioral Health Center (HPBHC) will continue to notify Virginia Department of Behavioral Health and Developmental Services (DBHDS) via the Comprehensive Human Rights Information System (CHRIS). 3. Risk Manager, in collaboration with Senior Leaders and Program Managers, continuously provides in-service training on Therapeutic Communication, Boundaries and Interactions with residents. This training occurs with 100% of staff, at a minimum, at hire and yearly thereafter, as needed based on employee performance. 5. Risk Manager/Performance Improvement Director, or designee, will continue to retain staff, provide corrective action and/or terminate employment based on the results of the facility's internal investigation.	3/18/2021

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-17-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			6. In regards to the staff identified in this case, staff was removed from the unit and removed from working with the resident making the allegation. Staff was reeducated on therapeutic communication. The staff member resigned her employment on 03-08-2021. Responsible Person: Risk Manager/Performance Improvement Director Human Resources Director Chief Executive Officer Monitoring System: Risk Manager/Performance Improvement Director will continuously monitor 100% of all internal and external allegations of abuse, neglect and exploitation to ensure a safe and therapeutic outcome for all residents served in compliance with 12VAC35-46-70 – Resident's Rights, as well as Human Rights Regulation 12VAC35-115-50 stating in receiving services, each individual has the right to be protected from harm including abuse, neglect and exploitation. 3/24/21- OHR Accepted, AD	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-17-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
Inspection ID: [redacted]
Location: Harbor Point Behavioral Health

Please respond with acceptable corrective action to [redacted]dbhds.virginia.gov and [redacted]dbhds.virginia.gov by 4/8/2021.

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] Review Specialist | (Signature of Organization Representative) | Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010235 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-29-2023**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-1070. C. - The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; 6. The name of the person to whom the report was made.	NS	Harbor Point Behavioral Health This regulation was NOT MET (Systemic) as evidenced by: CHRIS Number: 20230023 Date/Time of Discover: 03/13/2023 8:03PM Enter Date/Time: 03/14/2023 10:24PM Reporting Delay: 2:21:00 Location Name: Harbor Point Behavioral Health This is a systemic (NS) citation. Based upon the rolling year (March 30, 2022 – March 29, 2023) for 14-003 this is the Third Step in the Progressive Citation Process for violation of 12VAC35-46-1070.C. • The first citation was issued on 04/26/22 and is now a non-compliant. • The second citation was issued on 8/9/22 and is now a non-compliant. • The third citation was issued on 11/29/22 and is now a non-compliant-systemic. Per the Guidance on Incident Reporting Requirements, you are being required to attest to reviewing ALL CHRIS Training and guidance documents located on the DBHDS website as indicated by a check mark on the attestation form. Resolution to this licensing report requires two actions. The first action is to submitting an acceptable licensing report response. The second is to include the signed attestation form(s) for each individual within the organization who is required by you to receive training and	PR) 04/17/2023 CHRIS #20230023 was an incident that occurred on March 13, 2023 at 20:00hrs. A female resident was discovered in her room by staff while attempting to tie a bedsheet around her neck to self-harm. The staff called a code and the Unit Nurse arrived and assessed the resident. The nurse called the facility doctor at 20:03hrs and reported the incident. The Doctor gave orders for the resident to be transported to CHKD emergency department for psychiatric evaluation which was done that night. Per the facility's internal CHRIS reporting process, the emergency department visit should have been entered into the CHRIS and reported on the Supervisor's Shift Report. However, the shift supervisor that night was a proxy who was covering the shift in the absence of the actual Shift Supervisor. That acting supervisor did not have CHRIS login credentials and was unfamiliar with the CHRIS reporting requirements. He therefore did not enter the incident into the CHRIS neither did he notify incoming Shift Supervisors until late the next day when the Second Shift Supervisor became aware of the ER visit. It was that Supervisor who entered the incident into the CHRIS a little after 24 hours after the incident, in violation of 12VAC35-46-1070.C. To prevent recurrence, as of March 20, 2023, Shift Supervisors are now required to audit nursing and shift supervisors' reports from shifts that immediately precede their own shifts. This will be the first QA step in our CHRIS reporting process. Oversights discovered from the initial	4/17/2023

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-29-2023**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		to review guidance documents as attachments with the licensing report response. Both Items are due no later than the due date of 4/19/23. If the provider does not submit attestation(s) to confirm completion of required trainings and document reviews as indicated on the form, the provider may incur negative actions. The links for the trainings and guidance documents are listed in the attached attestation form.	QA process will be corrected by that supervisor entering the incident into the CHRIS. Additionally, each morning, Risk Management will audit nursing and shift supervisor reports, as well as incident reports, to determine CHRIS reportable incidents and if they were entered into the CHRIS on time. Risk Management will enter into the CHRIS any reportable incident(s) that are oversighted to ensure compliance with 12VAC35-46-1070.C. This will be an ongoing process to assure continued compliance with 12VAC35-46-1070.C. OLR) Accepted 04/26/2023	

General Comments / Recommendations:
Please be sure to review the Licensing Report Response Guidance in the CAP Issue Letter to aid in the acceptance of your CAP and return the following items no later than April 19, 2023.

1. Licensing Report Response
2. Signed Attestation Form(s) for each individual required by you to receive training and to review guidance documents.

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] Incident Management Unit

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010237 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-31-2020**
Program Type/Facility Name: **Harbor Point Behavioral Health**

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	12VAC35-46-1070. Serious incident reports. C. The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; and 6. The name of the person to whom the report was made. This regulation was NOT MET as evidenced by: Review of CHRIS Case #20200005 reveals a discovery date 03/12/2020 but the provider did not notify the department using the department's web-based reporting application 03/14/2020.	Note – Date of incident was 03-12-2020; however, facility unaware of serious injury. X-ray complete and results received by facility on 03-13-2020 at 1252, notifying of serious injury to resident. DBHDS notified via CHRIS on 03-14-20 at 1143 within 24 hours of the facility receiving notification of serious injury to resident. **Corrective Action Taken:** 1. Risk Manager/Performance Improvement Director redistributed the training manual for Senior Leaders and Managers when entering abuse, neglect, etc. allegations, as well as, serious incidents into the Comprehensive Human Rights Information System (CHRIS), the electronic human rights and reporting system for the Department of Behavioral Health and Developmental Services (DBHDS). 2. Risk Manager/Performance Improvement Director conducted an in-service training with Senior Leaders and Managers on completing internal incident report notification and ensuring submission to the Risk Department within the shift the incident occurred to allow for the Risk Department, Senior Leaders and Managers to retrieve and submit to CHIRS within the required time frame. 3. Director of Nursing to continue with collaborative efforts to allow the facility to receive x-ray results within same date of service, allowing for facility notification of serious injury to resident. **Responsible Person:** Risk Manager/Performance Improvement Director Chief Executive Officer **Monitoring System:** The Risk Manager/Performance Improvement Director audits 100% of internal incidents to ensure all required cases have been submitted to CHRIS in compliance with 12VAC35-115-230 – Provider Requirements for Reporting: A-.2. – Allegations must be reported "within 24 hours of receipt of the allegation". Re-trainings and/or corrective actions administered for noncompliance of DBHDS regulation.	04-08-2020 04-08-2020 04-08-2020

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-31-2020**
Program Type/Facility Name: **Harbor Point Behavioral Health**

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] Manager

[redacted]
(Signature of Organization Representative)

04/16/2020
Date

Email to: [redacted]@dbhds.virginia.gov

Due Date: 04-21-2020

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010239 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-31-2020**
Program Type/Facility Name: **Harbor Point Behavioral Health**

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	12VAC35-46-1070. Serious incident reports. C. The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; and 6. The name of the person to whom the report was made. This regulation was NOT MET as evidenced by: Review of CHRIS Case [redacted] reveals a discovery date 03/13/2020 but the provider did not notify the department using the department's web-based reporting application 03/17/2020.	Note – Resident reported ingesting item on 03-13-2020 and an x-ray was ordered and complete on 03-13-2020. X-ray results confirming ingestion of item received by facility on 03-16-2020, notifying facility of serious injury to resident. DBHDS notified via CHIRS on 03-17-2020 within 24 hours of the facility receiving notification of serious injury to the resident. **Corrective Action Taken:** 1. Risk Manager/Performance Improvement Director redistributed the training manual for Senior Leaders and Managers when entering abuse, neglect, etc. allegations, as well as, serious incidents into the Comprehensive Human Rights Information System (CHRIS), the electronic human rights and reporting system for the Department of Behavioral Health and Developmental Services (DBHDS). 2. Risk Manager/Performance Improvement Director conducted an in-service training with Senior Leaders and Managers on completing internal incident report notification and ensuring submission to the Risk Department within the shift the incident occurred to allow for the Risk Department, Senior Leaders and Managers to retrieve and submit to CHIRS within the required time frame. 3. Director of Nursing to continue with collaborative efforts to allow the facility to receive x-ray results within same date of service, allowing for facility notification of serious injury to resident. **Responsible Person:** Risk Manager/Performance Improvement Director Chief Executive Officer **Monitoring System:** The Risk Manager/Performance Improvement Director audits 100% of internal incidents to ensure all required cases have been submitted to CHRIS in compliance with 12VAC35-115-230 – Provider Requirements for Reporting: A-.2. – Allegations must be reported "within 24 hours of receipt of the allegation". Re-trainings and/or corrective actions administered for noncompliance of DBHDS regulation.	04-08-2020 04-08-2020 04-08-2020

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-31-2020**
Program Type/Facility Name: **Harbor Point Behavioral Health**

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] Manager

[redacted]
(Signature of Organization Representative)

04/16/2020
Date

Email to: [redacted]@dbhds.virginia.gov

Due Date: 04-21-2020

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010241 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-31-2020**
Program Type/Facility Name: **Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
1070.C - Report serious illness or injury w/in 24 hours to regulator	N	12VAC35-46-1070. Serious incident reports. C. The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; and 6. The name of the person to whom the report was made. This regulation was NOT MET as evidenced by: Review of CHRIS Case [redacted] reveals a discovery date 03/13/2020 but the provider did not notify the department using the department's web-based reporting application 03/16/2020.	Note – Date of incident was 03-15-2020 (not 03-13-2020 as noted in description of non-compliance) and an x-ray was ordered. X-ray received on 03-16-2020, notifying facility of serious injury to resident. DBHDS notified via CHRIS on 03-17-2020 (not 03-16-2020 as noted in description of non-compliance) at 1235 within 24 hours of the facility receiving notification of serious injury to resident. **Corrective Action Taken:** 1. Risk Manager/Performance Improvement Director redistributed the training manual for Senior Leaders and Managers when entering abuse, neglect, etc. allegations, as well as, serious incidents into the Comprehensive Human Rights Information System (CHRIS), the electronic human rights and reporting system for the Department of Behavioral Health and Developmental Services (DBHDS). 2. Risk Manager/Performance Improvement Director conducted an in-service training with Senior Leaders and Managers on completing internal incident report notification and ensuring submission to the Risk Department within the shift the incident occurred to allow for the Risk Department, Senior Leaders and Managers to retrieve and submit to CHIRS within the required time frame. 3. Director of Nursing to continue with collaborative efforts to allow the facility to receive x-ray results within same date of service, allowing for facility notification of serious injury to resident. **Responsible Person:** Risk Manager/Performance Improvement Director Chief Executive Officer **Monitoring System:** The Risk Manager/Performance Improvement Director audits 100% of internal incidents to ensure all required cases have been submitted to CHRIS in compliance with 12VAC35-115-230 – Provider Requirements for Reporting: A-.2. – Allegations must be reported "within 24 hours of receipt of the allegation". Re-trainings and/or corrective actions administered for noncompliance of DBHDS regulation.	04-08-2020 04-08-2020 04-08-2020

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **03-31-2020**
Program Type/Facility Name: **Harbor Point Behavioral Health**

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] Manager

[redacted]
(Signature of Organization Representative)

04/16/2020
Date

Email to: [redacted]@dbhds.virginia.gov

Due Date: 04-21-2020

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010243 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-08-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	Harbor Point Behavioral Health Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115). Human Rights Regulations: 12VAC35-115-50. Dignity. B.2. Which states: In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation. This regulation was NOT MET as evidenced by: According to the provider's investigative findings, Employee #1 failed to follow agency protocol by getting into a physical altercation with Individual #1, which included Employee #1 hitting Individual #1 and not using appropriate de-escalation and restraint techniques. According to the provider a camera review was conducted, and eyewitness statements were collected which confirmed that an altercation did indeed occur between Employee #1 and Individual #1. The altercation did not comply with any of the provider's internal policies.	Provider Response: 1. Risk Manager/Performance Improvement Director, in collaboration with Senior Leaders, continuously reviews the Patient Abuse, Neglect and Exploitation – Reporting and Investigating policy, along with 12VAC35-115-50 Resident's Rights to include the right to be protected from harm including abuse, neglect and exploitation. This training occurs with 100% of staff, at minimum, at hire and yearly thereafter. 2. The facility conducted an internal investigation for abuse and neglect and found staff to be violation of the facility Patient Abuse, Neglect and Exploitation – Reporting and Investigating Policy, as well as, Human Rights Regulation 12VAC35-115-50 stating each individual has the right to be protected from harm. Risk Manager will continue to investigate all internal and external allegations of abuse, neglect and/or exploitation. If substantiated, Harbor Point Behavioral Health Center (HPBHC) will continue to notify Virginia Department of Behavioral Health and Developmental Services (DBHDS) via the Comprehensive Human Rights Information System (CHRIS). 3. Risk Manager, in collaboration with Senior Leaders and Program Managers, continuously provides in-service training on Therapeutic Communication, Boundaries and Interactions with residents. This training occurs with 100% of staff, at a minimum, at hire and yearly thereafter, as needed based on employee performance. 5. Risk Manager/Performance Improvement Director, or designee, will continue to retain staff.	3/5/2021

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-08-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			provide corrective action and/or terminate employment based on the results of the facility's internal investigation. 6. In regards to the staff identified in this case, staff was immediately removed from working with the resident making the allegation. Staff was suspended pending an internal and external review. The staff member was subsequently terminated from employment on 03-05-2021, prior to returning to work. Responsible Person: Risk Manager/Performance Improvement Director Human Resources Director Chief Executive Officer Monitoring System: Risk Manager/Performance Improvement Director will continuously monitor 100% of all internal and external allegations of abuse, neglect and exploitation to ensure a safe and therapeutic outcome for all residents served in compliance with 12VAC35-46-70 – Resident's Rights, as well as Human Rights Regulation 12VAC35-115-50 stating in receiving services, each individual has the right to be protected from harm including abuse, neglect and exploitation. 4/12/2021: OHR Accepted, AD	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-08-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
Inspection ID[redacted]
Location: Harbor Point Behavioral Health

Please respond with acceptable corrective action to [redacted]**@dbhds.virginia.gov and** [redacted]**@dbhds.virginia.gov by 4/30/2021.**

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] Review Specialist | (Signature of Organization Representative) | Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010267 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-16-2020**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	12VAC35-46-70. Resident's rights. Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115). 12VAC35-115-50 Dignity B;2 which states: In receiving services, each individual has the right to; be protected from harm including abuse, neglect and exploitation. Per the OHR This regulation was NOT met as evidenced by the following: On 03/04/2020, Employee #1 did not follow proper procedure regarding treatment of residents. This placed the resident at risk for increased harm. Harbor Point Behavioral Health Center completed their investigation and found that Employee 1 failed to follow their behavioral management policy by dragging individual 1 across the classroom floor.	1. Risk Manager/Performance Improvement Director , in collaboration with Senior Leaders, continuously reviews the Patient Abuse, Neglect and Exploitation – Reporting and Investigating policy, along with 12VAC35-46-70 Resident's Rights to include the right to be treated with dignity as a human being and be free from abuse and neglect. This training occurs with 100% of staff, at minimum, at hire and yearly thereafter. 2. The facility conducted an internal investigation and complied with the external investigation conducted by Portsmouth Child Protective Services (CPS). Risk Manager will continue to investigate all internal and external allegations of abuse, neglect and/or exploitation. If substantiated, Harbor Point Behavioral Health Center (HPBHC) will continue to notify Virginia Department of Behavioral Health and Developmental Services (DBHDS) via the Comprehensive Human Rights Information System (CHRIS). 3. Risk Manager/Performance Improvement Director, or designee, will continue to retain staff, provide corrective action and/or terminate employment based on the results of the facility's internal investigation. Responsible Person: Risk Manager/Performance Improvement Director Human Resources Director Chief Executive Officer Monitoring System: Risk Manager/Performance Improvement Director will continuously monitor 100% of all	3/16/2020

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-16-2020**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			internal and external allegations of abuse, neglect and exploitation to ensure a safe and therapeutic outcome for all residents served in compliance with 12VAC35-46-70 – Resident's Rights, reporting all substantiated and unsubstantiated to DBHDS via CHRIS. RECEIVED 4.17.20 APPROVED	

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] (Signature of Organization Representative) Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010271 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-26-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-1070. C. - The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; 6. The name of the person to whom the report was made.	NS	Harbor Point Behavioral Health This regulation was NOT MET (SYSTEMIC) as evidenced by: CHRIS Number: 20220174 Date/Time of Discover: 04/23/2022 1:06PM Enter Date/Time: 04/24/2022 4:55PM Reporting Delay: 3:49:00 Location Name: Harbor Point Behavioral Health Note: As this is provider's second step in the Progressive Citation Cycle for the same regulation within a one-year period, measured on a rolling basis, provider has demonstrated systemic noncompliance. Provider was previously cited for late reporting • The first citation was issued on 8/20/21 and is now a non-compliant.	PR) 05/17/2022 Provider Response/Corrective Action Taken: The Director of Risk Management/Performance Improvement Director completed a re-training with Senior Leaders and Managers, as well as medical staff on completing an internal incident report at the time of incident or injury and/or time of discovery of incident or injury. Upon completion of the internal incident the staff will submit the form to the nursing department for review and notification of the substitute decision maker. The nursing department will submit the completed internal incident report to the Risk Management Department, in person for placing the form in the designated area in the mail room. 04-26-2022 The Director of Risk Management/Performance Improvement Director, or designee, completes a training with each newly assigned individual within the organization, with granted access to the Comprehensive Human Rights Information System (CHRIS), utilizing the following training materials: CHRIS System Training (May 2021), Guidance for Serious Incident Reporting (November 2020), Guidance on Incident Reporting Requirements (August 2020), Memo – CHRIS Updates (October 2019), as well as, Creating Delta Accounts: Local Administrator, DELTA Security Officer, DELTA Supervisor and Production Account Request. The training	5/11/2022

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-26-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			includes review of materials, as well as, case review and hands on system training for entry. 04-26-2022 The Director of Risk Management/Performance Improvement Director, re-educated all individuals, with granted access to CHRIS, on submitting serious incidents, including but not limited to serious injury requiring medical attention and an unplanned emergency room or urgent care facility visit, when not used in lieu of primary care, into CHRIS for the Department of Behavioral Health and Developmental Services (DBHDS). This training encompassed the responsibility of authorized users (identified as Administrators On-Call) to enter incidents into CHRIS on nights, weekends, holidays and/or any time the primary person (Director of Risk Management or the Assistant Director of Risk Management) is not available. 04-26-2022 The Director of Risk Management/Performance Improvement Director, re-educated all individuals, with granted access to CHRIS, on submitting serious incidents, on the 24-hour notification of all serious injury or illness, and unplanned or emergency room visits. The re-education included the requirements of entering the date and time the incident occurred, a description of the incident, the actions taken as a result of the incident, the name of the person completing the report, the name of the person making the report to the placing agency, patient	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-26-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			or legal guardian, the name of the persons to whom the report was made and notification of the licensing specialist no later than 24 hours from date and time the incident was discovered. 04-26-2022 The Director of Risk Management/Performance Improvement Director, in conjunction with the Chief Executive Officer will maintain oversight of submitted corrective action plans, ensuring compliance with submitted action steps, continuously reviewing the facility's obligation to adhere to the agreed upon action plan. 04-26-2022 In addition to re-training and re-education following an episode of non-compliance, the Director of Risk Management/Performance Improvement Director will conduct bi-annual training with all individuals, with granted access to CHRIS, on compliance with standard 12VAC35-46-170 – Serious Incident Reports. Training will include all required elements of reporting, required time frame for reporting and an analysis of defiant area and how to ensure compliance. 05-11-2022 Person Responsible:	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-26-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Director of Risk Management/Performance Improvement Director Assistant Director of Risk Management Chief Executive Officer Monitoring System: The Director of Risk Management/Performance Improvement Director audits 100% of internal incident reports to ensure all required case s have been submitted to CHRIS in compliance with 12VAC35-46-170 – Serious Incident Reports, noting the provider shall notify the department within 24-hours of any serious illness or injury, an death of a resident, and all other situations as required by the department. The audit is complete Monday – Friday by the Director of Risk Management, auditing Saturday and Sunday entries on Monday. If non-compliance is discovered, the Director of Risk Management/Performance Improvement Director completes an internal review, identifying the cause for non-compliance and immediately provides re-training to the identified individual (s). If repeat deficiencies are discovered, disciplinary action is initiated for non-compliance.	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-26-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The Director of Risk Management/Performance Improvement Director analyzes the data from the daily audit and reports findings monthly to the Quality Council Committee for findings and the development of additional actions plans as needed for compliance. The Director of Risk Management/Performance Improvement Director audits 100% of written corrective action plan to ensure compliance with 12VAC35-46-80 – written correction action plan, noting the provider will submit to the department and implement a written corrective action plan for each regulation for which the provider was found to be in noncompliance. OLR) Partially Accepted 05/23/2022 In addition to the above, the provider response needs to include the following: 1. Describe the specific issue that led to the late reporting(s). 2. Please ensure that if it is discovered during monitoring that an incident was not entered in CHRIS within 24 hours, please do so immediately. PR) 06/06/2022 The Director of Risk Management/Performance Improvement Director completed an internal review, determining the cause for late entry. It was discovered that the Administrator-On-Call, also the Program Manager, was managing acuity	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-26-2022**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			within the facility. At the time of managing crisis events, it was not communicated to another staff member, with accesses to CHRIS, that the incident needed to be entered; therefore it was entered post 24-hours from date/time of incident. Following discovery that an incident has not been entered, the assigned Administrator-On-Call, or designee, will immediately enter the serious incident to ensure notification via CHRIS. OLR) Accepted 06/09/2022	

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] Incident Management Unit

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010303 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID: [redacted]
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-02-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-750. E. - Quarterly addresses status of discharge planning		12VAC35-46-750. Individualized service plans/quarterly reports. E. There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter This reguation was NOT met as evidenced by: The Resident's record did not contain a quarterly review for October 2018.		6/21/2019
12VAC35-46-750. E. (1) - Quarterly shall review resident progress		12VAC35-46-750. Individualized service plans/quarterly reports. E. There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter This reguation was NOT met as evidenced by: The Resident's record did not contain a quarterly review for October 2018.		6/21/2019

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID: [redacted]
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-02-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-780. A. - Program provides case management services	N	12VAC35-46-780. Case management services. B. The provision of case management services shall be documented in each resident's record. This regulation was NOT met as evidenced by: Case management services were not documented in the Resident's record.	Provider Response Corrective Action Taken: The Director of Clinical Services and Clinical Coordinator provided re-training and re-education to 100% of the clinical services department, in regards to case management notes being complete, at a minimum of two times per month, and the Casework Services policy to ensure the coordination of care is documented accordingly. Case Management notes will be signed, dated, timed and authenticated within 24 hours of providing the service. The Case Management note will be filed in the resident's medical record. An attestation statement, acknowledging understanding of training, will be filed in the corresponding personnel file. Responsible Person: Director of Clinical Services Monitoring System: The Director of Clinical Services will utilize a daily tracking system to monitor the completion of documents submitted by the Therapist/Counselor. The Director of Clinical Services and Clinical Coordinator will document the submission of required case management notes, according to the Casework Services Policy, in the tracking system. The completed documents will then be filed in the corresponding medical record. RECEIVED 7.17.19 APPROVED	6/21/2019

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID: [redacted]
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-02-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
660.I - Entried current, dated, and authenticated	N	12VAC35-46-660. Maintenance of residents' records. B. Each record shall be kept up to date and in a uniform manner. This regulation was NOT met as evidenced by: The provider did not adhere to its own policy regarding the completion of monthly ISP reviews. At the time of the review, the Resident's record did not document an ISP review for October 2018.	Provider Response Corrective Action Taken: 1. The Director of Clinical Services re-trained and re-educated 100% of the Clinical Services Department on 12VAC35-46-660 – Maintenance of resident's records. The training included the Casework Services Policy in regards to the timeliness of completing documentation within 24 hours of the service being provided to include signature, date, time and authentication. Each record of service will be filed in the resident's medical record. An attestation statement, acknowledging understanding of training, will be filed in the corresponding personnel file. Responsible Person: Director of Clinical Services Director of Utilization Review Monitoring System: An excel spreadsheet which is formula driven will be utilized to calculate the ISP due date. The spreadsheet will be monitored by the Director of Utilization Review and utilized by the Treatment Team Coordinator when creating the ISP calendar and scheduling the ISP meeting. All meetings will be set no later than the due date that the formula calculates. Due dates will be adjusted backwards from the date calculated and never forward so that compliance is assured. The actual ISP meeting date will be plugged into the excel spreadsheet to calculate the next ISP due date. The time frames to be utilized are as follows: 1. Initial - Due within 10 days of admission 2. Second - Due within 14 days of Initial Team date	6/21/2019

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID: [redacted]
License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-02-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			3. Subsequent - Due within 30 days of the prior Team date RECEIVED 7.17.19 APPROVED	

General Comments / Recommendations:

1. LS recommends that provider document all case management services as performed.

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] (Signature of Organization Representative) Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010307 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-13-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	12VAC35-115-50. Dignity. B. In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation. Per the Office of Human Rights request, this regulation was NOT met as evidenced by: The provider's internal administrative findings documented in CHRIS on 4.9.19 substantiated verbal abuse of Individual #1 by Staff. Individual #1 stated that Staff was yelling at him, and alleged Staff came to the unit and said "by the end of the night he was going to punch me in my face".	1. Risk Manager/Performance Improvement Director developed a training manual for Senior Leaders and Managers when entering abuse, neglect, etc. allegations and incidents into the Comprehensive Human Rights Information System (CHRIS), the electronic human rights and reporting system for the Department of Behavioral Health and Developmental Services (DBHDS). 2. Risk Manager /Performance Improvement Director developed a training manual for Senior Leaders and Managers when entering serious injury incidents into CHRIS. 3. Risk Manager/Performance Improvement Director attended the DBHDS CHRIS training, reviewing training materials and expectations with Senior Leaders and Managers responsible for submitting CHRIS cases. 4. [redacted] Human Rights Advocate with DBHDS, to conduct an in-person training for Harbor Point Behavioral Health Center (HPBHC) Senior Leaders and Managers. Training to include all required elements for submitting incidents to CHRIS, to include reporting within 24-hours of receipt of the allegation. Note, training was rescheduled from May 2, 2019. Responsible Person: Risk Manager/Performance Improvement Director Chief Executive Officer Monitoring System: The Risk Manager/Performance Improvement Director audits 100% of internal incidents to	5/23/2019

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-13-2019**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			ensure all required cases have been submitted to CHRIS in compliance with 12VAC35-115-230 – Provider Requirements for Reporting: A-.2. – Allegations must be reported "within 24 hours of receipt of the allegation". Re-trainings and/or corrective actions administered for noncompliance of DBHDS regulation. APPROVED 7.1.19	

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] (Signature of Organization Representative) Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010309 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-20-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	Harbor Point Behavioral Health Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115). Human Rights Regulations: 12VAC35-115-50 Dignity B;2 which states: In receiving services, each individual has the right to; be protected from harm including abuse, neglect and exploitation. "Abuse means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectually disability, or substance abuse. This regulation was NOT MET as evidenced by: On April 26, 2021, Individual #1 attempted to attack another individual but was stopped by Employee #1. Individual #1 became upset and spit in Employee #1 face. Employee #1 responded by hitting the individual across the chest.	Provider Response: 1. Risk Manager/Performance Improvement Director, in collaboration with Senior Leaders, continuously reviews the Patient Abuse, Neglect and Exploitation – Reporting and Investigating policy, along with 12VAC35-115-50 Resident's Rights to include the right to be protected from harm including abuse, neglect and exploitation. This training occurs with 100% of staff, at minimum, at hire and yearly thereafter. 2. The facility conducted an internal investigation for abuse and neglect and found staff to be violation of the facility Patient Abuse, Neglect and Exploitation – Reporting and Investigating Policy, as well as, Human Rights Regulation 12VAC35-115-50 stating each individual has the right to be protected from harm. Risk Manager will continue to investigate all internal and external allegations of abuse, neglect and/or exploitation. If substantiated, Harbor Point Behavioral Health Center (HPBHC) will continue to notify Virginia Department of Behavioral Health and Developmental Services (DBHDS) via the Comprehensive Human Rights Information System (CHRIS). 3. Risk Manager, in collaboration with Senior Leaders and Program Managers, continuously provides in-service training on Therapeutic Communication, Boundaries and Interactions with residents. This training occurs with 100% of staff, at a minimum, at hire and yearly thereafter, as needed based on employee performance. 4. Risk Manager/Performance Improvement Director, or designee, will continue to retain staff.	4/27/2021

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-20-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			provide corrective action and/or terminate employment based on the results of the facility's internal investigation. 5. In regards to the staff identified in this case, staff was immediately removed from working with the resident making the allegation. Staff was suspended pending an internal and external review. The staff member was subsequently terminated from employment on 04-27-2021, prior to returning to work. Responsible Person: Risk Manager/Performance Improvement Director Human Resources Director Chief Executive Officer Monitoring System: Risk Manager/Performance Improvement Director will continuously monitor 100% of all internal and external allegations of abuse, neglect and exploitation to ensure a safe and therapeutic outcome for all residents served in compliance with 12VAC35-46-70 – Resident's Rights, as well as Human Rights Regulation 12VAC35-115-50 stating in receiving services, each individual has the right to be protected from harm including abuse, neglect and exploitation. OHR Accepted, LRW 10/12/21	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-20-2021**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
Inspection ID:[redacted]
Location: Harbor Point Behavioral Health

Please respond with acceptable corrective action to[redacted]**@dbhds.virginia.gov and**[redacted]**@dbhds.virginia.gov by 6/11/2021.**

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] Review Specialist | (Signature of Organization Representative) | Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010312 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **07-01-2020**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Compliance with human rights regulations	N	12VAC35-46-70. Resident's rights. Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115). Human Rights Regulations 12VAC35-115-50 Dignity Which states: In receiving services, each individual has the right to be protected from harm including abuse, neglect and exploitation. According to the OHR, this regulation was NOT met as evidenced by: On 05/13/2020, Employee #1 did not follow proper procedure regarding treatment of residents. This placed the resident at risk for increased harm. While a separate staff was conducting group, Individual 1 was disruptive, making noises, cursing. Individual 1 was asked to leave and he refused. Individual 1 continued to curse and be disruptive. Employee 1 attempted to get Individual 1 up, and Individual 1 pushed at staff. Employee 1 then dragged Individual 1 out of the dayroom into the hallway.	1. Risk Manager/Performance Improvement Director, in collaboration with Senior Leaders, continuously reviews the Patient Abuse, Neglect, and Exploitation - Reporting and Investigating policy, along with 12VAC35-46-70 Resident's Rights to include the right to be treated with dignity as a human being and be free from abuse and neglect. This training occurs with 100% of staff, at minimum, at hire and yearly thereafter. 2. The facility conducted an internal investigation for abuse and neglect. Portsmouth Child Protective Services di not complete an external investigation of the report made on 05-13-20. Risk Manager will continue to investigate all internal and external allegations of abuse, neglect and/or exploitation. It substantiated, Harbor Point Behavioral Health Center will (HPBHC) will continue to notify Virginia Department of Behavioral Health and Developmental services (DBHDS) via the Comprehensive Human Rights Information System (CHRIS). 3. Risk Manager/Performance Improvement Director, or designee, will continue to retain staff, provide corrective action and/or terminate employment based on the results of the facility's internal investigation. Response Person: Risk Manager/Performance Improvement Director Human Resources Director Chief Executive Officer Monitoring System: Risk Manager/Performance Improvement	6/1/2020

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **07-01-2020**
Program Type/Facility Name: **14-003**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Director will continuously monitor 100% of all internal and external allegations of abuse, neglect and exploitation to ensure a safe and therapeutic outcome for all residents served in compliance with 12VAC35-46-70 - Resident's Rights, reporting al substantiated and unsubstantiated to DBHDS via CHRIS. RECEIVED 7.21.20 APPROVED	

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] (Signature of Organization Representative) Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010347 [Redacted]

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **08-20-2021**
Program Type/Facility Name: **Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
1070.C - Report serious illness or injury w/in 24 hours to regulator	NS	12VAC35-46-1070. Serious incident reports. C. The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; and 6. The name of the person to whom the report was made. · This is a systemic (NS) citation. · This is the Third Step in the Progressive Citation Process for violation of 12VAC35-105-160 D.2 within a one-year period. This is measured on a rolling basis for (14-003) since October 1, 2020. • The first citation was issued on 12/02/2020. • The second citation was issued on 2/12/2021. · Per the Guidance on Incident Reporting Requirements, you are being required to attest to reviewing ALL CHRIS Training and guidance documents located on the DBHDS website as indicated by a check mark on the attestation form. Resolution to this licensing report requires two actions. The first action is to submitting an acceptable licensing report response. The second is to include the signed attestation form(s) for each individual within the organization who is required by you to receive training and to review guidance documents as attachments with the licensing report response. Both Items are due no later than the due date of 9/13/21. If the provider does not submit attestation(s) to confirm completion of required trainings and document reviews as indicated on the form, the provider may incur negative actions. The links for the trainings and guidance documents are listed in the attached attestation form. Review of CHRIS Case # [redacted] reveals a discovery date of 7/30/2021 5:20:00 PM but the provider did not notify the department using the department's web-based reporting application until 7/31/2021 7:09:00 PM. The entry was	Provider Response/Corrective Action Take: 1. The Director of Risk Management/Performance Improvement Director completed a re-training with Senior Leaders and managers, as well as, medical staff on completing an internal incident report at the time of incident or injury and/or time of discovery of incident or injury. Upon completion of the internal incident the staff will submit the form to the nursing department for review and notification of the substitute decision maker. The nursing department will submit the completed internal incident report to the Risk Management Department, in person or placing the form in the designated area in the mail room. 2. The Director of Risk Management/Performance Improvement Director completed a training with each individual within the organization, with granted access to the Comprehensive Human Rights Information System (CHRIS), utilizing the following training materials: CHRIS System Training (May 2021), Guidance for Serious Incident Reporting (November 2020), Guidance on Incident Reporting Requirements (August 2020), Memo – CHRIS Updates (October 2019), as well as, Creating Delta Accounts: Local Administrator, DELTA Security Officer, DELTA Supervisor and Production Account Request. The training included review of materials, as well as, case review of the identified cases for late entry as noted in this citation. 3. The Director of Risk Management/Performance Improvement Director re-trained and re-educated each individual within the organization, with granted access to CHRIS, on submitting serious incidents, including but not limited to residents testing positive for COVID-19, serious injury requiring medical attention and an unplanned emergency room or urgent care facility visit, when not used in lieu of primary care, into CHRIS for the Department of Behavioral Health and Developmental Services (DBHDS). This training including responsibility of authorized users (identified as Administrators On-Call) to enter incidents in CHRIS on night, weekends, holidays and/or any time the primary person (Director of Risk Management and the Risk Management Assistant) is not available. 4. The Director of Risk Management/Performance Improvement Director re-trained and re-educated each	09/10/2021

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #[redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **08-20-2021**
Program Type/Facility Name: **Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		made 1.8167 hours past the 24 hour reporting timeframe as required by regulation. Review of CHRIS Case #[redacted] reveals a discovery date of 8/15/2021 8:00:00 AM but the provider did not notify the department using the department's web-based reporting application until 8/17/2021 12:52:00 PM. The entry was made 4.8667 hours past the 24 hour reporting timeframe as required by regulation. Review of CHRIS Case #[redacted] reveals a discovery date of 8/15/2021 8:00:00 AM but the provider did not notify the department using the department's web-based reporting application until 8/17/2021 12:59:00 PM. The entry was made 4.9833 hours past the 24 hour reporting timeframe as required by regulation. Review of CHRIS Case #[redacted] reveals a discovery date of 8/21/2021 6:20:00 PM but the provider did not notify the department using the department's web-based reporting application until 8/22/2021 8:15:00 PM. The entry was made 1.916666 hours past the 24 hour reporting timeframe as required by regulation.	individual within the organization, with granted access to CHRIS, on the 24-hour notification of any serious illness or injury, death, and review of situations as required by the department. The Director of Risk Management/performance Improvement Director re-trained and re-educated each individual within the organization, with granted access to CHRIS, on the requirements of entering the date and time the incident occurred, a description of the incident, the action taken as a result of the incident, the name of the person who completed report, the name of the person who made the report to the placing agency/parent/legal guardian, and the person to whom the report was made. 5. The Director of Risk Management/Performance Improvement Director, in conjunction with the Chief Executive Officer, will maintain oversight of submitted corrective action plans, ensuring compliance with submitted action steps, continuously reviewing the facility's obligation to adhere to the agreed upon action plan. Person Responsible: Director of Risk Management/Performance Improvement Director Chief Executive Officer Monitoring System: The Director of Risk Management/Performance Improvement Director audits 100% of internal incident reports to ensure all required cased have been submitted to CHRIS in compliance with 12VAC35-46-170 – Serious Incident Reports, noting the provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. This audit is complete Monday – Friday by the Director of Risk Management, auditing Saturday and Sunday entries on Monday. If non-compliance is discovered, the Director of Risk Management/Performance Improvement Director completes an internal review, identifying the cause for non-compliance and immediately provides re-training to the identified individual(s).	

UHS-FINHELP-00010348

CONFIDENTIAL

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **08-20-2021**
Program Type/Facility Name: **Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The Director of Risk Management/Performance Improvement Director analyzes the data from the daily audit and reports the findings monthly to the Quality Council Committee for findings and the development of additional action plans as needed for compliance. The Director of Risk Management/Performance Improvement Director audits 100% of written corrective action plans to ensure compliance with 12VAC35-46-80 – Written corrective action plan, noting the "provider will submit to the department an implement a written corrective action plan for each regulation for which the provider found to be in noncompliance". OLR: CAP ACCEPTED (9/17/2021)	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:
License #: [redacted]
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **08-20-2021**
Program Type/Facility Name: **Harbor Point Behavioral Health**

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] Manager

[redacted] (Signature of Organization Representative)

09/22/2021 Date

Email to: [redacted]@dbhds.virginia.gov

Due Date: 09-13-2021

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

UHS-FINHELP-00010355 [Redacted]

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Connect™ / Quality Monitoring System for Healthcare Organizations

Logged-in, [redacted]
Harbor Point Behavioral Health Center, Inc.
[redacted]
Portsmouth VA,
HCO ID: [redacted] / Incident ID: [redacted]

Back to *Incident Selection*

Organization response to a safety event

Print

Incident Number: [redacted]
Incident Date: 9/26/2022
Programs: Behavioral Health Care and Human Services

Incident Sites

Site Name	Address
Harbor Point Behavioral Health Center, Inc.	[redacted] Portsmouth, VA [redacted]

Document Upload

Upload documents to be attached to your incident

File Description
Dental Report

Did you contact Reporter?

○ No ○ Yes ◉ N/A

Safety Event Summary

Source: Redacted - PII
Patient Redacted - PII

Our daughter has been a residential patient at Harbor point since April 2022 and has been assaulted or attacked multiple times, the most recent one being the worst. Several residents were going in and out of her room, touching and throwing her belongings, jumping on her bed. When she closed the door to attempt to avoid confrontation, a resident forced herself into my daughter's room and proceeded to attack her. My daughter was punched and kicked in the face. Not the first time she's been kicked in the face by another resident, either. The last time knocked a tooth loose. It seems that every time there is an incident, unit staff is either not present or not paying attention. We are in the process of getting her discharged because we feel that she is no longer safe in that facility under their care. She's leaving with MORE trauma than she walked in with.
****
If any of the assault allegations are valid and meet the definition of sentinel, please contact Redacted - PII at Redacted - PII for next steps. Thank you.

Also, in addition to the requests below, please respond to the following:
1. Please indicate whether patient attacks on other patients have increased.
2. What type of injuries did this patient sustain? Describe.
3. What type of training is provided for staff for workplace violence? Does the training provide for simulation to assess how staff are able to implement the training?
4. How is your workplace violence plan evaluated for effectiveness?
5. Does your organization conduct a culture of safety survey with staff? If so, when was the last survey?

Address the Specific allegation(s) and provide an analysis and review of related systems and processes:

Background:

Redacted - PII was admitted to Harbor Point on March 24, 2022. She was 11 years old at the time of admission (date of birth Redacted - PII). At admission, Redacted - PII psychiatric diagnoses included major depressive disorder, suicidal ideation, and dysregulation of mood, hearing voices, and seeing things Redacted - PII was treated previously for ADHD and depression, with a possibility of PTSD, aggression with psychotic symptoms, and a possibility of a reactive attachment disorder. Redacted - PII had a significant history of neglect and sexual abuse. Redacted - PII was placed on the younger pre-teen unit with similar age group. Upon admission, Redacted - PII listed her triggers as loud noises, bullying, and negative feedback/criticism. Staff provided her with noise-canceling headphones to minimize the noise on the unit. Redacted - PII was also permitted to have excess room time when she was unable to process her emotions while programming with her peers. She told staff that taking a walk, listening to music, or reading were some of her coping strategies. In addition, Redacted - PII was given the option of going to the patio to relax as part of her unit's daily schedule. She also had a radio and books she earned from the point store. Redacted - PII also participated in community groups as part of relationship building with her peers. When she became involved in a physical altercation with a peer, staff changed Redacted - PII group to keep her away from the peer. A unit safety plan was also developed for Redacted - PII

During one therapy session, Redacted - PII stepmother Redacted - PII requested for Redacted - PII to be placed on another unit away from the peer with whom she was having conflicts. Harbor Point could not process the request to move Redacted - PII to another unit due to age disparities on the unit. However, when Redacted - PII turned twelve, she was moved to another unit with similar age group.

Redacted - PII had regular assessments with her physician (as indicated below) as well as three Individual therapy sessions per week and one family session per week with her therapist. Direct care staff provide daily 15-minute observations and unit oversight for Redacted - PII safety.

Post Admission MD Assessments
April 13, 2022
April 28, 2022
May 5, 2022
June 7, 2022
July 12, 2022
July 22, 2022
August 18, 2022
September 23, 2022
All medical and clinical notes and assessments are available upon request

Incidents during Redacted - PII Length of Stay

- April 8, 2022 19:00hrs: A peer was banging a book on the floor in the hallway of the unit Redacted - PII became agitated by her peer's action and Redacted - PII physically attacked the peer. The peer retaliated; they were separated by staff. The nurse assessed Redacted - PII and reported no injury. Redacted - PII stepmother and legal guardian Redacted - PII was notified at 21:46hrs on April 8, 2022. In adherence to Harbor Point's conflict resolution process, a peer to peer mediation occurred between Redacted - PII and the peer. Upon review, staffing ratio (1:8 during evening shift) was being maintained in accordance with facility policy and state staffing requirements.
- April 26, 2022 20:15hrs: Redacted - PII reported to staff that she slipped in her bathroom and hit the corner of her mouth on the bathroom sink. Redacted - PII claimed that one of front teeth became loose from the incident, but she denied pain; there was no bleeding or swelling to her mouth. Redacted - PII stepmother Redacted - PII was notified on April 26, 2022. On April 30, 2022, at 10:20hrs, Harbor Point staff accompanied Redacted - PII to a dental appointment at Friendly Faces. Redacted - PII underwent dental exam and dental cleaning; no abnormalities were reported. Contrary to mother's perception that the tooth was loosened during a confrontation with a peer, upon our review of the incident, and after Redacted - PII visited the dentist, it became clear that the tooth was not loose.

- On May 14, 2022 at 12:12hrs Redacted - PII left Harbor Point with her stepmother for a family visit. At departure, Redacted - PII was noted to be well, was dressed appropriately, and was able to verbalize her treatment goals during the visit Redacted - PII and her stepmother Redacted - PII returned to Harbor Point same day at 15:30hrs without incident.
- July 13, 2022 15:15hrs Redacted - PII and her peers (from the same unit) were at the swimming pool when her peers reported that Redacted - PII had exposed her breasts to them. Redacted - PII claimed that she only showed them her birthmarks, and that the bathing suit did not fit properly. Nursing observed the "birthmark" to be a bruise but Redacted - PII insisted that it was a birthmark. Redacted - PII stepmother and legal guardian Redacted - PII was notified, during which she Redacted - PII expressed frustration and reported that the Redacted - PII did not have a birthmark. Redacted - PII was placed on special precaution for sexual misconduct by the doctor; the doctor also ordered a psychosexual evaluation for Redacted - PII After the incident, Harbor Point purchased a fitting bathing suit for Redacted - PII to prevent a recurrence. Upon review, staff ratio (1:8 during day shift) was being maintained in accordance with facility policy and state staffing requirements.
- July 17, 2022 0900hrs: A peer assaulted Redacted - PII unprovoked. Redacted - PII slapped the peer back and the peer punched her in the face. They were separated by staff. Redacted - PII stepmother Redacted - PII was notified. Nurses assessed Redacted - PII and noted no injury. Upon review, staff ratio (1:8 during day shift) was being maintained in accordance with facility policy and state staffing requirements.
- July 20, 2022 22:00hrs Redacted - PII was sitting quietly on the floor in front of her room when an agitated peer kicked Redacted - PII in the head. The aggressor was removed and nursing was notified. Upon assessment, the nurse did not notice any swelling or redness to Redacted - PII head. Redacted - PII was asked to notify the nurse if she experienced headache or discomfort. The Medical Director and Redacted - PII stepmother Redacted - PII were notified. Upon review, staffing ratio (1:8 during evening shift) was being maintained in accordance with facility policy and state staffing requirements.
- August 6, 2022 11:10hrs: Redacted - PII left Harbor Point with her stepmother Redacted - PII for a family outing. The nurse reviewed with Redacted - PII her therapeutic goals during the visit that were developed in collaboration with her therapist. Both Redacted - PII and her stepmother Redacted - PII verbalized their understanding of the therapeutic goals during the visit. Redacted - PII and her stepmother Redacted - PII returned to Harbor Point safely that evening.
- August 21, 2022 21:56hrs: A peer verbally provoked Redacted - PII triggering her to anger. Redacted - PII was removed from the unit for safety, and was brought back later to go to bed. The Medical Director and Redacted - PII stepmother Redacted - PII were notified. Upon review, staffing ratio (1:8 during evening shift) was being maintained in accordance with facility policy and state staffing requirements.
- September 11, 2022 10:15hrs: Redacted - PII left Harbor Point with her stepmother for a family visit. She was dressed appropriately for the weather and all risk assessments were completed prior to their departure. Both Redacted - PII and her stepmother Redacted - PII returned to Harbor Point at 20:16hrs. No contraband was found upon Redacted - PII return and all risk assessments were completed by the nurse.
- September 17, 2022 0947hrs: Redacted - PII left Harbor Point with her father/legal guardian Redacted - PII Her therapeutic goals for the visit were reviewed with both Redacted - PII and Redacted - PII Both verbalized their understanding of the goals. All risk assessments were done prior to their departure from Harbor Point.
- September 25, 2022 1930hrs

During medication pass Redacted - PII was heard screaming to peers to "get out my room, get out my room." Staff witnessed Redacted - PII peers coming out of her room. The staff called a code and the peers were removed from Redacted - PII room. Redacted - PII then went to the medication window and began to cry, telling the nurse that her peers were invading her boundaries by touching per personal items in her room. She stated that in an attempt to close her room, she hurt her shoulder and index finger. The nurse provided icepack and notified the pediatrician and Redacted - PII mother Redacted - PII Upon review, staff ratio (1:8 during shift) was being maintained in accordance with facility policy and state requirements. On the night of the incident, Harbor Point provided an extra staff on the unit to increase the margin of safety.

- September 26, 2022 0935hrs

Redacted - PII was agitated by one of her peers; she went into her room and closed the door. The peer went into the room and assaulted Redacted - PII In defending herself Redacted - PII bit the peer; the peer then kicked Redacted - PII in the face. The staff called a code and the peer was removed from Redacted - PII room. Upon assessment

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Systems Improvements and/or Follow-up Actions:

Harbor Point now leverages the collective expertise and experience of a multidisciplinary team to review admission packets to determine suitability of residents to individual programs based on their pre-admission and post-admission treatment needs.

Unit Program Managers, Clinicians, Nursing, and Risk Management are also now regularly discuss treatment modalities and share information with families and other stakeholders on how to address behavioral challenges from residents, including bullying incidents.

A 48-hour review process is in place to track how residents are adjusting to their new treatment environment forty-eight hours after admission. With input from the resident, this is an opportunity for the entire treatment team – admissions, education, nursing, risk management, medical and clinical teams, dietary and residential program managers, to discuss ways to support the new resident in acclimating to the treatment program.

A Patient Care Monitoring (PCM) process is in place to discuss and implement additional support processes to address the needs of residents who become involved in multiple incidents with a 48-hour period. Clinicians, the medical team, program managers and facility leadership participate in the PCM and implement agreed interventions at the highest level of the facility within a continuum of care and support for residents involved in PCM.

To prevent a recurrence of conflict between and among residents, we have also implemented a robust peer mediation program and active community engagement to address individual conflicts and ameliorate difference between and among residents with immediacy. Peer mediation is conducted twenty-four hours after a conflict between residents. During (unit) community meetings, residents are given the opportunity to voice their opinions of issues that affect their wellbeing. Results of the meetings are communicated to leadership for overall program improvement. As a result of these interventions, Harbor Point is now experiencing incremental decrease in patient aggression incidents.

Measurement/sustainability of compliance to related standards:

Data on safety and acuity issues is collected monthly through chart audits, incident and event reports, our Quality of Care Dashboard which includes a domain for Restraint/Seclusion as well as for Safety trends. In addition, the facility participates in a Fidelity Project which is designed to ensure robust programming and attendance, active/alternative treatment, and representation of the Psychiatrist, Therapist and Nurse in the master treatment planning and update process. All data is reported monthly via the Quality Assurance Performance Improvement leadership committee meeting through indicators. The goal is to use data to make improvements and identify areas of opportunity for improving our treatment program.

Request for Additional Information (First):

Additional Information (First):

Request for Additional Information (Second):

Additional Information (Second):

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UHS-FINHELP-00010359 [Redacted]



Final Accreditation Report

Harbor Point Behavioral Health Center, Inc.

[redacted]

Portsmouth, VA [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 3/20/2018 - 3/23/2018

Program Surveyed
Behavioral Health

Final Report: Posted 4/25/2018

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health	03/20/2018 - 03/23/2018	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

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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.02.02.07	1	Moderate / Limited	✓
EC.02.06.01	1	Low / Pattern	✓
EC.02.06.03	1	Low / Pattern	✓
EM.02.01.01	2	Low / Limited	✓
EM.03.01.03	1	Low / Pattern	✓
LD.04.01.07	1	Low / Limited	✓
	2	Low / Widespread	✓
LS.04.02.30	20	Moderate / Pattern	✓

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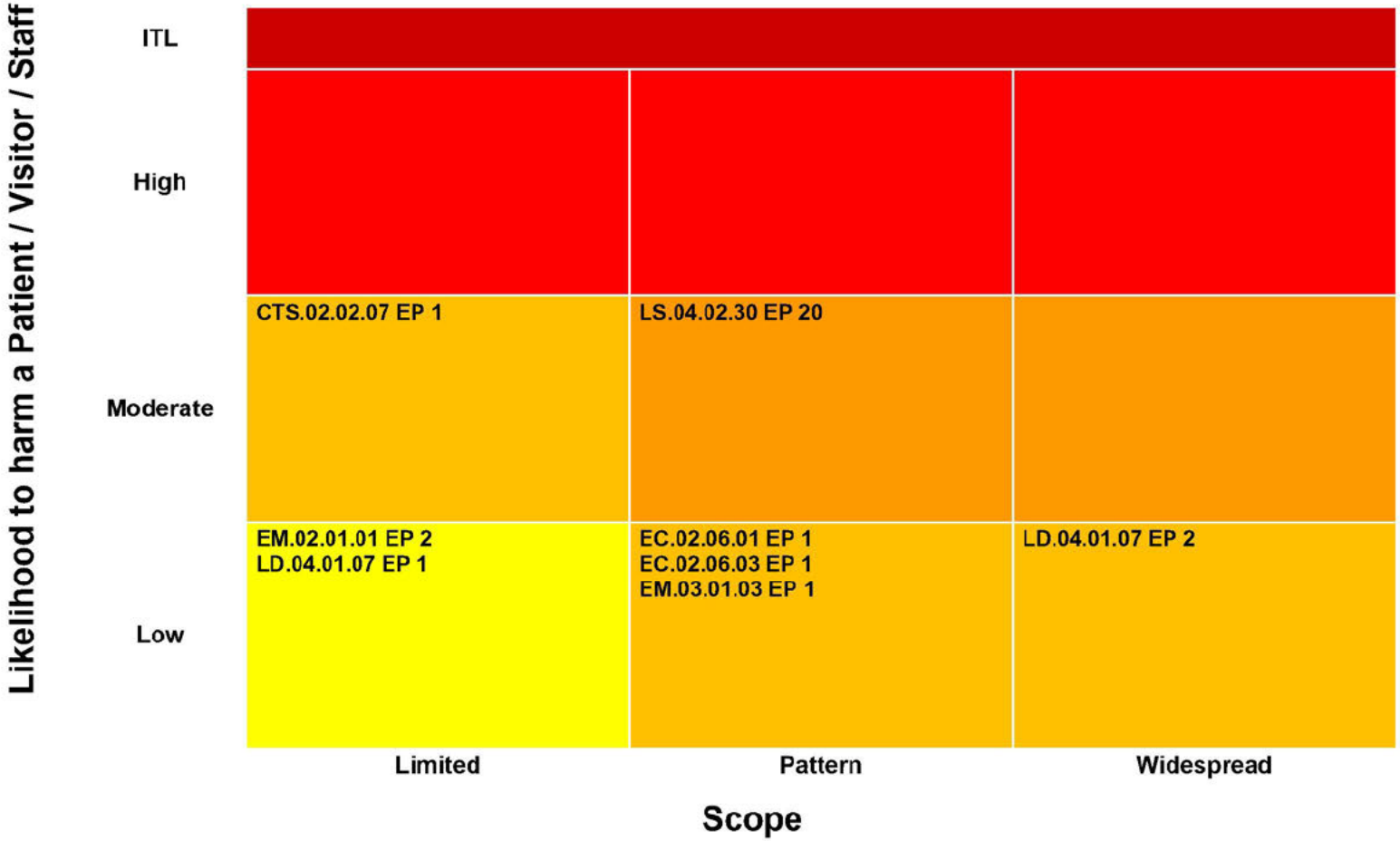
SAFER™ Matrix
Program: Behavioral Health



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Requirements for Improvement

Program: Behavioral Health

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.02.07	1	Moderate Limited	The organization reassesses each individual served, as needed.	1). Observed in Individual Tracer at Harbor Point Behavioral Health Center, Inc. [redacted]Portsmouth, VA) site . While touring Oasis A, after lunch on day-one of the survey, one patient was observed sleeping on the floor with head covered outside the comfort room. There was no staff in the hallway providing supervision to this patient. On the morning of day-two of the survey the same patient was observed in the same place sleeping on the floor with no visible supervision being provided to her. House keeping staff and painters were working in the hallway(s) of this unit and were required to clean the floor around her since was not amenable to moving. The patient moved farther down the hall way, again out of the line of vision of supervision, and put a blanket on the floor and went back to sleep. The MHT was providing supervision four patient in a day room at the end of another hallway. The MHT was completing the daily 15-minute observation/point sheets. The patient who was sleeping in the hallway was scored 1's for being on task and participating appropriately.
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 Harbor Point Behavioral Health Center, Inc.[redacted]ortsmouth, VA) site . While it was recognized that environmental rounds are made regularly the following observations were made during the building tour (1) ceiling vents in the kitchen and in medical records were in need of cleaning ....corrected on site (2) there appeared to be some corrosion or substance leaking out of the water filtration system in the main kitchen.....corrected on site (3) sprinkler heads were missing the escutcheons in about 10 sprinklers in areas throughout the building (4) one ceiling light cover was missing in one classroom at the school....corrected on site.
EC.02.06.03	1	Low Pattern	The dining environment encourages eating and socialization.	1). Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted]Portsmouth, VA) site . Two styrofoam foam food containers and empty milk cartons were piled on a table in the dayroom of Oasis A. The mental health tech who was sitting at the table said the containers were brought over at breakfast for the patients who didn't want to go to the dining room. The MHT said that if the patients didn't want to go to the dining room their food was brought to them on the unit. When queried about the

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Standard	EP	SAFER™ Placement	EP Text	Observation
				practice of delivering food to the unit, the Food Service Manager said that food could be delivered to the unit but it was not the practice.
				2). Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . There are two dining rooms and the smaller dining room is used for 2 of the 11 unit's residents that are deemed as needing separation for safety purposes. While the larger dining room was observed to have pictures on the walls the smaller dining room is void of decoration. The EOC Coordinator said that the room had recently been wallpapered or painted which did give the room some color.
EM.02.01.01	2	Low Limited	The organization has a written Emergency Management Plan that describes the response procedures to follow when emergencies occur. (See also EM.02.02.11, EP 1; EM.03.01.03, EP 5) Note 1: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following: - Maintaining or expanding services - Conserving resources - Curtailing services - Supplementing resources from outside the local community - Closing the organization to new individuals for service - Staged evacuation - Total evacuation Note 2: Organizations that do not provide 24-hour care may plan to close in response to an emergency; their activities may be focused on notification and communication to individuals served and strategies for resuming service following the emergency.	1). Observed in Emergency Management Session at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . The Emergency Management Plan required greater specificity related to the logistics and delineated staff responsibilities associated with the provision of medication, clothing, food, as appropriate, in the event of a disaster requiring relocation of residents.
EM.03.01.03	1	Low Pattern	As an emergency response exercise, the organization activates its Emergency Management Plan once a year at each site included in the plan for non-24-hour settings; 24-hour settings are required to activate the plan twice each year. Note 1: If the organization activates its Emergency Management Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Note 2: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.	1). Observed in Emergency Management Session at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . One emergency drill was conducted in 2017 and it was for a thunder storm. The critique of the thunder storm noted that each program's initiation of their plan was satisfactory. The scope of the thunderstorm as an emergency/disaster exercise was not clearly represented in the critique. However, as a 24-hour setting a second activation of the emergency management plan was not conducted. Aa critique of a "Security Issue" was critiqued. The CEO and the Facilities Director said the security issue was an intruder. There was no documentation in the critique that identified the issue as an intruder and the content of the critique did not

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Standard	EP	SAFER™ Placement	EP Text	Observation
				relate or identify an intruder as the emergency situation.
LD.04.01.07	1	Low Limited	Leaders review and approve policies and procedures that guide and support care, treatment, or services.	1). Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . There were no policies and procedures that addressed the management of food that was prepared and delivered to the patient units. No policies addressed delivery, temperature, disposal of food delivered to the units in styrofoam containers. The organization began the process of amending the policy and procedures pending involvement of dietary and nutrition and clinical services.
LD.04.01.07	2	Low Widespread	The organization manages the implementation of policies and procedures.	1). Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . The medical record of a discharged resident was supposed to be within 30-days of the discharge. This was confirmed with the new HIS director who was recently hired. While on tour more than 38 medical records were observed to be pending closure do missing documentation. The 38 records ranged in discharge dates from 9/7/2017 to 12/31/2017. Additional records in 2018 had also passed the 30- day closure date. Information obtained from the HIS staff noted there was only one staff person working in the medical records area since a hiring freeze more than a year ago.
LS.04.02.30	20	Moderate Pattern	The organization meets all other Life Safety Code building feature requirements related to NFPA 101-2000: 28/29.3.	1). Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . During the building tour at least 10 sprinklers located throughout the building did not have escutcheons. Discussion with the CEO noted the contracted vendor began upgrading the sprinkler system in November, 2017. The vendor is upgrading in phases. The CEO agreed to implement ISLM and increase surveillance, provide education on fire safety features and conduct additional drills in areas where the escutcheons remain missing.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance(EP-8), Conduct additional fire drill per quarter(EP-11), Train staff on fire safety features(EP-14)

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Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.02.07	1	The organization reassesses individuals served, as needed. Note: The scope and intensity of any further assessments are based on the individual's functioning; the setting; the individual's preferences for care, treatment, or services; and the individual's response to care, treatment, or services provided. Each individual may be reassessed for many reasons, including the following: - To evaluate his or her response to care, treatment, or services - To respond to a significant change in status and/or diagnosis or condition - To satisfy legal or regulatory requirements - To meet time intervals specified by the organization - To meet time intervals determined by the course of the individual's care, treatment, or services	The organization reassesses each individual served, as needed.
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.
EC.02.06.03	1	The organization establishes and maintains a safe and functional dining environment when food is provided.	The dining environment encourages eating and socialization.
EM.02.01.01	2	The organization has an Emergency Management Plan. Note: The organization's Emergency Management Plan (EMP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.	The organization has a written Emergency Management Plan that describes the response procedures to follow when emergencies occur. (See also EM.02.02.11, EP 1; EM.03.01.03, EP 5) Note 1: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following: - Maintaining or expanding services - Conserving resources - Curtailing services - Supplementing resources from outside the local community - Closing the organization to new individuals for service - Staged evacuation - Total evacuation Note 2: Organizations that do not provide 24-hour care may plan to close in response to an emergency; their activities may be focused on notification and communication to individuals served and strategies for resuming service following the emergency.

The Joint Commission

Standard	EP	Standard Text	EP Text
EM.03.01.03	1	The organization evaluates the effectiveness of its Emergency Management Plan.	As an emergency response exercise, the organization activates its Emergency Management Plan once a year at each site included in the plan for non-24-hour settings; 24-hour settings are required to activate the plan twice each year. Note 1: If the organization activates its Emergency Management Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Note 2: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.
LD.04.01.07	1	The organization has policies and procedures that guide and support care, treatment, or services.	Leaders review and approve policies and procedures that guide and support care, treatment, or services.
LD.04.01.07	2	The organization has policies and procedures that guide and support care, treatment, or services.	The organization manages the implementation of policies and procedures.
LS.04.02.30	20	The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. Note 1: This standard applies to behavioral health care settings that provide sleeping arrangements for 17 or more individuals served as a required part of their care, treatment, or services. Note 2: If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.	The organization meets all other Life Safety Code building feature requirements related to NFPA 101-2000: 28/29.3.

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

Harbor Point Behavioral Health Center, Inc.
[redacted]
Portsmouth, VA[redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 5/23/2018

ESC Programs Reviewed
Behavioral Health

Final Report: Posted 6/4/2018

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
Behavioral Health	5/23/2018	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.02.07	Compliant
EC.02.06.01	Compliant
EC.02.06.03	Compliant
EM.02.01.01	Compliant
EM.03.01.03	Compliant
LD.04.01.07	Compliant
LS.04.02.30	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.02.07	1	The organization reassesses individuals served, as needed. Note: The scope and intensity of any further assessments are based on the individual's functioning; the setting; the individual's preferences for care, treatment, or services; and the individual's response to care, treatment, or services provided. Each individual may be reassessed for many reasons, including the following: - To evaluate his or her response to care, treatment, or services - To respond to a significant change in status and/or diagnosis or condition - To satisfy legal or regulatory requirements - To meet time intervals specified by the organization - To meet time intervals determined by the course of the individual's care, treatment, or services	The organization reassesses each individual served, as needed.
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.
EC.02.06.03	1	The organization establishes and maintains a safe and functional dining environment when food is provided.	The dining environment encourages eating and socialization.
EM.02.01.01	2	The organization has an Emergency Management Plan. Note: The organization's Emergency Management Plan (EMP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.	The organization has a written Emergency Management Plan that describes the response procedures to follow when emergencies occur. (See also EM.02.02.11, EP 1; EM.03.01.03, EP 5) Note 1: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following: - Maintaining or expanding services - Conserving resources - Curtailing services - Supplementing resources from outside the local community - Closing the organization to new individuals for service - Staged evacuation - Total evacuation Note 2: Organizations that do not provide 24-hour care may plan to close in response to an emergency; their activities may be focused on notification and communication to individuals served and strategies for resuming service following the emergency.

The Joint Commission

Standard	EP	Standard Text	EP Text
EM.03.01.03	1	The organization evaluates the effectiveness of its Emergency Management Plan.	As an emergency response exercise, the organization activates its Emergency Management Plan once a year at each site included in the plan for non-24-hour settings; 24-hour settings are required to activate the plan twice each year. Note 1: If the organization activates its Emergency Management Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Note 2: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.
LD.04.01.07	1	The organization has policies and procedures that guide and support care, treatment, or services.	Leaders review and approve policies and procedures that guide and support care, treatment, or services.
LD.04.01.07	2	The organization has policies and procedures that guide and support care, treatment, or services.	The organization manages the implementation of policies and procedures.
LS.04.02.30	20	The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. Note 1: This standard applies to behavioral health care settings that provide sleeping arrangements for 17 or more individuals served as a required part of their care, treatment, or services. Note 2: If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.	The organization meets all other Life Safety Code building feature requirements related to NFPA 101-2000: 28/29.3.

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Standard: CTS.02.02.07

The organization reassesses individuals served, as needed. Note: The scope and intensity of any further assessments are based on the individual's functioning; the setting; the individual's preferences for care, treatment, or services; and the individual's response to care, treatment, or services provided. Each individual may be reassessed for many reasons, including the following: - To evaluate his or her response to care, treatment, or services - To respond to a significant change in status and/or diagnosis or condition - To satisfy legal or regulatory requirements - To meet time intervals specified by the organization - To meet time intervals determined by the course of the individual's care, treatment, or services	EP 1 Likelihood to Cause Harm: Moderate Scope: Limited Observed in Individual Tracer at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site. While touring Oasis A, after lunch on day-one of the survey, one patient was observed sleeping on the floor with head covered outside the comfort room. There was no staff in the hallway providing supervision to this patient. On the morning of day-two of the survey the same patient was observed in the same place sleeping on the floor with no visible supervision being provided to her. House keeping staff and painters were working in the hallway(s) of this unit and were required to clean the floor around her since was not amenable to moving. The patient moved farther down the hall way, again out of the line of vision of supervision, and put a blanket on the floor and went back to sleep. The MHT was providing supervision four patient in a day room at the end of another hallway. The MHT was completing the daily 15-minute observation/point sheets. The patient who was sleeping in the hallway was scored 1's for being on task and participating appropriately.
EP	Element Of Performance (EP) Text
1	1. The organization reassesses each individual served, as needed.

Assigning Accountability: Director of Residential Services **Completed by: 04/20/18**

Correcting the Non-Compliance

To ensure that the issue was corrected a review of the facility's policies and procedures pertaining to staff providing supervision and monitoring was conducted to ensure that the description of what constitutes active supervision and/or monitoring was clearly delineated in the policy language. Once it was determined that the language was clear then the Director of Residential Services set a date to review the policy with the Program Managers. This review occurred 04/03/18. Program Managers then submitted to the Director of Residential Services staff review dates for all Mental Health Techs (MHTs). Review dates were scheduled for 04/04-11/18. To assist with emphasizing the importance of providing active supervision and/or monitoring; the Director of Risk Management was in attendance to discuss the importance of accurate documentation.

Ensuring Sustained Compliance

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

To ensure Harbor Point's compliance with this element of performance the facility will continue to utilize established policy and procedures which delineate staff's responsibilities with providing appropriate supervision to residents. Instituted procedures will continue to include daily discussion during the AM Flash meetings of any individual that may require additional supervision or monitoring. Also during the meeting, discussion will incorporate issues associated with

the individual's non-compliance with accepting supervision. Once it is determined that individual(s) will need additional supervision and/or monitoring, the Director of Residential Services will work with Program Managers and Lead Mental Health Techs (LMHTs) to determine appropriate staffing.

Secondly, to ensure compliance with documentation accuracy Harbor Point will continue to conduct multiple audits throughout daily shifts to monitor the accuracy and timeliness of staff's documentation. Lead Mental Health Techs (LMHTs) will ensure that all Q15s documentation is completed and accurate prior to the conclusion of shifts. The Nursing Dept. will also continue to review and sign off on Q15 forms 2x per shift. Finally, the Administrator on Duty (AOC) will review Q15s and sign off daily. Also, the AOC will randomly review an individual's documentation, to ensure that an individual's action/activity posted on the weekly schedule is accurately documented on the Q15s. Any issues that arise from these daily audits will be addressed with the Program Managers, who will be responsible for accountability and ensuring that the Director of Residential Services is aware of these issues.

What is the frequency of the monitoring activities?

The written data collected for ensuring appropriate monitoring, supervising and documenting of residents' activities and actions will supported by the nursing and AOC observations and documentation.

To whom, and how often, will this data be reported?

The data will be recorded monthly to the Quality Council and quarterly to the Medical Executive and Governing Body meetings.

Standard EC.02.06.01

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Standard Text	Surveyor Findings
The organization establishes and maintains a safe, functional environment.	EP 1 Likelihood to Cause Harm: Low Scope: Pattern Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted]VA) site. While it was recognized that environmental rounds are made regularly the following observations were made during the building tour (1) ceiling vents in the kitchen and in medical records were in need of cleaning ....corrected on site (2) there appeared to be some corrosion or substance leaking out of the water filtration system in the main kitchen.....corrected on site (3) sprinkler heads were missing the escutcheons in about 10 sprinklers in areas throughout the building (4) one ceiling light cover was missing in one classroom at the school....corrected on site.

Please select/highlight the element of performance (EP) you would like to respond to. Save

EP	Element Of Performance (EP) Text
1	1. Interior spaces meet the needs of the individuals served for safety and suitability for the care, treatment, or services provided.

Assigning Accountability: Director of Plant Operations **Completed by: 04/06/18**

Correcting the Non-Compliance

To ensure that all identified environmental concerns are resolved in a timely manner, daily inspections will continue to be conducted by the Director of Plant Operations, unit staff and the AOC designee. The following issues observed during the survey have been successfully re-dressed on 03/23/18: Ceiling vents in the kitchen and in medical records 2) mineral build-up corrosion on the water filtration system in the main kitchen and one ceiling light cover was missing in one classroom at the school. Missing escutcheons for the 10 sprinkler heads were purchased and installed by contractor vendor by 04/06/18.

Project prioritization and completion deadlines will be determined by the CEO, CFO and the Director of Plant Operations based on safety significance, impact on quality service delivery and resources availability. These deadlines will be incorporated more consistently and strictly adhered to as a checks and balance intervention. Projection completions will be signed off by either the CFO or Dir. of Risk Management after final inspections. Updates of project completions will be incorporated into the AM Flash meetings. Responsible EOC staff was trained to the expectations of the standard.

Ensuring Sustained Compliance

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

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

To ensure Harbor Point's compliance with this element of performance the facility will continue to utilize established policy and procedures which delineate staff's responsibilities with maintaining the building and all environments, internally and externally. Instituted procedures will continue to include daily discussion during the AM Flash meetings of any environmental issues that may require immediate attention and/or additional resources or monitoring. Once it is determined the type of resources required for the appropriate re-dress, the Director of Plant Operations will work with the Maintenance and/or Housekeeping teams to remedy the environmental concern. Additionally, daily inspection of the vents has been added to the inspection checklist utilized by the housekeeping department and the maintenance department will continue to repair or replace as needed when received via work orders submitted daily, including light covers. Cleaning the water filtration unit has been added to the kitchen cleaning checklist.

The Administrator on Duty (AOC) will review the previous day's report and while conducting their daily observation tour determine the status of reported maintenance issues. Finally, any issues that may negatively impact a projected deadline will be addressed with the Director of Plant Operations and CFO who will be responsible for accountability and ensuring that the CEO is aware of these issues.

What is the frequency of the monitoring activities?

The Director of Plant Operations, maintenance and housekeeping teams will continue to inspect the building daily. Staff will continue to be encouraged to report any issues in need of repair or replacement by completing a work order and submitting it to the maintenance office. Additionally, Administrator on Call (AOC) and Unit 4 teams during their daily walk through will also complete checklists and submit to the Director of Plant Operations via email or mailbox any issues needing to be addressed.

What data will be collected from these activities?

The Director of Plant Operations will continue to utilize a Work Order log that prioritizes issues to be addressed and include anticipated work completion dates.

To whom, and how often, will this data be reported?

The Director of Plant Operations' daily report will be shared during AM meetings and a report will be submitted during EOC and Quality Council meetings monthly.

Standard EC.02.06.03

CONFIDENTIAL

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Standard Text	Surveyor Findings
The organization establishes and maintains a safe and functional dining environment when food is provided.	EP 1 Likelihood to Cause Harm: Low Scope: Pattern Observed in Building Tour at Harbor Point Behavioral Health Center, Inc [redacted] Portsmouth, VA) site. Two styrofoam foam food containers and empty milk cartons were piled on a table in the dayroom of Oasis A. The mental health tech who was sitting at the table said the containers were brought over at breakfast for the patients who didn't want to go to the dining room. The MHT said that if the patients didn't want to go to the dining room their food was brought to them on the unit. When queried about the practice of delivering food to the unit, the Food Service Manager said that food could be delivered to the unit but it was not the practice. Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted] ortsmouth, VA) site. There are two dining rooms and the smaller dining room is used for 2 of the 11 unit's residents that are deemed as needing separation for safety purposes. While the larger dining room was observed to have pictures on the walls the smaller dining room is void of decoration. The EOC Coordinator said that the room had recently been wallpapered or painted which did give the room some color.

Please select/highlight the element of performance (EP) you would like to respond to. Save

EP	Element Of Performance (EP) Text
1	1. The dining environment encourages eating and socialization.

Assigning Accountability: Director of Plant Operations **Completed by: 05/10/18**

Correcting the Non-Compliance

To ensure Harbor Point's compliance with this element of performance for **Observation #1** the facility has amended its established policy and procedures for Nutritional Services on 03/31/18 which delineates staff's responsibilities with ensuring that all residents be served meals in the dining room since it is Harbor Point's policy that that all residents will be served meals in the dining room unless confined to their unit due to illness and/or physician's order or on an outing or appointment. Additionally, the Dietary Manager will ensure that all packaging will include the following information: The individual's initials and residential unit; date and time the meal was prepared and it is to be retrieved and by whom. The Dietary Manager will maintain a retrieval checklist which will include a column for when staff was notified of meal readiness and estimated expiration times. Retrieval staff will also have to sign for the meal(s).

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

The Residential Director will review all requests submitted by staff, clinical or medical teams prior to meal times. Upon review, the requests will be send a copy of the reviewed request to the Dietary Director in advance to ensure that the meal is properly prepared. Another copy will be given to the Lead Mental Health Tech (LMHT) for timely retrieval, consumption and disposal. Responsible EOC staff was trained to the expectations of the standard.

To ensure Harbor Point's compliance with this element of performance for **Observation #2** that all identified concerns associated with the décor of the small dining hall were re-dressed in a timely manner the Chief Financial Officer (CFO) began receiving quotes for new tables and chairs in February 2018 and allotted funds in March 2018 for the purchase of new tables and chairs. Donated artwork was framed and hung in the space on 05/03/18. Tables and chairs were delivered on 05/04/18 and after assembly, were placed in the smaller dining room by 05/10/18.

ENSURING SUSTAINED COMPLIANCE

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

To ensure Harbor Point's compliance with this element of performance for **Observation #1,** the Director of Environmental Services and the Dietary Manager will meet on weekly basis review any meal requests submitted and discuss any concerns.

To ensure Harbor Point's compliance with this element of performance for **Observation #2,** the Director of Environmental Services and the Director of Plant Operations will on an annual basis determine the need for refreshing the dining room spaces. Immediate concerns such sectional painting or cleaning will be addressed by maintenance and/or housekeeping weekly.

What is the frequency of the monitoring activities?

For **Observation #1** the Dietary Manager will note any meal requests via form daily.

For **Observation #2** the Director of Plant Operations will note any repair or replacement issues observed during daily building inspections, prioritizing any concerns associated with safety concerns.

What data will be collected from these activities?

For **Observation #1** the Dietary Manager will note any meal requests via form daily.

For **Observation #2** the Director of Plant Operations will note any repair or replacement issues observed during daily building inspections, prioritizing any concerns associated with safety concerns in a Repairs Log for all projects.

To whom, and how often, will this data be reported?

Separate written reports by the Dietary Manager and the Director of Plant Operations will be submitted to monthly EOC meetings and Quality Council meetings for concerns delineated in **Observations 1 and 2.**

Standard EC.02.01.01

CONFIDENTIAL

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

The organization has an Emergency Management Plan. Note: The organization's Emergency Management Plan (EMP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This 'all hazards' approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.	EP 2 Likelihood to Cause Harm: Low Scope: Limited Observed in Emergency Mana[redacted]ortsmouth, VA) site. The Emergency Management Plan required greater specificity related to the logistics and delineated staff responsibilities associated with the provision of medication, clothing, food, as appropriate, in the event of a disaster requiring relocation of residents.

Please select/highlight the element of performance (EP) you would like to respond to. Save

EP	Element Of Performance (EP) Text
2	2. The organization has a written Emergency Management Plan that describes the response procedures to follow when emergencies occur. (See also EM.02.02.11, EP 1; EM.03.01.03, EP 5) Note 1: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following: - Maintaining or expanding services - Conserving resources - Curtailing services - Supplementing resources from outside the local community - Closing the organization to new individuals for service - Staged evacuation - Total evacuation Note 2: Organizations that do not provide 24-hour care may plan to close in response to an emergency; their activities may be focused on notification and communication to individuals served and strategies for resuming service following the emergency.

Assigning Accountability: Director of Plant Operations **Completed by: 04/19/18**

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Correcting the Non-Compliance

To ensure that this standard is correctly re-dressed the facility administration with the Director of Plant Operations as Lead Reviewer will actively review its Emergency Management Plan in late-June, after key facility staff (CFO, Risk Manager and Director of Plant Operations) have participated in the State of Virginia's Emergency Preparedness Training for Healthcare Facilities to be held on June 6, 2018 in Chesapeake, VA. Also, the Director of Plant Operations will develop tabletop sessions and scenarios to be utilized for additional training opportunities throughout the year to supplement the Emergency Management Plan. Responsible EOC staff was trained to the expectations of the standard.

Additionally, to ensure Harbor Point's compliance with this element of performance the Director of Plant Operations and Risk Manager reviewed the submitted Emergency Management Plan and outlined in greater details the responsibilities of the following staff groups:

Medical staff, including nursing under the joint leadership of the Medical Director and the Director of Nursing will address all aspects of medication management; advance ordering with time permitting; distribution, and safe storage and proper disposal of meds and equipment.

Residential services under the leadership of the Residential Director have the following responsibilities assigned and delineated: the provision of clothing, sheltering in place, staff assignments and working with the Office of Risk Management, Nursing and Clinical to ensure that all communications and notifications are completed in an orderly manner.

Nutritional Services under the leadership of the Dietary Manager; have the following responsibilities assigned and delineated: Preparation, transportation/ delivery of food products from outside sources, determining when, where and how meals will be prepared, served and finally, disposal of all foods and associated meals.

Conserving utilities resources will be a primary responsibility of the maintenance/operations department, under the leadership of the Director of Plant Operations: Additionally, operations department would be responsible for instituting any curfews for utilities conservation.

The CEO will determine the status of daily programming and services would be suspended and with in-put from the Educational Director decide when the 'No School' schedule would be instituted. The CEO will also determine the duration of the suspension of service delivery to outside entities.

A joint responsibility for the departments of maintenance, purchasing, nursing and housekeeping will be the task of supplementing resources from the outside local community. Each department would be tasked with ensuring that appropriate supplies which are needed to maintain operations are identified and then contact with appropriate outside resources for assistance. Additionally, resources donated from outside sources will be inspected, logged and identified for specific use by the purchasing department. The only exceptions to this mandate will be medications which will be handled by medical department and perishables, which will be handled by the Dietary Department.

Curtailment of services would be instituted by order of the CEO and would remain in place until the facility's operations returned to normal activity.

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

In the event of an emergency that impacts telephone usage the Office of Risk Management will coordinate with the following departments to ensure that all notifications and communications are expedited in a timely manner: residential, nursing and clinical.

Staged evacuations will be conducted 1x per quarter by facility operations and will include moving the residents to safe and identified locations throughout the building during different times of the day. Prior to the staged evacuation the Director of Plant Operations will conduct in-services with staff, teachers, therapists and residents to ensure that proper policy and procedures are followed.

A total evacuation utilizes the same procedures, however, the Director of Plant Operations ensures that all staff throughout the building (housekeeping, reception, administrative, ancillary services, including dietary) receives an in-service prior to the event. With a total evacuation, the entire building is evacuated and special attention is given to ensure that groups that are to remain separated and contained.

ENSURING SUSTAINED COMPLIANCE

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

To ensure that this element of performance's compliance is sustained the Director of Plant Operations will a minimum of 4x yearly meet with the Leadership team during AM Flash meeting to either review Plan procedures and/or provide any relevant updates to the Plan.

What is the frequency of the monitoring activities?

The Emergency Management Plan is review annually at the EOC meeting. Additionally, at the advent of the hurricane season for the local area, the Director of Plant Operations will review the Plan to ensure implementation and execution procedures remain relevant.

What data will be collected from these activities?

Data on compliance include review of the evacuation routes, ensuring that they are efficient and safe. Alternate routes are identified. Communications systems are properly functioning and utilized. To ensure that the facility's notification monitoring vendor is properly notified. Evacuation times are reviewed to determine any obstacles encountered by residents, visitors and staff and ensuring that all fire doors are operational.

To whom, and how often, will this data be reported?

Written reports by the Director of Plant Operations will be submitted to monthly EOC meetings.

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Standard EM.03.01.03

Standard Text	Surveyor Findings
The organization evaluates the effectiveness of its Emergency Management Plan.	EP 1 Likelihood to Cause Harm: Low Scope: Pattern Observed in Emergency Management Session at Harbor Point Behavioral Health Center, Inc [redacted] Portsmouth, VA) site. One emergency drill was conducted in 2017 and it was for a thunder storm. The critique of the thunder storm noted that each program's initiation of their plan was satisfactory. The scope of the thunderstorm as an emergency/disaster exercise was not clearly represented in the critique. However, as a 24-hour setting a second activation of the emergency management plan was not conducted. Aa critique of a "Security Issue" was critiqued. The CEO and the Facilities Director said the security issue was an intruder. There was no documentation in the critique that identified the issue as an intruder and the content of the critique did not relate or identify an intruder as the emergency situation.

Please select/highlight the element of performance (EP) you would like to respond to. Save

EP	Element Of Performance (EP) Text
1	1. As an emergency response exercise, the organization activates its Emergency Management Plan once a year at each site included in the plan for non-24-hour settings; 24-hour settings are required to activate the plan twice each year. Note 1: If the organization activates its Emergency Management Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Note 2: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.

Assigning Accountability: Director of Plant Operations **Completed by: 05/21/18**

Correcting the Non-Compliance

To ensure successful compliance with this element of performance, Harbor Point leadership elected to conduct an emergency response exercise on June 28, 2018, after key facility staff (CFO, Risk Manager and Director of Plant Operations) have participated in the State of Virginia's Emergency Preparedness Training for Healthcare Facilities to be held on June 6, 2018. A second emergency response exercise is scheduled for September 27, 2018.

To re-dress the concerns for ensuring that the facility's emergency drill exercises are descriptively more comprehensive, the Director of Plant Operations and the Risk Management Office developed the following descriptions; first utilizing the event of a thunderstorm: The scenario for the emergency response exercise will revolve around a thunderstorm upgraded to major hurricane status by NOAA. The upgraded status will include an official notification from the Dept. of Transportation, closing all bridges and tunnels at the onset of 25 - 50 mph winds and a mandatory curfew imposed by

the City officials. A second emergency response training exercise will be scheduled for late September, utilizing the intruder scenario: The intruder will be a former resident, now working for a contracted vendor, who has been hired to install equipment. The former resident returns and uses their knowledge of the facility and staff to gain access to a residential area. When asked to leave the area becomes increasingly non-compliance. Finally, responsible EOC staff was trained to the expectations of the standard.

ENSURING SUSTAINED COMPLIANCE

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

The Director of Plant Operations will coordinate and execute the Emergency Response exercise a minimum of two times per year. To ensure Harbor Point's compliance with this element of performance this responsibility will be shared with the Office of Risk Management. Tabletop exercises will be implemented a minimum of 2x per year to augment and enhance the exercises.

What is the frequency of the monitoring activities?

The Emergency Response Exercise will occur a minimum of two times per year.

What data will be collected from these activities?

Data compliance for the execution of the Emergency Response Exercises will collected, reviewed and appropriate adjustments and/or changes will be addressed in the immediate AM Flash meeting and by HP leadership in a timely manner.

To whom, and how often, will this data be reported?

A written report will be submitted by the Director of Plant Operations to the monthly Environmental OC and Quality Council meetings.

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Standard LD.04.01.07

Standard Text	Surveyor Findings
	EP 1 Likelihood to Cause Harm: Low Scope: Limited Observed in [redacted]t Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site. There were no policies and procedures that addressed the management of food that was prepared and delivered to the patient units. No policies addressed delivery, temperature, disposal of food delivered to the units in styrofoam containers. The organization began the process of amending the policy and procedures pending involvement of dietary and nutrition and clinical services.
The organization has policies and procedures that guide and support care, treatment, or services.	EP 2 Likelihood to Cause Harm: Low Scope: WideSpread Observed in Building Tour at Harbor Point Behavioral Health Center, Inc. [redacted] ortsmouth, VA) site. The medical record of a discharged resident was supposed to be within 30-days of the discharge. This was confirmed with the new HIS director who was recently hired. While on tour more than 38 medical records were observed to be pending closure do missing documentation. The 38 records ranged in discharge dates from 9/7/2017 to 12/31/2017. Additional records in 2018 had also passed the 30- day closure date. Information obtained from the HIS staff noted there was only one staff person working in the medical records area since a hiring freeze more than a year ago.

Please select/highlight the element of performance (EP) you would like to respond to. Save

EP	Element Of Performance (EP) Text
1	1. Leaders review and approve policies and procedures that guide and support care, treatment, or services.
2	2. The organization manages the implementation of policies and procedures.

Assigning Accountability: CEO **Completed by: 05/21/18**

Correcting the Non-Compliance

To ensure that all identified concerns associated with the management of foods consumed outside of the dining hall are resolved in a timely manner, the CEO, Dietary Director, Residential Director, Director of Nursing and Risk Management collaborated and reviewed the facility's Nutritional Services policy. The policy was amended to delineate specific responsibilities for the nutritional services and residential unit staffs. The nutritional staff will be responsible for ensuring that foods are clearly labeled with time of prep; individual's name & unit; expiration of prepared food. The

Residential Director will work with Program Managers to ensure that staff properly trained on the policy amendment, with emphasis on timely retrieval. The Residential Director will work with the Clinical and Medical Directors to ensure that an individual's request is either therapeutically necessary or medically required for safety purposes. Staff will continue to encourage residents that all meal consumptions should to be completed in the dining hall, unless otherwise informed by clinical or medical staff. Responsible staff was trained to the expectations of the standard. Staff attestations were completed by 05/21/18.

ENSURING SUSTAINED COMPLIANCE

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

To ensure Harbor Point's compliance with this element of performance for the facility has amended its established policy and procedures for Nutritional Services on 03/31/18 which delineates the dietary staff's responsibilities with ensuring that all meals designated to be consumed outside of the dining room are properly packaged and identified for the appropriate residents. The Dietary Director will ensure that all packaging will include the following information: The initials of the individual; the residential unit; date and time meal is prepared and when it is to be either retrieved and by whom. The Dietary Director will have a retrieval checklist which will include a column for when the staff was notified that the meal(s) were ready for pick-up and that preparation receiving meals on the residential units or taking a prepared meal outside of the facility due to an appointment or outing be served meals in the dining room since it is Harbor Point's policy that that all residents will be served meals in the dining room unless confined to their unit due to illness and/or physician's order or on an outing or appointment.

What is the frequency of the monitoring activities?

The Dietary Manager will monitor and log all meal preps when such requests are submitted.

What data will be collected from these activities?

Data compliance will reflect the timeliness of meal preps and retrievals to ensure individual safety.

To whom, and how often, will this data be reported?

The written report will be shared and submitted monthly at Quality Council, Medical Executive and quarterly to the Governing Body meetings.

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Standard LD.04.01.07 con't

2	2. The organization manages the implementation of policies and procedures.

Assigning Accountability: Director of Health Information Management **Completed by: 04/23/18**

Correcting the Non-Compliance

To ensure that all identified discharge records maintenance are resolved in a timely manner, the Health Information department will work to ensure that all discharge records are closed within 30 days of residents' discharges as per policy and procedures. The 38 records ranged in discharge dates from 9/7/2017 to 12/31/2017 were all successfully closed by 04/23/18 to include all records prior to March 27, 2018 (Total: 50 charts). The HIM department currently does not have a backlog of discharge records for closing.

ENSURING SUSTAINED COMPLIANCE

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

To ensure Harbor Point's compliance with this element of performance for records management the facility leadership when requested will ensure that Health Information Management (HIM) department will have sufficient staffing resources to ensure that the goal for timely record closures/filings is consistently maintained.

What is the frequency of the monitoring activities?

The Director of Health Information Management (HIM) will monitor record filings/closures weekly and will close 3-5 discharge records per week or as necessary to comply with policy and procedures.

What data will be collected from these activities?

Data compliance with HIM record closures will include late or incomplete documentation submissions. This information will be collected and reported by the HIM Director during AM Flash meetings.

To whom, and how often, will this data be reported?

A written report on late or incomplete documentation submissions will be shared at the monthly Quality Council and the Governing Body meetings.

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Standard LS.04.02.30

Standard Text	Surveyor Findings
The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. Note 1: This standard applies to behavioral health care settings that provide sleeping arrangements for 17 or more individuals served as a required part of their care, treatment, or services. Note 2: If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.	EP 20 Likelihood to Cause Harm: Moderate Scope: Pattern Observed in Building Tour at Harbor Point Behavioral Health Center, Inc [redacted] Portsmouth, VA) site. During the building tour at least 10 sprinklers located throughout the building did not have escutcheons. Discussion with the CEO noted the contracted vendor began upgrading the sprinkler system in November, 2017. The vendor is upgrading in phases. The CEO agreed to implement ISLM and increase surveillance, provide education on fire safety features and conduct additional drills in areas where the escutcheons remain missing. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance(EP-8),Conduct additional fire drill per quarter(EP-11),Train staff on fire safety features(EP-14)

Please select/highlight the element of performance (EP) you would like to respond to. Save

EP	Element Of Performance (EP) Text
20	20. The organization meets all other Life Safety Code building feature requirements related to NFPA 101-2000: 28/29.3.

Assigning Accountability: Director of Plant Operations **Completed by: 04/05/18**

Leadership Involvement

Success and sustainability are highly influenced by support from the top level of leadership in the organization. In order to ensure this leadership commitment occurs, details surrounding leadership involvement for higher risk findings is required. Types of leadership involvement may include, but are not limited to: providing resources (e.g., staff, money, expertise), serving as a champion for the change, direct participation on teams, motivating employees, establishing intervals for communication and/or reporting, direct oversight of change, etc.).

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

- ☐ President
- ☑ Chief Executive

Joint Commission Response 2018

Survey Conducted: March 20 – 23, 2018

Officer

- ☐ Vice President
- ☐ Chief Quality Officer
- ☐ Chief Medical Officer
- ☐ Chief Nursing Officer
- ☑ Chief Operating Officer
- ☐ Medical Director
- ☐ Director of Nursing/Nurse Administrator
- ☐ Facilities Director/Manager
- ☐ Director of Clinical Services
- ☐ Chief Information Officer
- ☐ Administrator
- ☐ Administrative Director
- ☐ Assistant Vice President
- ☑ Director of Environmental Services/Support Services
- ☐ Director of Materials Management
- ☑ Chief Financial Officer
- ☐ Clinical Coordinator

Joint Commission Response 2018
Survey Conducted: March 20 – 23, 2018

☑ Other

Please enter text for Other: Risk Manager

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

The above leadership involvement will assist with ensuring sustained compliance with this element of performance by ensuring that necessary resources and tools are readily available for utilization. The Chief Operating Officer (CEO), CFO/Environmental Services/Support Services Director will directly participate in allotting appropriate monetary resources for purchasing the required equipment and/or contracted services. The Risk Manager will provide an additional level of inspection checks to ensure work is being properly completed and in a timely manner.

Correcting the Non-Compliance

The Director of Plant Operations successfully contacted the facility's contracted vendor for the sprinkler system and requested additional escutcheons. The vendor was able to supply the escutcheons by 04/04/18 and installation was completed by 04/05/18. Additionally, EOC staff was trained to the expectations of the standard.

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

To ensure Harbor Point's compliance with this element of performance for the facility will incorporate a review of building maintenance issues into its AM Flash meeting. The Director of Plant Operations will maintain a building checklist which will include a column for when the issue was initially reported and when it was resolved.

What is the frequency of the monitoring activities?

The Director of Plant Operations will conduct facility inspections and review all work order requests daily.

What data will be collected from these activities?

The Director of Plant Operations will maintain a log of the building's needed repairs and or replacement items. This information will be available in the Maintenance Office and the Office of Risk Management for review to ensure consistent compliance and safety.

To whom, and how often, will this data be reported?

A written summation of the submitted work orders and facility observation forms completed by AOC will be incorporated and reviewed during the monthly Environmental OC and Quality Council meetings for HP leadership.

UHS-FINHELP-00010395 [Redacted]



Final Accreditation Report

Harbor Point Behavioral Health Center, Inc.

[redacted]

Portsmouth, VA [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 4/6/2021 - 4/9/2021

Program Surveyed
Behavioral Health Care and Human Services

Final Report: Posted 4/9/2021

The Joint Commission
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Executive Summary

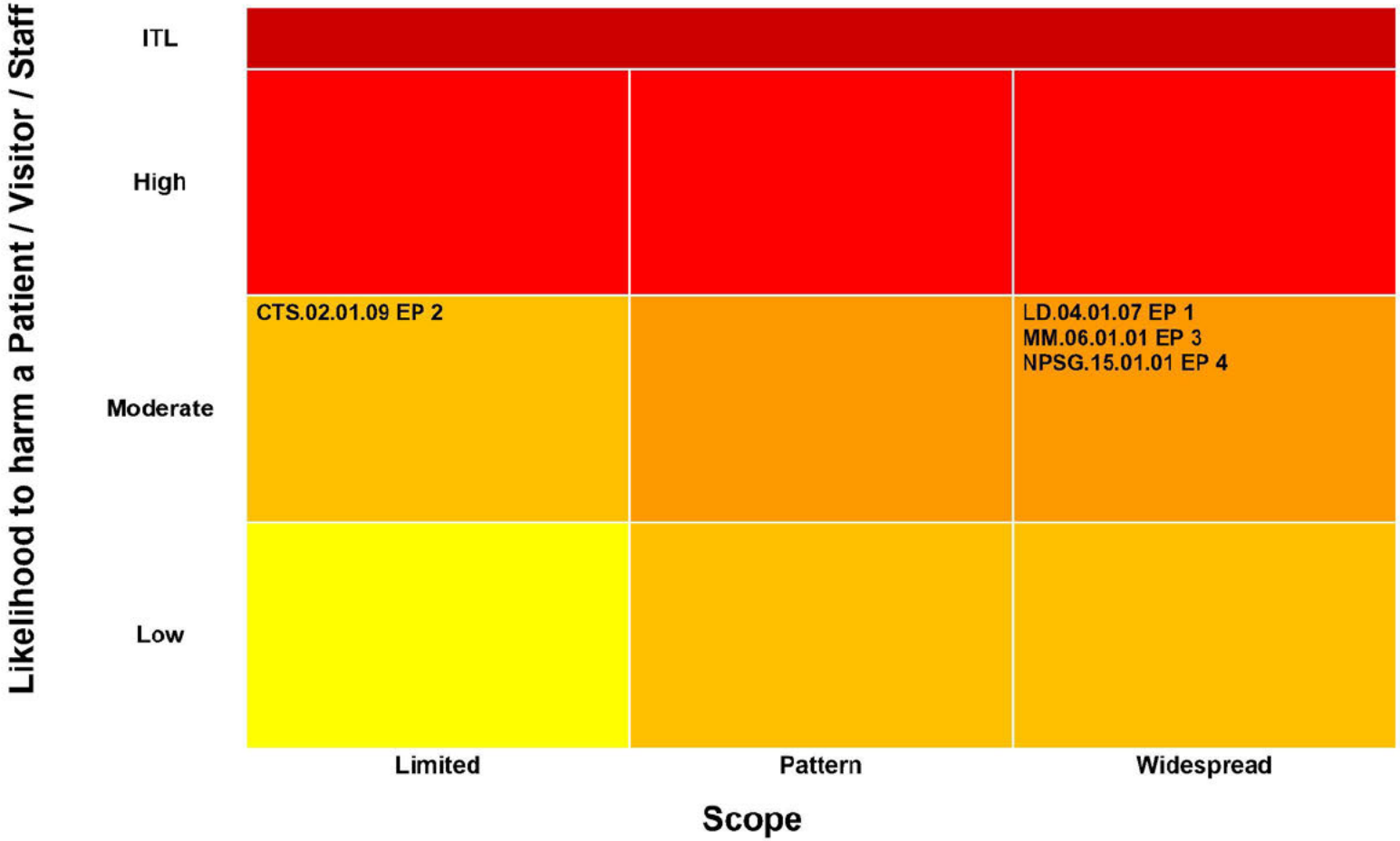
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	04/06/2021 - 04/09/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards 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.02.01.09	2	Moderate / Limited	✓
LD.04.01.07	1	Moderate / Widespread	✓
MM.06.01.01	3	Moderate / Widespread	✓
NPSG.15.01.01	4	Moderate / Widespread	✓

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.02.01.09	2	Moderate Limited	Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment. Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the health care practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.	1) Observed in Individual Tracer at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . A rating of pain as part of the assessment process and response to intervention was not completed as indicated by the patients self-report and medical record. The standard requires that Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment based on the patients reported clinical status. Patient reported on 11/6/20 that someone stepped on his hand during the course of playing basketball. He reported that his hand was swollen. The medical record indicated in the nursing note that no pain was present, but he was referred for an x-ray that indicated a fracture. At another point on 11/21/20 patient reported chest pain due to colliding with another resident while playing basketball, but no pain assessment was documented at the time of the incident. The resident also reported at the point of admission in May 2020 that he experienced migraines 2-3 times per week. He later reported to his physician that he was having migraines 2-3 times per week during the week of July 15, 2020, but no pain assessment was completed. He was referred for a consultation 7/17/20 and started on Topamax to prevent migraine headaches.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
LD.04.01.07	1	Moderate Widespread	Leaders review, approve, and manage the implementation of policies and procedures that guide and support care, treatment, or services.	1) Observed in Leadership Session at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . There is not clear indication that leadership regularly reviews, updates, and approves policies and procedures related to care, treatment and services. The intent is for leadership to regularly review policies and procedures to ensure these documents remain current with evolving standards of care and practice and that policies and procedures are used by leadership to guide and support care, treatment, or services throughout the organization. The organization's policy on Telepsychiatry had no date to indicate when it was approved, implemented or reviewed. Several policies related to care and treatment had not been reviewed for update since January 1, 2012 (e.g., Request for Consultation, Medical Orders, Speech and Language Assessment, and Food and Drug Interaction Policies). Other policies was reported to be last updated on January 13, 2015 (e.g., Medical Services, Antipsychotic, Antidepressant, Antianxiety, Psychostimulant Policies). Other policies were last recorded as having not been reviewed since March 24, 2017 (e.g., Biopsychosocial Assessment, Substance Abuse Assessment Policies).
MM.06.01.01	3	Moderate Widespread	For organizations that administer medications: Before administration, the staff member administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3) - Verifies the medication has not expired - Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route Note: For opioid treatment programs: Medications that are best administered by directly observed therapy (DOT)—such as tuberculosis and psychiatric medications—can be given at the same time as the opioid dose. - Discusses any unresolved concerns about the medication with supervisory staff or the prescriber	1) Observed in Medical Management Session at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . During the discussion at the Medication Management Session the nursing staff present acknowledged that the wrong medication has been placed in the bubble pack by the pharmacy in rare instances that have been caught by the nurse conducting the administration of medication on the residential units. The current practice involves inspecting the received bubble packs by the reviewing of the attached label for correct medication, dose, patient name, and other information including on the label by the pharmacy. There was a discussion during the Medication Management Session of the need to visually verify the actual medication in the bubble pack at the time of receiving from the pharmacy prior to placement in the medication carts on the units. Visual verification of the correct medication in the package is needed in addition to the current practice of reviewing the label to ensure that the correct medication is being administered to the individual residents in order to further reduce the risk of a medication error related to the packaging by the external pharmacy prior to arrival on the residential units in the medication carts.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
NPSG.15.01.01	4	Moderate Widespread	Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.	1) Observed in Individual Tracer at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site . The organization is using the Columbia Rating Scale to assess for suicide, but the organization is not documenting the individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide at the time of completing the Columbia Rating Scale. In one case a patient had a documented history of self-harm prior to admission and placed a bra around her neck during the course of treatment, but the overall level of risk was not documented at the time of completion of the Columbia. In another case the patient reported a history of self-harm prior to admission and also reported that he did not believe he had control of his thoughts of suicide at the time of the Columbia administration, but the level of risk and plan to mitigate the risks were not documented at the time of completing the Columbia. The organization reported that this was the standard practice of the organization, but they had another version of the Columbia, which included the risk rating section. The organization reported that this version would be used in future suicide risk assessments to show the level of risk at the time of completing the Columbia.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.01.09	2	The organization screens all individuals served for physical pain.	Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment. Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the health care practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.
LD.04.01.07	1	The organization has policies and procedures that guide and support care, treatment, or services.	Leaders review, approve, and manage the implementation of policies and procedures that guide and support care, treatment, or services.
MM.06.01.01	3	The organization safely administers medications. Note: This standard is applicable only to organizations that administer medications.	For organizations that administer medications: Before administration, the staff member administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3) - Verifies the medication has not expired - Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route Note: For opioid treatment programs: Medications that are best administered by directly observed therapy (DOT)—such as tuberculosis and psychiatric medications—can be given at the same time as the opioid dose. - Discusses any unresolved concerns about the medication with supervisory staff or the prescriber
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.

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

Harbor Point Behavioral Health Center, Inc.
[redacted]
Portsmouth, VA[redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 5/28/2021

ESC Programs Reviewed
Behavioral Health Care and Human Services

Final Report: Posted 5/28/2021

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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	5/28/2021	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.02.01.09	Compliant
LD.04.01.07	Compliant
MM.06.01.01	Compliant
NPSG.15.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.01.09	2	The organization screens all individuals served for physical pain.	Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment. Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the health care practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.
LD.04.01.07	1	The organization has policies and procedures that guide and support care, treatment, or services.	Leaders review, approve, and manage the implementation of policies and procedures that guide and support care, treatment, or services.
MM.06.01.01	3	The organization safely administers medications. Note: This standard is applicable only to organizations that administer medications.	For organizations that administer medications: Before administration, the staff member administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3) - Verifies the medication has not expired - Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route Note: For opioid treatment programs: Medications that are best administered by directly observed therapy (DOT)—such as tuberculosis and psychiatric medications—can be given at the same time as the opioid dose. - Discusses any unresolved concerns about the medication with supervisory staff or the prescriber
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.

Joint Commission Health Care Organization

Organization ID: [redacted] Harbor Point Behavioral Health Center, Inc.
[redacted] Portsmouth, VA 2[redacted]

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 5/28/2021

Behavioral Health Care and Human Services CTS.02.01.09 EP 2
Likelihood: Moderate Scope: Limited

Standard Text: The organization screens all individuals served for physical pain.

EP Text: Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment.Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the health care practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.

Finding(s): 1) Observed in Individual Tracer at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site .
A rating of pain as part of the assessment process and response to intervention was not completed as indicated by the patients self-report and medical record. The standard requires that Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment based on the patients reported clinical status. Patient reported on 11/6/20 that someone stepped on his hand during the course of playing basketball. He reported that his hand was swollen. The medical record indicated in the nursing note that no pain was present, but he was referred for an x-ray that indicated a fracture. At another point on 11/21/20 patient reported chest pain due to colliding with another resident while playing basketball, but no pain assessment was documented at the time of the incident. The resident also reported at the point of admission in May 2020 that he experienced migraines 2-3 times per week. He later reported to his physician that he was having migraines 2-3 times per week during the week of July 15, 2020, but no pain assessment was completed. He was referred for a consultation 7/17/20 and started on Topamax to prevent migraine headaches.

Assigning Accountability

The Director of Nursing 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

In order to maintain compliance with screening all individuals served for physical pain, the Director of Nursing revised Nursing Policy 029: Assessment of Pain/Pain Management and the Pain Assessment Form. The Director of Nursing trained the nursing staff via staff meetings and individual trainings, utilizing the Assessment of Pain/Pain Management Policy and the Pain Assessment Tool. The trainings emphasized the requirement for the nursing staff to complete an initial assessment for physical pain and

psychological pain upon admission, as well as, nursing staff completing a new Pain Assessment Form for any new complaints of severe or persistent pain or injury, evaluating initial assessment and completing a follow-up assessment within one-hour of the provided intervention.

Q. All corrective actions described above were completed by

May 05, 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, or RN designee, will randomly select twenty (20) medical records and complete a Pain Audit. The audit includes the following components: verifying a pain assessment tool is complete for any complaint of pain or injury, verifying evidence of documentation on the Medication Administration Record (MAR) for initial pain management, verifying evidence of documentation on the MAR for pain management reassessment, and verifying evidence of documentation of the assessment in the nurse's progress note. The results of the audit will be reported monthly to the Quality Council Committee. If our compliance is below our 100% target rate, the Director of Nursing will implement a corrective action plan.

Q. What is the frequency of the monitoring activities?

The Pain Audit of twenty (20) medical records will occur on a monthly basis and the data from the observations will be reported to the Quality Council Meeting. In the event the organization falls below our 100% target rate, a performance improvement initiative will be initiated and the data will be collected, analyzed and reported to the Quality Council Committee on a monthly basis and to the Medical Executive Council Committee on a quarterly basis.

Q. What data will be collected from these activities?

During the monthly audit, the Director of Nursing, or RN designee, assesses the following: verifying a pain assessment tool is complete for any complaint of pain or injury, verifying evidence of documentation on the Medication Administration Record (MAR) for initial pain management, verifying evidence of documentation on the MAR for pain management reassessment, and verifying evidence of documentation of the assessment in the nurses progress note. Any areas of deficiency are recorded on the Pain Audit Tool Form. This data will be collected and reported to the Performance Improvement Director and Quality Council Committee.

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

Upon completion of the monthly audit, the Director of Nursing, or RN designee, immediately submits the audit results to the Performance Improvement Director and the Quality Council Committee for

review. If the results show compliance below our 100% target rate, the Director of Nursing will report the data and analysis to the Quality Council Committee on a monthly basis and to the Medical Executive Council Committee meeting on a quarterly basis. Data will be collected until a trend of three (3) consecutive months of 100% compliance is achieved.

Behavioral Health Care and Human Services LD.04.01.07 EP 1
Likelihood: Moderate Scope: WideSpread

Standard Text: The organization has policies and procedures that guide and support care, treatment, or services.

EP Text: Leaders review, approve, and manage the implementation of policies and procedures that guide and support care, treatment, or services.

Finding(s): 1) Observed in Leadership Session at Harbor Point Behavioral Health Center, Inc. ([redacted] Portsmouth, VA) site .
There is not clear indication that leadership regularly reviews, updates, and approves policies and procedures related to care, treatment and services. The intent is for leadership to regularly review policies and procedures to ensure these documents remain current with evolving standards of care and practice and that policies and procedures are used by leadership to guide and support care, treatment, or services throughout the organization. The organization's policy on Telepsychiatry had no date to indicate when it was approved, implemented or reviewed. Several policies related to care and treatment had not been reviewed for update since January 1, 2012 (e.g., Request for Consultation, Medical Orders, Speech and Language Assessment, and Food and Drug Interaction Policies). Other policies was reported to be last updated on January 13, 2015 (e.g., Medical Services, Antipsychotic, Antidepressant, Antianxiety, Psychostimulant Policies). Other policies were last recorded as having not been reviewed since March 24, 2017 (e.g., Biopsychosocial Assessment, Substance Abuse Assessment Policies).

Assigning Accountability

The Chief Executive Officer 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
Director of Nursing/Nurse Administrator
Other

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

The Chief Executive Officer, the Director of Nursing and the Director of Risk Management have been involved in the corrective action and are maintaining ongoing compliance with this standard.

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

The Chief Executive Officer, Director of Nursing and the Director of Risk Management directly participated in meetings where discussions occurred about facility policies and procedures, ensuring they are reviewed, revised and submitted for approval on, at most, a bi-annual basis. On April 27, 2021, the Director of Risk Management and Director of Nursing modified the Approval of Policies, Procedures and Forms to include the format for facility policies and procedures, the process for the review and revisions to existing polices/procedures or development of new polices/procedures, the development of a table of contents, the approval process and the frequency for reviewing facility policies/procedures. The Chief Executive Officer is serving as champion ensuring all facility leaders, responsible for departmental policies, are reviewing their policies for accuracy, revising as necessary, and submitting to the policy and forms committee for review, approval from the Chief Executive Officer, and final approval from the Board of Governors. The Director of Risk Management is serving as champion for auditing facility leaders reviewing their policies for accuracy, revising as necessary, approval from the Chief Executive Officer and final approval from the Board of Governors. A monitoring process was developed to assure the compliance with the standard.

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 Chief Executive Officer, Director of Nursing and Director of Risk Management met to discuss and develop an understanding of why facility policies and procedures were not reviewed on a consistent basis. The focus of the analysis included: 1) the facility policy had not defined a time frame for reviewing and/or revising facility policies and procedures, 2) leadership responsibility for the supervision of policies and procedures being reviewed and/or revised, and 3) process for the verification that facility policies and procedures were reviewed and/or revised with the approval of the Chief Executive Officer and Board of Governors. To prevent concerns with policies being reviewed and/or revised, the Director of Risk Management developed a system to audit the compliance of reviewing policies for accuracy, revising as necessary, obtaining approval from Chief Executive Officer and obtaining final approval from the Board of Governors.

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

In order to maintain compliance with ensuring the organization has policies and procedures that guide and support care, treatment and services, the Director of Risk Management revised Administration Policy 005: Approval of Policies, Procedures and Forms. The Director of Risk Management trained facility directors via staff meetings and individual trainings, utilizing the Approval of Policies, Procedures and Forms Policy. The trainings emphasized the time frame in which all facility policies are to be reviewed, revised and approved, the format each policy will maintain, responsibility of directors responsible for corresponding policies and how facility policies, procedures and forms are maintained.

Q. All corrective actions described above were completed by

May 21, 2021

Ensuring Sustained Compliance

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

The Director of Risk Management, or designee, will monitor 100% compliance with Facility Directors reviewing and/or revising assigned facility policies and procedures using the Policy and Procedure Compliance with Bi-Annual Review Audit Tool. The audit includes the following components: name of Facility Director, policies assigned to the Facility Director, polices being complete within the designated time frame, Facility Directors submitting policies to the Chief Executive Officer (CEO) for approval, the Table of Contents signifying the CEO's approval being uploaded to the corresponding policy folder on the facility public derive and the Board of Governors approval of facility policies and procedures. In the event our compliance is below our 100% target rate, the Chief Executive Officer will initiate a corrective action plan with the identified Facility Director not in compliance with the review and approval of assigned facility policies and procedures, reporting results monthly to the Quality Council Committee and quarterly to the Board of Governors.

Q. What is the frequency of the monitoring activities?

The Policy and Procedure Audit of facility policies being reviewed bi-annually will occur on a bi-annual basis, more frequently as new policies and procedures are created and/or when policies are reviewed and revised outside the bi-annual maximum facility requirement. The Director of Risk Management, or designee, will send tickler reminders to Facility Directors beginning six months prior to the assigned deadline, monthly thereafter and weekly prior to the assigned deadline, reporting findings to the Chief Executive Officer. In the event the organization falls below our 100% target rate, a performance improvement goal will be initiated and the data will be collected, analyzed and reported to the Quality Council Committee on a monthly basis.

Q. What data will be collected from these activities?

During the bi-annual audit, more frequently as deemed necessary and appropriate, the Director of Risk Management, or designee, assesses the following: name of Facility Director, policies assigned to the Facility Director, polices being complete within the designated time frame, Facility Directors submitting policies to the Chief Executive Officer (CEO) for approval, the Table of Contents signifying the CEO's approval being uploaded to the corresponding policy folder on the facility public derive and the Board of Governors approval of facility policies and procedures. Any areas of deficiency are recorded on the Policy and Procedure Audit Tool. This data will be collected and reported to the Chief Executive Officer.

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

Upon completion of the bi-annual audit, more frequently as deemed necessary and appropriate, the Director of Risk Management, or designee, immediately submits the audit results to the Chief Executive Officer (CEO) for review. If the results show compliance below our 100% target rate, the CEO will initiate a corrective action plan with the identified Facility Director not in compliance with the review and approval of assigned facility policies and procedures, reporting results to the Quality Council Committee on a monthly basis and the Board of Governors on a quarterly basis.

Behavioral Health Care and Human Services MM.06.01.01 EP 3
Likelihood: Moderate Scope: WideSpread

Standard Text: The organization safely administers medications.Note: This standard is applicable only to organizations that administer medications.

EP Text: For organizations that administer medications: Before administration, the staff member administering the medication does the following:- Verifies that the medication selected matches the medication order and product label- Visually inspects the medication for particulates, discoloration, or other loss of integrity (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3)- Verifies the medication has not expired- Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct routeNote: For opioid treatment programs: Medications that are best administered by directly observed therapy (DOT)—such as tuberculosis and psychiatric medications—can be given at the same time as the opioid dose.- Discusses any unresolved concerns about the medication with supervisory staff or the prescriber

Finding(s): 1) Observed in Medical Management Session at Harbor Point Behavioral Health Center, Inc. [redacted] Portsmouth, VA) site .
During the discussion at the Medication Management Session the nursing staff present acknowledged that the wrong medication has been placed in the bubble pack by the pharmacy in rare instances that have been caught by the nurse conducting the administration of medication on the residential units. The current practice involves inspecting the received bubble packs by the reviewing of the attached label for correct medication, dose, patient name, and other information including on the label by the pharmacy. There was a discussion during the Medication Management Session of the need to visually verify the actual medication in the bubble pack at the time of receiving from the pharmacy prior to placement in the medication carts on the units. Visual verification of the correct medication in the package is needed in addition to the current practice of reviewing the label to ensure that the correct medication is being administered to the individual residents in order to further reduce the risk of a medication error related to the packaging by the external pharmacy prior to arrival on the residential units in the medication carts.

Assigning Accountability

The Director of Nursing 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)

Director of Nursing/Nurse Administrator
Other

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

The Director of Nursing and the Director of Risk Management have been involved in the corrective action and are maintaining ongoing compliance with this standard.

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

The Director of Nursing and the Director of Risk Management directly participated in meetings where discussions occurred about visually verifying the medication selected matches the medication order and the product label. On April 27, 2021, the Director of Nursing modified the Administration of Medication, Recording of Refusals, Licensure and Authority Policy to include ensuring medications are labeled in accordance with facility requirements and state and federal laws, verifying that the medication selected matches the medication order and product label and visually verifying the medication for particulates, discoloration, or other loss of integrity and verifying the medication has not expired, noting methods of verification could include picture reference on the Medication Administration Record, picture reference on the packaging or a medication reference app. The Director of Nursing is serving as champion for auditing pharmacy discrepancies, ensuring visual inspections are complete upon receipt of medication from the pharmacy, noting if there is a discrepancy and what action was taken to resolve the discrepancy. A monitoring process was developed to assure the compliance with the standard.

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 Director of Nursing and Director of Risk Management met to discuss and develop an understanding of why the visual inspection of medications was not being complete upon receipt of the medication from the external pharmacy. The focus of analysis included: 1) nursing staff not being aware that a picture verification was required when receiving medications from the pharmacy, 2) identifying the impact of inaccuracies in receiving and/or administering the wrong medication, and 3) presence of clear expectations for compliance. To prevent concerns with medication management, the Director of Nursing developed a system to audit the compliance of visual inspections of medications received from the pharmacy, identifying discrepancies and the actions steps to immediately resolve the noted concern.

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

In order to maintain compliance with ensuring the organization safely administers medication, the Director of Nursing revised Nursing Policy 004: Administration of Medication, Recording of Refusals, Licensure and Authority. The Director of Nursing trained the nursing staff via staff meetings and individualized trainings, utilizing the Administration of Medication, Recording of Refusal, Licensure and Authority Policy. The trainings emphasized verifying the medication selected matches the medication ordered and product label, visually inspecting the medication for particulates, discoloration or loss of integrity, visually verifying the medication is not expired and verifying the medication is being administered at the proper time, with the proper dose and route.

Q. All corrective actions described above were completed by

May 21, 2021

Ensuring Sustained Compliance

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

Nurse Manager, or RN designee, will visually verify 100% of medications received from the external pharmacy are the medications that have been ordered by the attending physician. The results of the visual verification will be documented on the Pharmacy Discrepancy Audit Form. The audit includes the following components: date and time of inspection, documenting if a visual inspection of the medication occurred, noting if there was a discrepancy, what actions were taken if a discrepancy was identified and the nursing staff completing the audit. The results of the audit will be reported quarterly to the Pharmacy and Therapeutics Committee and the Medical Executive Council Committee. In the event our compliance is below our 100% target rate, the Director of Nursing will initiate a medication management goal which will be reported in the monthly Quality Council Committee meeting, requiring a corrective action plan to be initiated.

Q. What is the frequency of the monitoring activities?

An audit of 100% of medications received from the external pharmacy will occur on a monthly basis and the data from the observations will be reported to the Director of Nursing on a monthly basis and to the Pharmacy and Therapeutics Committee and the Medical Executive Council Committee on a quarterly basis. In the event the organization falls below our 100% target rate, a performance improvement goal will be initiated and the data will be collected, analyzed and reported to the Quality Council Committee on a monthly basis.

Q. What data will be collected from these activities?

During the monthly audit, the Nurse Manager, or designee, assesses the following: date and time of inspection, documenting if a visual inspection of the medication occurred, noting if there was a discrepancy, what actions were taken if a discrepancy was identified and the nursing staff completing the audit. Any areas of deficiency are recorded on the Pharmacy Discrepancy Audit Form. This data will be collected and reported to the Director of Nursing and to the Pharmacy and Therapeutics Committee and the Medical Executive Council Committee.

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

Upon completion of the monthly audit, the Nurse Manager, or designee, immediately submits the audit results to the Director of Nursing. The Director of Nursing, or designee, submits the results to the Pharmacy and Therapeutics Committee and the Medical Executive Council Committee on a quarterly basis. If the results show compliance below our 100% target rate, the Director of Nursing will report the data and analysis to the Quality Council Committee meeting on a monthly basis. Data will be collected until a trend of three (3) consecutive months of 100% compliance is achieved.

Likelihood: Moderate Scope: WideSpread

Standard Text: Reduce the risk for suicide.

EP Text: Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.

Finding(s): 1) Observed in Individual Tracer at Harbor Point Behavioral Health Center, Inc [redacted] Portsmouth, VA) site .
The organization is using the Columbia Rating Scale to assess for suicide, but the organization is not documenting the individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide at the time of completing the Columbia Rating Scale. In one case a patient had a documented history of self-harm prior to admission and placed a bra around her neck during the course of treatment, but the overall level of risk was not documented at the time of completion of the Columbia. In another case the patient reported a history of self-harm prior to admission and also reported that he did not believe he had control of his thoughts of suicide at the time of the Columbia administration, but the level of risk and plan to mitigate the risks were not documented at the time of completing the Columbia. The organization reported that this was the standard practice of the organization, but they had another version of the Columbia, which included the risk rating section. The organization reported that this version would be used in future suicide risk assessments to show the level of risk at the time of completing the Columbia.

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)

Medical Director
Director of Nursing/Nurse Administrator
Director of Clinical Services
Other

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

Director of Clinical Services, Medical Director, Director of Nursing, Director of Risk Management, Director of Medical Records and the PI Director have been involved in the corrective action and are maintaining ongoing compliance with this standard.

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

The Director of Clinical Services, Director of Nursing and the Director of Risk Management directly participated in meetings where discussions occurred about the Columbia-Suicide Severity Rating Scale (C-SSRS), documenting low, moderate or high risk for suicidality. On April 28, 2021, the Director of Risk Management modified the Suicide Risk Assessment Policy to include performing a full suicide risk assessment upon admission utilizing the C-SSRS, documenting low, moderate or high risk for suicidality. Modifications to the policy also included conducting a suicide screening using the C-SSRS

Screening – Since Last Contact for reassessment of risk for suicide, documenting low, moderate or high risk for suicidality, as well as, assessment of risk, reassessment of risk, heightened observations, suicide precautions, safety and environmental rounds, discharge planning, and suicide prevention and safety planning. The Medical Director is serving as champion of the education of the Medical Staff regarding the requirement to have the C-SSRS, documenting low, moderate or high risk for suicidality, complete and filed in the resident's medical record within 24 hours of admission. The Director of Clinical Services is serving as champion of the education of the Clinical Staff regarding the requirement of completing the C-SSRS Screening – Since Last Contact for reassessment of risk for suicide, documenting low, moderate or high risk for suicidality. The Director of Nursing is serving as champion of the education of the Nursing Staff regarding the requirement of completing the C-SSRS Screening – Since Last Contact for reassessment of risk for suicide, documenting low, moderate or high risk for suicidality. The Director of Medical Records is serving as champion for auditing the completion of the C-SSRS Risk Assessment upon admission, verifying the completion of the Summary of Current Suicide Risk noting the identification of low, moderate or high risk for suicidality. The Performance Improvement Director is serving as the champion for auditing the completion of the C-SSRS Screening – Since Last Contact Audit to include the date of completion and the identification of low, moderate or high risk for suicidality. A monitoring process was developed to assure the compliance with the standard.

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 Director of Clinical Services, Director of Nursing and the Director of Risk Management met to discuss and develop an understanding of why the Columbia-Suicide Severity Rating Scale (C-SSRS) and the C-SSRS Screening – Since Last Contact was not being complete to include the documentation of Summary of Current Suicide Risk noting the identification of low, moderate or high risk for suicidality. The focus of analysis included: 1) medical, clinical and nursing staff not being aware of the requirement for a Summary of Current Suicide Risk to include the identification of low, moderate or high risk for suicidality and 2) presence of clear expectation for compliance. To prevent concerns with the Suicide Risk Assessment, The Director of Medical Records and the Performance Improvement Director developed a system to audit the completion of the C-SSRS and the C-SSRS Screening – Since Last Contact to ensure documentation of a resident's low, moderate, high risk for suicidality.

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

In order to maintain compliance with ensuring the organization reduces the risk for suicide, the Director of Risk Management revised Clinical-Medical Policy 028: Suicide Risk Assessment. The Director of Risk Management, Director of Nursing and the Director of Clinical Services trained the medial staff via staff meetings and individual trainings, utilizing the evidence based Suicide Risk Assessment Policy. The Director of Nursing trained the nursing staff via staff meetings and individualized trainings, utilizing the evidence based Suicide Risk Assessment Policy. The Director of Clinical Services trained the clinical staff via staff meetings and individualized trainings, utilizing the evidence based Suicide Risk Assessment. The trainings emphasized performing a full suicide risk assessment upon admission, including identification of risk factors and high-risk behaviors, utilizing the Columbia-Suicide Severity Rating Scale (C-SSRS), documenting low, moderate or high risk for suicidality. The trainings emphasized conducting a suicide screening using the C-SSRS Screening – Since Last Contact for reassessment of risk for suicide, documenting low, moderate or high risk for

suicidality. The trainings emphasized assessment of risk, reassessment of risk, heightened observations, suicide precautions, safety and environmental rounds, discharge planning, and suicide prevention and safety planning.

Q. All corrective actions described above were completed by

May 21, 2021

Ensuring Sustained Compliance

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

The Director of Medical Records, or designee, will audit 100% of all new admissions, verifying the completion of the Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment with documented evidence of the Summary of Current Suicide Risk noting the identification of low, moderate or high risk for suicidality, if moderate or high verifying the physician was notified with date and time of contact, verifying that the outcome was documented and verifying the Summary of Current Suicide Risk was signed, date and timed. The Performance Improvement Director, or designee, will randomly select twenty (20) medical records and complete a C-SSRS Screening – Since Last Contact Audit. The audit includes the following components: identifying the patient and medical record number, date the C-SSRS Since Last Contact Form was complete, evidence of low, moderate or high risk for suicidality, evidence of physician notification, evidence of staff signature, date and time, evidence of the Suicide/Self-Injury Risk Assessment being complete, date special precautions were ordered if identified as moderate or high risk, dates of additional C-SSRS Since Last Contact Forms were complete and date special precautions were discontinued based on low risk assessment for suicidality or self-injurious behavior. The results of the audit will be reported monthly to the Quality Council Committee. If our compliance is below our 100% target rate, the Performance Improvement Director will implement a corrective action plan.

Q. What is the frequency of the monitoring activities?

The audit of the Columbia-Suicide Severity Rating Scale (C-SSRS), Full Risk Assessment, will be complete each time the facility receives a new admission. The C-SSRS Screening – Since Last Contact Audit of twenty (20) medical records will occur on a monthly basis. The data from each audit will be collected, analyzed and reported to the Quality Council Meeting on a monthly basis. In the event the organization falls below our 100% target rate, a corrective action plan will be implemented.

Q. What data will be collected from these activities?

In completing the audit, the Director of Medical Records, or designee, assesses the following: verifying the completion of the Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment with documented evidence of the Summary of Current Suicide Risk noting the identification of low, moderate or high risk for suicidality at the time of admission, if moderate or high verifying the physician was notified with date and time of contact, verifying that the outcome was documented and verifying the Summary of Current Suicide Risk was signed, date and timed. In completing the audit, the Performance

Improvement Director, or designee, assesses the following: identifying the patient and medical record number, date the C-SSRS Since Last Contact Form was complete, evidence of low, moderate or high risk for suicidality, evidence of physician notification, evidence of staff signature, date and time, evidence of the Suicide/Self-Injury Risk Assessment being complete, date special precautions were ordered if identified as moderate or high risk, dates of additional C-SSRS Since Last Contact Forms were complete and date special precautions were discontinued based on low risk assessment for suicidality or self-injurious behavior. Any areas of deficiency are recorded on the C-SSRS – Since Last Contact Form Audit. This data will be completed and reported to the Quality Council Committee.

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

Upon completion of the monthly audit, the Director of Medical Records, or designee, submits the audit results to the Quality Council Committee for review. Upon completion of the monthly audit, the Performance Improvement Director, or designee, submits the audit results to the Quality Council Committee for review. If the results show compliance below our 100% target rate, the Performance Improvement Director will report the data and analysis to the Quality Council Committee meeting on a monthly basis. If our compliance is below our 100% target rate, the Performance Improvement Director will implement a corrective action plan. Data will be collected until a trend of three (3) consecutive months of 100% compliance is achieved.

UHS-FINHELP-00010425 [Redacted]

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

ELECTRONIC NOTICE:

SANCTION NOTICE

Hospital - PSYCHIATRIC [redacted]

April 1, 2022

Mr. [redacted] Administrator
Willow Springs Center
[redacted]
Reno, NV [redacted]

YOU ARE HEREBY NOTIFIED that the DIVISION OF PUBLIC AND BEHAVIORAL HEALTH intends to impose sanctions effective eleven working days after your receipt of this notice.

Facts Supporting the Sanction

The Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance (Bureau) conducted a survey at Willow Springs Center with an exit date on August 16, 2021. The specific factual findings that serve as the basis of the underlying deficiencies are set forth in the Statement of Deficiencies (SOD), issued on September 9, 2021.

Statutory or Regulatory Authority

The Bureau is imposing sanctions on your facility in accordance with Nevada Revised Statutes (NRS) 449.163 through 449.170 and Nevada Administrative Code (NAC) 449.9982 through 449.99939. The imposition of sanctions is based on the severity and the scope of the deficiency as defined by NAC 449.99861 and NAC 449.9986. The severity and scope scores assigned to the deficiencies was provided in the online licensing and certification system, Aithent Licensing System (CLICs).

Monetary Penalties

NAC 449.99895 authorizes the Bureau to impose monetary penalties.

NAC 449.99899 outlines the determination of the amount of penalties.

In determining the amount of the monetary penalty where the severity level is less than four, both severity and scope must be considered.

In determining whether to impose a daily monetary penalty, the Bureau shall consider the severity and scope and the factors indicated for increased and decreased penalties provided in NAC 449.99902 and 449.99904.

For initial deficiencies with a severity level of three and a scope level of two or less:

(a) If the violation creates harm or a risk of harm to one person, an initial monetary penalty

of $1,500 per deficiency must be imposed.

The Bureau is imposing:

1) Initial penalties of $ 1500.00 assessed for the deficiency at TAG S 0300 - NAC 449.3622 - Appropriate Care of Patient (S-S= G) and;
2) Initial penalties of $ 1500.00 at TAG S 0320 - NAC 449.3628 - Protection of Patient (S-S= G).

NAC 449.99899 (4) indicates for initial deficiencies with a severity level of three and a scope level of two or less which creates harm or risk of harm to one person, an initial monetary penalty of $1,500 per deficiency must be imposed. No daily penalty will be imposed at this time.

Total of Monetary Penalties = $3000.00

NAC 449.99898 outlines the procedure for the imposition of a monetary penalty.
If the Bureau imposes a monetary penalty, the penalty must be imposed as provided in NAC 449.99899 to 449.99908, inclusive, and NAC 449.998995. In imposing the monetary penalty, the total penalty assessed against any facility bears interest at the rate of 10 percent per annum.

NAC 449.99911 outlines the penalties for failure to pay a penalty.
1. If the facility fails to pay a monetary penalty and the Bureau has not approved the use of the penalty for corrections pursuant to NAC 449.998995, the Division may suspend the license of the facility.
2. The Division shall, in accordance with the requirements of NAC 439.345, provide notice of its intention to suspend the license of the facility.
3. If the facility fails to pay the monetary penalty, including any additional costs incurred in collection of the penalty, within 10 days after receipt of the notice and the Bureau has not approved the use of the penalty for corrections pursuant to NAC 449.998995), the Division shall suspend the license of the facility. The suspension must not be stayed during the pendency of any administrative appeal.

Other Circumstances Considered

The Bureau has reviewed the Plan of Correction (POC) submitted on 09/20/21 in response to the survey. A revisit was conducted on 12/09/21, for all previous deficiencies cited on 08/16/21. All deficiencies have been corrected, and no new noncompliance was found.

Notice of Right to Appeal

Nevada Revised Statutes 449.170(2) affords the facility the right to contest the action of the Bureau. If you wish to oppose this action, you must send a written appeal to [redacted] Division of Public and Behavioral Health Administrator, 4150 Technology Way, Suite 300, Carson City, Nevada 89706. You can fax your written appeal to [redacted]

CONFIDENTIAL UHS-FINHELP-00010426

In order for you to receive a hearing, the Administrator must receive this written appeal by 5:00 pm on the 10th working day after you have received this notice. The local Bureau office cannot accept your appeal. Your written appeal must include the following information: a) the action to be contested, b) the name of the division officer or employee who signed this notice, c) the reasons that the appellant believes the action is incorrect, and d) whether or not the appellant is seeking an informal internal resolution prior to the formal appeal process.

You are entitled to be represented by counsel at your own expense in these proceedings. If you retain an attorney, your counsel must notify the Administrator of his or her representation of you.

Effective Date of Sanction

If you submit a timely request for appeal, the effective date of the action will be stayed, pending the hearing on appeal. If you do not request a hearing within the next ten working days, you will waive your rights to a hearing and the action will be imposed as of the 11th working day after you receive this notice.

NAC 439.348 indicates that except as otherwise provided in NAC 449.99908 the effective date of the disciplinary action is stayed upon receipt of an appeal until the hearing officer renders a decision regarding the appeal. NAC 449.99908 indicates that initial monetary penalty assessment payments are due within 15 days after the notice of the penalty and must be paid irrespective of any administrative appeal.

Reduction of Monetary Penalties

If you waive your right to hearing, correct the deficiencies and pay the fines within 15 days of this notice, your penalty will be reduced by 25% pursuant to NAC 449.99904. Please contact the supervisor listed below in order to adjust the payment due in the online licensing and certification system, Aithent Licensing System (CLICs).

Use of Monetary Penalty Towards Correction pursuant to NAC 449.998995

1. A facility may submit to the Bureau a request to use all, or a portion of an initial monetary penalty imposed upon the facility pursuant to NAC 449.99899 to correct the deficiency for which the penalty was imposed in lieu of paying the penalty to the Bureau. The Bureau may approve such a request if the deficiency results from the facility's first violation of a particular provision of law or regulation.

If the Bureau approves a request pursuant to subsection 1, the facility must:

(a) Adhere to any requirements prescribed in a plan of correction approved pursuant to NAC 449.9987 concerning the use of the monetary penalty.
(b) Complete all corrections for which the monetary penalty is used not later than 1 year after the date on which the request was approved.
(c) Submit to the Bureau proof satisfactory to the Bureau that the monetary penalty was used to make corrections for which the use of the monetary penalty was approved by the Bureau pursuant to subsection 1; and
(d) Remit to the Bureau any portion of the monetary penalty that is not used to correct the deficiency.

Payments

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Please access our online licensing and certification system, Aithent Licensing System (CLICs) at https://nvdpbh.aithent.com to submit the sanction payment of $3,000 within 15 days of this notice. Kiosks are available by appointment only at the Las Vegas and Carson City offices to allow providers use of CLICs if you do not have access to the internet. Appointments can be made by calling (702) 486-6515.

Other Notifications

You may receive a separate invoice if the sanction(s) listed above were imposed due to a substantiated complaint investigation. NAC 449.01685 authorizes the Division to charge and collect fees from licensee to recover costs of investigating complaints if the complaint is substantiated. (NRS 439.150, 439.200 and 449.0302). The fee will be based upon the hourly rate established for each surveyor of health facilities as determined by the budget of the Division and cannot be appealed.

The Bureau may upload information about sanctions applied to medical facilities to the National Practitioners Databank within 30 days of providing the sanction notice to the facility.

If you have any questions about this notice or the contents therein, please call the supervisor indicated below at [redacted].

Sincerely,

[redacted]

[redacted] RN, Health Facilities Inspector III
For [redacted] Bureau Chief

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS CENTER	[redacted] RENO, NEVADA [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
0000	Initial Comments - Inspector Comments: This Statement of Deficiency was generated as a result of a complaint investigation started on 05/26/2021 and completed in your facility on 08/16/2021 in accordance with Nevada Administrative Code (NAC), Chapter 449, Hospital. The census was 68 on 05/26/2021. The sample size was 3. There were two complaints investigated. Complaint [redacted] with the following allegation could not be substantiated due to lack of evidence. Allegation #1, The facility did not return a patient's clothing when the patient was discharged. The facility informed the patient's guardian the clothing could not be returned due to COVID-19 protocols and the clothing would be laundered and then mailed to the patient. The clothing had not been mailed to the patient. The investigation into the allegation included: An interview was conducted with the Director of Nursing. Review of three medical records including the patient of concern. Review of facility policies for routine laundering of patient's clothes and resident belongings. Complaint [redacted] with the following allegations was substantiated. Allegation #1, the facility staff documented a patient was located in a common area of the facility, the activity room, when the patient was actually in a room with another patient. During the same time frame, staff did not open the door to a patient's room to complete a scheduled visual observation (See Tag S300). Allegation #2, lack of protective supervision of patients by staff allowed two patients to engage in sexual contact in a patient's room resulting in physical harm to a patient (See Tag S320). The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS CENTER	[redacted] RENO, NEVADA [redacted]

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	The following deficiencies were identified:			
0300 SS= G	NAC 449.3622 - Appropriate Care of Patient - 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. Inspector Comments: Based on interview, record review, and document review the facility failed to ensure the minimum level of observation, per facility policy, was completed for 2 of 3 sampled patients (Patient #1 and #2) resulting in physical harm to 1 of 3 sampled patients (Patient #1). Findings include: Patient #1 Patient #1 was admitted to the facility on 04/01/21, with a diagnosis of major depressive disorder, recurrent, severe. Patient #2 Patient #2 was admitted to the facility on 03/16/21, with diagnoses including disruptive mood dysregulation disorder, major depressive disorder, recurrent, unspecified, and post traumatic stress disorder. A Child Protective Services Incident Report, dated 04/26/21, documented on 04/24/21, Patient #1 and Patient #2 were observed on camera view to have been in the activity room at 7:30 PM. At 7:33 PM, both patients exited the activity room and went into the room of Patient #2. Both patients remained in the room with the door closed for 20 minutes. On 04/24/21, facility staff were notified by Patient #1 of sexual acts occurring between Patient #1 and Patient #2 during the time both patient's were in the room of Patient #2. The Progress Note for Patient #1, dated 04/24/21, documented the following: - 7:30 PM - Location: Activity Room; Behavior: Programming - 7:45 PM - Location: Activity Room; Behavior: Programming The Progress Note for Patient #2, dated 04/24/21, documented the following: - 7:30 PM - Location: Bathroom - 7:45 PM - Location: Hallway; Behavior: Programming	0300		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		A. BUILDING _____ B. WING _____	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS CENTER	[redacted] RENO, NEVADA [redacted]

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	On 05/26/21 at 9:32 AM, the Director of Clinical Programming verbalized staff on 04/24/21, were unaware the two patients had gone into Patient #2's room together. The staff misidentified Patient #1 when documenting the every 15 minute observations. A Reno Police Department report narrative, dated 04/28/21, documented an exam of Patient #1 denoted the patient to have a superficial tear of anal mucosa. Both Patient #1 and Patient #2 admitted to engaging in sexual acts during the 20 minutes both patients were in the room of Patient #1 on 04/24/21. On 05/26/21 at 10:48 AM, the Director of Risk Management and Performance Improvement, verbalized the staff should have opened the door to Patient #2's room on the evening of 04/24/21, to have visualized the patient prior to documenting the patient was observed on the progress note. The facility policy titled "Level of Observation Orders," last revised 06/2020, documented every 15 minute observations were the minimum level of observation for all patients. Staff would observe patients and document on the Patient Observation Record every 15 minutes. Assigned staff would make direct visual contact with patient and confirm they were in no danger or distress. Severity: 3 Scope: 1			
0320 SS= G	NAC 449.3628 - Protection of Patient - 1. A governing body shall develop and carry out policies and procedures that prevent and prohibit: (a) Verbal, sexual, physical and mental abuse of patients Inspector Comments: Based on interview, record review, and document review, the facility failed to ensure a patient was provided the minimum level of observation to protect the patient from harm for 1 of 3 sampled patients (Patient #1). Findings include: Patient #1 Patient #1 was admitted to the facility on 04/01/21, with a diagnosis of major depressive disorder, recurrent, severe. Patient #2 Patient #2 was admitted to the facility on 03/16/21, with diagnoses	0320		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2021
NAME OF PROVIDER OR SUPPLIER WILLOW SPRINGS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE [redacted]RENO, NEVADA[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
	including disruptive mood dysregulation disorder, major depressive disorder, recurrent, unspecified, and post traumatic stress disorder. A Progress Note for Patient #1, dated 04/25/21, documented the patient had a dry affect and reported to staff another peer had touched the patient inappropriately. A Registered Nurse Behavioral Progress Note, dated 04/26/21, documented the Risk Manager spoke to Patient #1 and Patient #1 reported being in Patient #2's room on 04/24/21 and the patient's engaged in sexual behaviors including sexual penetration of Patient #1 by Patient #2. A Child Protective Services Incident Report, dated 04/26/21, documented on 04/24/21, Patient #1 and Patient #2 were observed on camera view to have been in the activity room at 7:30 PM. At 7:33 PM, both patients exited the activity room and went into the room of Patient #2. Both patients remained in the room with the door closed for 20 minutes. On 04/24/21, Patient #1 informed facility staff Patient #2 had forced Patient #1 to engage in sexual acts during the time both patients were in the room with the door closed. A Patient Observation Record for Patient #1, dated 04/24/21, documented the following: - 7:30 PM - Location: Activity Room; Behavior: Programming - 7:45 PM - Location: Activity Room; Behavior: Programming A Patient Observation Record for Patient #2, dated 04/24/21, documented the following: - 7:30 PM - Location: Bathroom - 7:45 PM - Location: Hallway; Behavior: Programming On 05/26/21 at 9:32 AM, the Director of Clinical Programming verbalized staff on 04/24/21, were unaware the two patients had gone into Patient #2's room together. The staff misidentified Patient #1 when documenting the every 15 minute observations. On 05/26/21 at 10:25 AM, the Director of Risk Management and Performance Improvement, verbalized the patient's were moving around a lot on the evening of 04/24/21, because patient's had been drinking alcohol based hand sanitizer			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER WILLOW SPRINGS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE [redacted] RENO, NEVADA [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
	(ABHR) from the nurse's station. The staff had asked Patient #1 and Patient #2 if they had drank any of the ABHR and both patient's denied doing so. On 05/26/21 at 10:48 AM, the Director of Risk Management and Performance Improvement, verbalized the staff should have opened the door to Patient #2's room on the evening of 04/24/21, to have visualized the patient prior to documenting the patient was observed on the progress note. A Reno Police Department report narrative, dated 04/28/21, documented an exam of Patient #1 denoted the patient to have a superficial tear of anal mucosa. Both Patient #1 and Patient #2 admitted to engaging in oral and anal sexual acts during the 20 minutes both patients were in the room of Patient #1 on 04/24/21. Patient #2 reported the patient had drank four or five glasses of hand sanitizer on 04/24/21 and was drunk and recalled engaging in anal sex with Patient #1. The facility policy titled "Level of Observation Orders," last revised 06/2020, documented every 15 minute observations were the minimum level of observation for all patients. Staff would observe patients and document on the Patient Observation Record every 15 minutes. Assigned staff would make direct visual contact with patient and confirm they were in no danger or distress. The facility policy titled "Alleged Sexual Contact Between Patients and Sexual Contact Between Patients," revised 06/2020, documented it was the policy of the facility to prevent sexual activity by providing staff supervision and environmental safeguards. Severity: 3 Scope: 1			

UHS-FINHELP-00010805 [Redacted]



Final Accreditation Report

Willow Springs Center
[redacted]
Reno, NV [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 3/12/2018 - 3/15/2018

Program Surveyed
Behavioral Health

Final Report: Posted 4/24/2018

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	03/12/2018 - 03/15/2018	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

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
CTS.02.01.09	1	Low / Limited	✓
CTS.02.01.11	1	Low / Limited	✓
CTS.02.02.01	1	Low / Widespread	✓
CTS.02.02.05	2	Low / Widespread	✓
CTS.03.01.01	1	Low / Limited	✓
CTS.03.01.03	1	Low / Widespread	✓
	2	Low / Pattern	✓
EC.02.06.01	26	Low / Pattern	✓
HRM.01.02.01	1	Moderate / Limited	✓
HRM.01.06.01	1	Low / Pattern	✓
	2	Low / Limited	✓
	3	Moderate / Pattern	✓
HRM.01.06.05	1	Low / Pattern	✓
LS.02.01.20	40	Low / Limited	✓
MM.03.01.01	8	Low / Limited	✓
MM.04.01.01	9	Low / Pattern	✓
MM.07.01.01	1	Low / Pattern	✓

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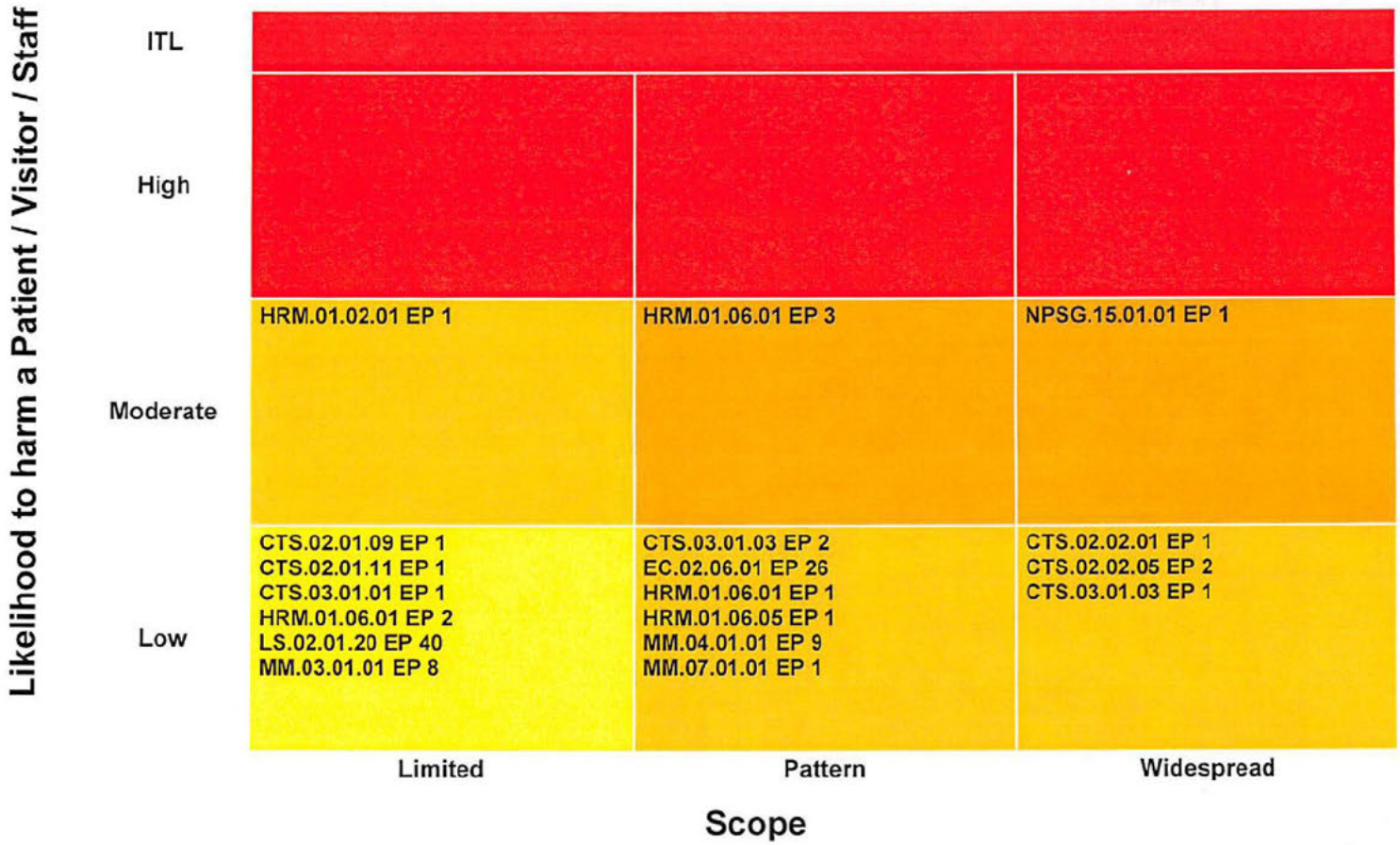
Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
NPSG.15.01.01	1	Moderate / Widespread	✓

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.02.01.09	1	Low Limited	The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)	1). Observed in Individual Tracer at Willow Springs Center Outpatient [redacted] Reno, NV) site . The record does not contain a screen for physical pain. Screening for pain is an important issue given the population serves.
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 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 Willow Springs Center Outpatient [redacted] Reno, NV) site . There is no documentation within the assessments to evaluate the nutritional status of the individual. There are notes indicating the possibility of an eating disorder but no screen to indicate the need for the nutritional status to be further evaluated.
CTS.02.02.01	1	Low Widespread	As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served: - Environment and living situation(s) - Leisure and recreational interests - Religion or spiritual orientation - Cultural preferences - Childhood history - Military service history, if applicable - Financial issues - Usual social, peer-group, and environmental setting(s) - Language preference and language(s) spoken - Ability to self-care - Family circumstances, including bereavement - Current and past trauma - Community resources accessed by the individual served Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services. Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these	1). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The assessments of this 11 year old child do not contain sufficient information regarding the changes within the family constellation and the time frame when significant issues occurred. The child has enuresis and a host of other issues but there is no documentation regarding the development of these issues that are important in defining problems and developing effective intervention strategies.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
			groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.	
				2). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The assessments do not fully document the cultural preferences of the patient. Given the ethnicity of the individual and the ethnic make up of her adoptive family, assessing and documenting cultural preferences is relevant to the care being provided to the patient.
				3). Observed in Individual Tracer at Willow Springs Center Outpatient ([redacted] Reno, NV) site . The assessments do not fully examine cultural preferences and religious/spiritual components of the child receiving services. The background information is lacking some information about the adoptive father and other family information that would give a more complete picture of the needs of the child.
				4). Observed in Individual Tracer at Willow Springs Center ([redacted] Reno, NV) site . The assessments do not fully assess the spirituality of the individual being served. The patient has significant substance abuse issues and is being referred for additional treatment within the facility for substance abuse. The complete assessment of spirituality is especially important based on the identified problem.
CTS.02.02.05	2	Low Widespread	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 Willow Springs Center ([redacted] Reno, NV) site . There is no documentation that reflects that neglect or exploitation were assessed. The assessment of possible neglect and exploitation is of similar importance to abuse and trauma currently assessed by the organization.
				2). Observed in Individual Tracer at Willow Springs Center ([redacted] Reno, NV) site . The assessments do not address possible exploitation.
				3). Observed in Individual Tracer at Willow Springs Center ([redacted] Reno, NV) site . The record does not assess for exploitation although there is documentation that indicates the

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
				patient may be the victim of exploitation. It is important based on the at risk youth served by the organization to fully assess for possible exploitation.
CTS.03.01.01	1	Low Limited	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 Willow Springs Center ([redacted] Reno, NV) site . The treatment plan contains a component that is developed based on the recreational therapy assessment. The actual treatment plan located in the patients record contains the name of another patient that is crossed out and over written with the name of the patient for whom the treatment plan was developed. The objectives and interventions appear to be template as they were not changed from the other plan and are not individualized and based on the specific needs of the child.
CTS.03.01.03	1	Low 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 Willow Springs Center ([redacted] Reno, NV) site . Issues identified with the assessments such as a history of physical abuse and ADHD are not reflected in the plan of care as being an active focus of treatment, resolved, referred or deferred. The patient is being treated for ADHD by the psychiatrist but there is no mention of this problem and resultant treatment within the treatment plan.
				2). Observed in Individual Tracer at Willow Springs Center ([redacted] Reno, NV) site . The assessments indicated a recent history of physical assault. However the treatment plan does not address the assault as being an active focus of treatment, resolved, referred or deferred.
				3). Observed in Individual Tracer at Willow Springs Center Outpatient ([redacted] Reno, NV) site . There are multiple issues identified on the assessments including being the victim of bullying, self harming behaviors, suicidal ideation that are not reflected in the plan of care as being an active focus of clinical attention, resolved, referred or deferred.
				4). Observed in Individual Tracer at Willow Springs Center ([redacted] Reno, NV) site . The treatment plan is not individualized and contains generic goals that do not capture the words or intent of the patient, does not build upon identified strengths, and does not reflect all of the issues identified on the assessments as being resolved, an active focus of treatment, referred or deferred.
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	1). Observed in Individual Tracer at Willow Springs Center ([redacted] Reno, NV) site . The goals on the treatment plan do not capture the words or intent of the patient. Capturing the words or intent of the patient is critical in developing objectives to meet the

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
			- 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.	patients identified goals.
				2). Observed in Individual Tracer at Willow Springs Center ([redacted] Reno, NV) site . The goals on the treatment plan do not capture the words or intent of the patient and are more prescriptive in nature.
				3). Observed in Individual Tracer at Willow Springs Center Outpatient [redacted] Reno, NV) site . The goals do not capture the words or intent of the patient and appear more prescriptive in nature.
EC.02.06.01	26	Low Pattern	The organization keeps furnishings and equipment safe and in good repair.	1). Observed in Building Tour at Willow Springs Center [redacted] Reno, NV) site . There are multiple instances of cracked or broken ceiling tiles in various parts of the building that are in need of repair or replacement. All of the ceiling tiles are in corridors or areas under constant monitoring of staff. This was corrected while the surveyor was on site.
				2). Observed in Building Tour at Willow Springs Center [redacted] Reno, NV) site . The smoke detector in the pediatric group room is missing a cover and is in need of replacement. This was corrected while the surveyor was on site.
HRM.01.02.01	1	Moderate Limited	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	1). Observed in Competency Session at Willow Springs Center [redacted] Reno, NV) site . There is no primary source verification of the LCPC's license. This was corrected while the surveyor was on site. .

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
			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 organization, then primary source verification does not need to be completed a second time by the behavioral health care organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.	
HRM.01.06.01	1	Low Pattern	For each of its programs or services, the organization defines the competencies it requires of staff members who provide care, treatment, or services. Note: Competencies may be based on the programs or services provided and the populations served. (See also NPSG.03.06.01, EP 3)	1). Observed in Competency Session at Willow Springs Center [redacted]Reno, NV) site . The peer evaluations on the dietician and the clinical psychologist do not assess for competence in the duties they are hired to perform within the facility and are templates used by medical staff that assess competence outside the scope of practice of non physician licenses
HRM.01.06.01	2	Low Limited	Staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence. Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.	1). Observed in Competency Session at Willow Springs Center [redacted]Reno, NV) site . The registered dietician providing services has an evaluation of competency performed by a non dietician. The competency evaluation does not contain verification by an individual possessing the experience, knowledge and background necessary to evaluate performance.
HRM.01.06.01	3	Moderate Pattern	The organization conducts an initial assessment of staff competence. This assessment is documented.	1). Observed in Competency Session at Willow Springs Center [redacted]Reno, NV) site . In all three of the therapy staff HR files, there is no documentation that the therapists performing services within the facility have competencies verified. Verification of competencies based on the job description or what services the individual is hired to perform within the organization is an important function of the organization.
HRM.01.06.05	1	Low Pattern	Staff who provide care, treatment, or services to children or youth demonstrate an understanding of the developmental milestones of children or youth.	1). Observed in Competency Session at Willow Springs Center [redacted]Reno, NV) site . There is no documentation within the therapist's files that they have demonstrated an understanding of developmental milestones of children and youth.
LS.02.01.20	40	Low Limited	Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are four or more inches high (or six inches high if externally lit). Exit and directional signs displayed with continuous illumination are also	1). Observed in Building Tour at Willow Springs Center ([redacted]Reno, NV) site . The exit sign in the corridor leaving the pediatric unit has a punch out removed that indicates the exit goes to a wall. The punch out needs to be repaired to indicate the path

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Standard	EP	SAFER™ Placement	EP Text	Observation
			served by the emergency lighting system unless the building is one story with less than 30 occupants, and the line of exit travel is obvious. (For full text, refer to NFPA 101-2012: 18/19.2.10; 7.10.1.4; 7.10.1.5.1; 7.10.5; 7.10.6; 7.10.7)	of exit in the event an emergency exit is necessary. This was corrected while the surveyor was on site.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	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 Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The pediatric program's medication room contained one bottle of peroxide which had an expiration date of May 2017 which indicated the medication was expired but available for use on the day of the survey. This issue was corrected while the surveyor was on site.
MM.04.01.01	9	Low Pattern	For organizations that prescribe medications: A diagnosis, condition, or indication for use exists for each medication ordered. Note: This information can be anywhere in the clinical/case record and need not be on the order itself. For example, it might be part of the medical history.	1). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The record contains a medication order for PO Vistaril to be given now, but does not state what symptom or condition the medication is necessary to treat.
				2). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The patient was ordered Clonidine .1 mg now as a prn on March 9 but there is no documentation about the reason for the prn medication.
MM.07.01.01	1	Low Pattern	For organizations that prescribe or administer medications: The organization monitors the side effects and effectiveness of the medications, as reported by the individual served or his or her family. Note: This element of performance is also applicable to sample medications.	1). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . There is no documentation that indicates the effectiveness for a prn order for 50 mg Vistaril. It is important to reassess the patient following the administration of a prn medication to determine effectiveness.
				2). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . There is no documentation that indicated if the prn order for Clonidine administered on March 9 was effective in treating the problem being experienced by the patient.
NPSG.15.01.01	1	Moderate Widespread	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 Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The child scored 21 on a suicidal scale which is defined as severe risk. However, there is no clinical formulation of the degree of risk and there is no documentation about protective factors or things that would increase or decrease risk.
				2). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The suicide assessment does not fully assess for potential lethality of the patient given her prior attempts

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Standard	EP	SAFER™ Placement	EP Text	Observation
				and multiple risk factors present.
				3). Observed in Individual Tracer at Willow Springs Center Outpatient [redacted] Reno, NV) site . The patient has a significant history of suicidal ideation but the documentation lacks important risk factors which could increase the risk of possible self harm.
				4). Observed in Individual Tracer at Willow Springs Center [redacted] Reno, NV) site . The patient attempted suicide prior to admission however, there is no identification of factors which might increase or decrease the risk of self harm. In addition, the suicide assessment utilized by the organization indicates no risk at the time the assessment was conducted. Performing a complete risk assessment for potential suicidality is a critical component of the assessment process.

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Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.01.09	1	The organization screens all individuals served for physical pain.	The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)
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.02.02.01	1	The organization collects assessment data on each individual served.	As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served: - Environment and living situation(s) - Leisure and recreational interests - Religion or spiritual orientation - Cultural preferences - Childhood history - Military service history, if applicable - Financial issues - Usual social, peer-group, and environmental setting(s) - Language preference and language(s) spoken - Ability to self-care - Family circumstances, including bereavement - Current and past trauma - Community resources accessed by the individual served Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services. Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide

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Standard	EP	Standard Text	EP Text
			range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.
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.03.01.03	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, 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

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Standard	EP	Standard Text	EP Text
			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.
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.
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. 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 organization, then primary source verification does not need to be completed a second time by the behavioral health care organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.
HRM.01.06.01	1	Staff are competent to perform their job duties and responsibilities.	For each of its programs or services, the organization defines the competencies it requires of staff members who provide care, treatment, or services. Note: Competencies may be based on the programs or services provided and the populations served. (See also NPSG.03.06.01, EP 3)
HRM.01.06.01	2	Staff are competent to perform their job duties and responsibilities.	Staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence. Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.
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.
HRM.01.06.05	1	Staff who provide care, treatment, or services to children or youth have specific competencies.	Staff who provide care, treatment, or services to children or youth demonstrate an understanding of the developmental milestones of children

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Standard	EP	Standard Text	EP Text
			or youth.
LS.02.01.20	40	The organization maintains the integrity of the means of egress. 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.	Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are four or more inches high (or six inches high if externally lit). Exit and directional signs displayed with continuous illumination are also served by the emergency lighting system unless the building is one story with less than 30 occupants, and the line of exit travel is obvious. (For full text, refer to NFPA 101-2012: 18/19.2.10; 7.10.1.4; 7.10.1.5.1; 7.10.5; 7.10.6; 7.10.7)
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.
MM.04.01.01	9	Medication orders are clear and accurate. Note: This standard is applicable only to organizations that prescribe medications. The elements of performance in this standard do not apply to prescriptions written by a prescriber who is not affiliated with the organization.	For organizations that prescribe medications: A diagnosis, condition, or indication for use exists for each medication ordered. Note: This information can be anywhere in the clinical/case record and need not be on the order itself. For example, it might be part of the medical history.
MM.07.01.01	1	The organization monitors individuals served to determine the effects of their medication(s). Note: This standard is applicable only to organizations that prescribe or administer medications.	For organizations that prescribe or administer medications: The organization monitors the side effects and effectiveness of the medications, as reported by the individual served or his or her family. Note: This element of performance is also applicable to sample medications.
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.

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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

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

Willow Springs Center
[redacted]
Reno, NV [redacted]

Organization Identification Number: [redacted]
60-day Evidence of Standards Compliance Submitted: 6/22/2018

ESC Programs Reviewed
Behavioral Health

Final Report: Posted 6/26/2018

The Joint Commission
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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	6/22/2018	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Behavioral Health

Standard	Level of Compliance
CTS.02.01.09	Compliant
CTS.02.01.11	Compliant
CTS.02.02.01	Compliant
CTS.02.02.05	Compliant
CTS.03.01.01	Compliant
CTS.03.01.03	Compliant
EC.02.06.01	Compliant
HRM.01.02.01	Compliant
HRM.01.06.01	Compliant
HRM.01.06.05	Compliant
LS.02.01.20	Compliant
MM.03.01.01	Compliant
MM.04.01.01	Compliant
MM.07.01.01	Compliant
NPSG.15.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health

Standard	EP	Standard Text	EP Text
CTS.02.01.09	1	The organization screens all individuals served for physical pain.	The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)
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CTS.02.02.01	1	The organization collects assessment data on each individual served.	As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served: - Environment and living situation(s) - Leisure and recreational interests - Religion or spiritual orientation - Cultural preferences - Childhood history - Military service history, if applicable - Financial issues - Usual social, peer-group, and environmental setting(s) - Language preference and language(s) spoken - Ability to self-care - Family circumstances, including bereavement - Current and past trauma - Community resources accessed by the individual served Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services. Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide

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Standard	EP	Standard Text	EP Text
			range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.
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.03.01.03	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, 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

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Standard	EP	Standard Text	EP Text
			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.
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HRM.01.06.01	2	Staff are competent to perform their job duties and responsibilities.	Staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence. Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.
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.
HRM.01.06.05	1	Staff who provide care, treatment, or services to children or youth have specific competencies.	Staff who provide care, treatment, or services to children or youth demonstrate an understanding of the developmental milestones of children

The Joint Commission

Standard	EP	Standard Text	EP Text
			or youth.
LS.02.01.20	40	The organization maintains the integrity of the means of egress. 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.	Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are four or more inches high (or six inches high if externally lit). Exit and directional signs displayed with continuous illumination are also served by the emergency lighting system unless the building is one story with less than 30 occupants, and the line of exit travel is obvious. (For full text, refer to NFPA 101-2012: 18/19.2.10; 7.10.1.4; 7.10.1.5.1; 7.10.5; 7.10.6; 7.10.7)
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.
MM.04.01.01	9	Medication orders are clear and accurate. Note: This standard is applicable only to organizations that prescribe medications. The elements of performance in this standard do not apply to prescriptions written by a prescriber who is not affiliated with the organization.	For organizations that prescribe medications: A diagnosis, condition, or indication for use exists for each medication ordered. Note: This information can be anywhere in the clinical/case record and need not be on the order itself. For example, it might be part of the medical history.
MM.07.01.01	1	The organization monitors individuals served to determine the effects of their medication(s). Note: This standard is applicable only to organizations that prescribe or administer medications.	For organizations that prescribe or administer medications: The organization monitors the side effects and effectiveness of the medications, as reported by the individual served or his or her family. Note: This element of performance is also applicable to sample medications.
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.

UHS-FINHELP-00010854 [Redacted]

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services

DIVISION OF BEHAVIORAL HEALTH
Anchorage Regional Office

[redacted]
Anchorage, Alaska 99503-5924
Main: [redacted]
Toll Free:
Fax:

October 01, 2018

North Star RTC Palmer
[redacted]
Palmer, AK [redacted]

Dear: [redacted]
Fax: [redacted]

Re: Site Review

As you are aware, the Code of Federal Regulations (42 CFR 456.600-614) requires State Medicaid Agencies to conduct reviews of inpatient psychiatric facilities on an annual basis. North Star RTC Palmer was reviewed 9/5/2018 to 9/6/2018, and conducted by:

State of Alaska Department of Health and Social Services (DHSS) representatives from Behavioral Health (BH)
Manager: [redacted] MAA IV

The team consists of:
[redacted] RN BSN
[redacted] LPC
[redacted] M.Ed.
[redacted] C&L

TYPE OF REVIEW
◉ Annual
○ Critical Incident

REPORT
Enclosed is the **Site Review Summary of Findings** report dated . This document contains a description and history of your organization, purpose and process of the site review, a summary of Behavioral Health findings, and recommendations. This report also contains detailed information pertaining to the medical necessity clinical chart review conducted by Behavioral Health staff.

This report is also available without Medicaid numbers. This non-confidential version is submitted to your licensing organization.

PLAN OF IMPROVEMENT

Plan of Improvement (POI) may be required as a result due to deficit found during the site/chart review process. Your facility must take corrective action based on the recommendations of the review team (42 CFR 465.613). If a POI is requested, North Star RTC Palmer is expected to respond in writing to BH within 20 business days after the site review.

Address: State of Alaska
Attention: [redacted] MAA IV
Department of Health and Social Services
[redacted]
Anchorage, AK [redacted]

Fax: [redacted]

If you have questions in regards to areas for improvement identified in the HSS integrated site review report, please contact [redacted] MAA IV at [redacted]

The Alaska site review team thanks the staff at the North Star RTC Palmer for their hospitality, flexibility and willingness to accommodate our requests while on site.

Sincerely,

[redacted]
[redacted] MAA IV
Division of Behavioral Health

CC: AK Licensing
North Star RTC Palmer, Utilization Review Team

State of Alaska Department of Health and Social Services
Division of Behavioral Health
Site Review Summary of Findings

Provider: North Star RTC Palmer
Provider ID: [redacted]

Start Date of Review: 9/5/2018
End Date of Review: 9/6/2018

Lead Reviewer: [redacted] MAA IV

Other Reviewers:
[redacted] RN BSN
[redacted] LPC
[redacted] M.Ed.
[redacted] C&L

Date of Report:

Number of Charts Reviewed: 26

ORGANIZATIONAL DESCRIPTION AND HISTORY

The Summit is the North Star Palmer psychiatric residential treatment facility. It sits in a rural setting on grounds surrounded by natural forest.
The facility treats male recipients between ages of 11 and 17 years old, and can provide treatment for 30 youth.
A wilderness experience is included in treatment for all youth.
---Camping opportunities are offered in all seasons.
---This program identifies competency in wildlife safety, shelter building survival skills, fire skills, etc. for all seasons.
---The facility has staff that are wilderness first responders who lead camping staff.
The facility utilizes the level system aligned with the analogy of progressing on a climb to the top of a mountain, beginning with base camp and moving toward the top of the mountain, the summit, to enhance the reinforcement aspects for progressing in treatment.
North Star Palmer accepts youth with IQ's of 70 or higher.
The facility has a large amount of outdoor recreational equipment, large lawns and paved courts in which to play or engage in therapeutic activities.
The facility offers gardening as an activity during the summer.
Youth are encouraged to participate in community based projects such as making knit hats for the homeless and the recycling project at the state fair.
---Outings include doing community service in both Palmer/Wasilla and Anchorage.
The program has two housing units; the larger of the two buildings houses the cafeteria and dining room for the program, two wings of this unit house 10 youth each.
---The second unit, the Eagle house, houses 10 youth who are usually on a higher level and includes a music room with instruments.
---Living areas are large and well lit by natural light.
---The program has added a library of many volumes for youth to check out books.

Education is provided by the Mat-Su School District in a separate school building.
---Youth who have progressed in treatment are able to enroll and attend the local public school appropriate to their age.

SITE REVIEW PURPOSE AND PROCESS

Per 42 CFR 456.606 site reviews are required to be performed yearly.

FINDINGS

Plan of Care: ***42 CFR 441.155(b)(1); 42 CFR 441.155 b(2); 42 CFR 456.609;7 AAC 140.410 (a)(3); 42 CFR 441.155(b)(3); 42 CFR 441.155 (c)(2); 42 CFR 441.156; 7 AAC 140.405(b)(5); 7 AAC 140.410 (a)(4); 7 AAC 140.410 (a)(6)***

The intake documents incorporate a number of the Initial Plan of Care (IPOC) requirements including an IPOC which does not have all of the required elements.
---This document has been changed over the past year and suggestions were made to the leadership of options to have all of the required elements included in the one document with no duplication of efforts.
Plans of care were missing documentation of required team members involvement in the plan of care development.
Plans of care were missing discharge dates and specific discharge providers.
The plan of care is based on a complete diagnostic evaluation.
Goals and objectives are updated on the plans of care.
Plans show involvement of client and family/guardians involvement in the setting of goals and objectives and progress in treatment.
The reviewers noted some plans were not updated with new dates when the discharge date was changed in other documentation.
Plans of care were updated every 30 days.

Progress Notes: ***42 CFR 456.610 (a); 42 CFR 456.610 (b)(1); 42 CFR 456.610 (c); 42 CFR 456.610 (d)***
Psychiatrist documents weekly contact with youths. Psychiatrists' progress notes include a comprehensive summary and were clearly related to the treatment goals of the youth documented in the Plan of Care.
---Reviewed progress notes documented evidence of changes to the clients' psychological and physical condition, responses to, and outcomes of treatment. Psychiatrists documented the reasons for medication use, adjustments, and discontinuances.
Nursing staff assess youth upon admission and complete weekly summary. RNs also document nursing and medical issues by exception for specific behavioral and medical issues.
---Nursing documents follow through of care provided for specific medical needs. It was evident during the youths' interviews that RN provides outstanding Medication Education to the youth.
The majority of the youth were able to state their medications, including dosage, time, reason for use, and possible side effects.
Clinical progress notes are thorough and complete and document active treatment is occurring in the sessions.
Case management notes are connected to the clinical progress notes to allow for documentation of contact with collateral agencies.

Restraint and Seclusion: ***42 CFR 483.350 through 42 CFR 483.376***

The facility utilizes brief physical holds (restraints) and seclusion to manage behavioral crisis.
Program has limited use of brief physical holds and seclusions.
3 out of 26 youth were placed in holds or secluded: this finding was supported by youths' report during interviews.
It was evident that there was effective progress in providing youth with treatment and coping skills that decreased behavioral crisis's that required being held.
Reviewed restraint events were found to be compliant with Center for Medicare &Medicaid Services (CMS) regulations.
There was no indication during the review that restraints and seclusions were inappropriately used.
There was evidence in reviewed records the parent and youth had been notified of the facility's philosophy for the use of brief physical holds.

Youth Interview Findings: ***42 CFR 456.608(a)(1)***
25 youth were interviewed.

Like:
- Most of the youth indicated they liked the amount of outings and being able to be outdoors, to include learning camping skills, as things that they liked about the program.

Dislike:
- Several youth noted they disliked the point system and found "making their daily points" was difficult for them.
- A couple of youth that were interviewed mentioned not liking "being away from home".

Make Better:
Residents suggested that there be more outings and that the privileges associated with the level system be less restrictive.

Learned:
- Youth reported learning coping skills and anger management techniques. One resident specifically mentioned that he learned "that having depression is not a weakness".

Get along:
- A majority of residents indicated getting along with their peers, and if there were difficulties, those problems would eventually be resolved.

Relations:
- Residents regarded milieu staff favorably, offering that they "got along most of the time" and that they "fished for positives", which one resident saw as reinforcing while in treatment.
- Residents viewed their therapists as helpful, but noted that there were some "challenges" discussing uncomfortable topics, and it required them to "dig deeper" to overcome these obstacles.
- Residents trusted their doctors and the medications prescribed to help them. Residents spoke approvingly of the nurses, and several youth commented "they go out of their way" (to help).

Medication:
- Almost all the youth were able to identify their medications by name and what their intended purposes were.

Family:
- Youth indicated having family therapy one time per week and having telephonic contact with their family members several times a week along with visits and passes, if they were eligible.
- *Only two youth reported having* probation officers involved in their case, and confirmed their participation in the treatment process while at North Star Palmer.

Plan:

- Most youth presented with an understanding of what was on their treatment plan, when asked what their "treatment objectives" were.
- Some of the youth replied that they were able to provide input to what was on their treatment plan and others felt that staff determined what was on their respective treatment plans.

Discharge plans:

- Most residents knew the basic elements (i.e., where they would live, go to school and aftercare) of their discharge plan when questioned.

Grievance:

- All of the youth indicated an understanding of the process associated with submitting any formal complaints in writing.

Safety:

- Youth indicated not having any safety concerns while at North Star Palmer, other than those instances where there were occasional fights between peers .

Anything else:

One resident complained about food, wanting "less greasy foods" because of weight gain.

-

Parent Interviews:

11 of the 24 parents were reached.
2 youth are in the custody of DJJ
0 youth in tribal custody
0 youth discharged before the completion of the review
8 parents recalled being informed of the seclusion and restraint policy, and if their child had been restrained, they would have been notified by the staff.
3 parents were unable to recall being informed of the seclusion and restraint policy if their child had been restrained and then later notified by the staff.
0 parents had concerns about the safety of their child.
11 parents were aware of the grievance or complaint process for the facility.
11 parents expressed positive comments about the program and the communication with the facility.
11 parents were given the contact information for the Disability Law Center of Alaska.

QUALITY OF CARE

PLAN OF IMPROVEMENT (POI)

Provide a POI that addresses how you will correct the following deficiency/s:

Identified CFR / State of Alaska Regulation and Deficiency

42 CFR 441.155(b)(2)

Findings:

Plans of care are to be developed by a team. Some plans of care did not have documentation of the involvement of required team members. This was especially problematic with regards to the Initial Plan of Care.

Please provide a plan of improvement showing an updated Initial plan of care which has all of the requirements of a plan of care.

Identified CFR / State of Alaska Regulation and Deficiency

42 CFR 441.155(b)(5) and 7 AAC 140.410(6)

Findings:
Plans of care are to have a discharge date and specific discharge providers identified at the time of admission.

Please provide a copy of the Initial plan of care indicating how this will be addressed on the form to have compliance with the requirement.

Submit POI by:

Mail To:
State of Alaska
Department of Health and Social Services
Division of Behavioral Health
Attn: [redacted] MAA IV
[redacted]
Anchorage, AK [redacted]

Or
E- Mail To: [redacted]
Or
Fax POI To: [redacted] attention [redacted] MAA IV

Summary of Chart Review Findings

42 CFR 441.155(a) and 456.180

26 out of 26 chart(s) met this requirement.

42 CFR 441.155(b)(1)

26 out of 26 chart(s) met this requirement.

42 CFR 441.155(b)(3)

26 out of 26 chart(s) met this requirement.

42 CFR 441.155(b)(2)

22 out of 26 chart(s) met this requirement.

AB 0601228997	Inconsistent documentation of involvement of required team members
LC 0601167070	IPOC missing client signature
JC 0600888919	IPOC missing required signature
JC 0601333983	IPOC missing required signature

42 CFR 441.155(b)(4)

26 out of 26 chart(s) met this requirement.

42 CFR 441.155(b)(5) and 7 AAC 140.410(6)

23 out of 26 chart(s) met this requirement.

JC 0600888919	Discharge date missing on plans of care
CC 0601235176	specific providers and discharge date missing on plans of care
RM 0600915978	Discharge providers not identified

42 CFR 441.155(c)

26 out of 26 chart(s) met this requirement.

42 CFR 441.156 and 7 AAC 140.405(d)

26 out of 26 chart(s) met this requirement.

42 CFR 456.609(a)(b)(c)(d)

26 out of 26 chart(s) met this requirement.

42 CFR 456.610(a)

23 out of 26 chart(s) met this requirement.

LP 0601057014	Missing dietitian assessment for 7/13/18 referral.
JR 0601202396	Missing dietitian assessment for 8/15/18 referral.
BS 0601143742	No follow-up on 6/2/18 dietitian's recommendation to start Metformin.

42 CFR 456.610(b)(1)
26 out of 26 chart(s) met this requirement.

42 CFR 456.610(c)
26 out of 26 chart(s) met this requirement.

42 CFR 456.610(d)
26 out of 26 chart(s) met this requirement.

42 CFR 456.610(e)
26 out of 26 chart(s) met this requirement.

42 CFR 483.350 through 42 CFR 483.376
26 out of 26 chart(s) met this requirement.

It should be noted that the actions described in this report, or the plan of improvement, do not limit any administrative, civil, or criminal liability of the provider either for conduct which is the subject of this report, or the plan of improvement, or other instances of provider misconduct, or noncompliance with Behavioral Health or the Alaska Medicaid Program.

UHS-FINHELP-00010948 [Redacted]

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF LABOR STANDARDS AND SAFETY
AFFIDAVIT FOR MAILING

Alaska Department of Labor and Workforce Development
Division of Labor Standards and Safety
Occupational Safety and Health Section

COMPLAINANT

vs

Frontline Residential Treatment Center
Dba North Star Palmer Residential Treatment Center

CONTESTANT

Inspection No. [redacted]

Docket No. [redacted]

I, [redacted] Project Assistant, in the Anchorage OSH office, being first duly sworn, on 9/22/2021, state that I mailed the enclosed Complaint by placing a copy in an envelope, postage prepaid properly addressed to the following:

Frontline Residential Treatment Center
and its successors
[redacted]
Anchorage, AK [redacted]

Which is the last known address for the company listed above, and deposited it in the United States Mail for delivery.

[redacted]
Project Assistant, AKOSH

Subscribed and sworn to before me this September 23rd of 2021.

[redacted]
Notary Public
In and for the State of Alaska
My commission expires: With Office

[redacted]

NOTARY PUBLIC With Office STATE OF ALASKA

TO: OCCUPATIONAL SAFETY AND HEALTH REVIEW BOARD
COMPLAINT

Alaska Department of Labor and Workforce Development Division of Labor Standards and Safety Occupational Safety and Health Section	)	
COMPLAINANT	)	Case No. [redacted]
vs	)	
Frontline Residential Treatment Center, LLC dba North Star Palmer Residential Treatment Center	)	Docket No. [redacted]
CONTESTANT	)	

1. On or about 4/22/2021, a representative of the Division of Labor Standards and Safety, Occupational Safety and Health Section, Alaska Department of Labor and Workforce Development, conducted an inspection of a workplace under the operation, control or ownership of Frontline Residential Treatment Center dba North Star Palmer Residential Treatment Center.

2. Inspection # [redacted] conducted by [redacted] revealed violations of safety and health regulations or standards adopted by the Alaska Department of Labor and Workforce Development for which a citation was issued and penalty proposed which is contested by Frontline Residential Treatment Center.

3. Frontline Residential Treatment Center, LLC dba North Palmer Residential Treatment Center violated 29 CFR 1910.1200 (e) and (h) by failing to develop, implement, and maintain at each workplace a written hazard communication program and provide information and training to the employees. These are the repeat violations. Please see previous AKOSH enforcement inspection [redacted]

4. Frontline Residential Treatment Center, LLC dba North Palmer Residential Treatment Center violated 29 CFR 1910.22 (a)(1) General Requirements for Surface conditions in all places of employment, passageways, storerooms, service rooms and walking-working surfaces.

5. These items are related to inspection # [redacted] by [redacted] "Exhibit A and Return Receipts".

6. Frontline Residential Treatment Center, dba North Star Palmer Residential Treatment Center pursuant to AS 18.60.093 and 8 AAC 61.150, has filed a notice of contest with the Commissioner of Labor and Workforce Development. This case is hereby certified to the Occupational Safety and Health Review Board.

Documents that were issued or received on the dates listed below are attached.

No. [redacted] **Date** 9/21/2021 CONTESTED CITATIONS.

[redacted]

9/23/2021
Date

Director, Labor Standards & Safety [redacted]

PLEASE READ NEXT PAGE FOR IMPORTANT INFORMATION

NOTICE TO EMPLOYER

Item number two on the previous page lists the citations, proposed penalties or abatement dates you have contested.

If you wish to file an answer to the complaint, you must file an answer to this complaint within 30 days as specified in 8 AAC 61.175, Rules of Procedure (Alaska Administrative Code). Your answer is to be mailed by certified mail to the Commissioner, Department of Labor and Workforce Development, and to all other parties of record. To expedite handling, please mail your answer to Commissioner, Alaska Department of Labor and Workforce Development, **C/O Alaska Occupational Safety and Health (AKOSH),** [redacted] **Anchorage, Alaska 99504.**

Failure to answer this complaint will initiate an administrative dismissal of the contest.

SELECTED PORTIONS OF THE ALASKA ADMINISTRATIVE CODE

8 AAC 61.170. RULES OF PROCEDURE.

(a) The rules of procedure in this chapter govern the proceedings for notices of contest before the board. In the absence of a specific provision, procedure is governed by the rules of civil procedure. The board may make other rulings of procedure in a specific case if the board finds that the ruling is necessary for the fair and orderly conduct of the proceeding.

(b) The board's rules of procedure are intended to facilitate business and promote a speedy and just resolution of contested cases. The board may relax the rules of procedure if strict adherence to them would work an injustice to one or more of the parties. (Eff. Register 53; am 11/22/75, Register 56; am 01/04/78, Register 64; am 01/26/78, Register 65; am 12/31/80, Register 76; am 12/02/94, Register 132).

8 AAC 61.175. PLEADINGS AND PARTIES

(a) Within 30 days of receipt by the department of a timely notice of contest, if the matter has not been settled or otherwise resolved, the department will file a complaint with the board. The complaint must specify the alleged violations, proposed penalties, and abatement dates that are contested. A copy of the complaint must be mailed or personally delivered to the party filing the notice of contest and to all parties of record.

(b) Within 30 days of receipt of the department's complaint, the party against whom the complaint was issued shall file an answer with the board. The answer must contain a statement responding the allegations in the department's complaint and must include any affirmative

defenses known to the party. A copy of the answer must be mailed or personally delivered to the department and to all parties of record.

(c) An employer, affected employee, or authorized employee representative, who has not filed a notice of contest, may participate as a party in the proceedings before the board by filing a written notice of participation with the board at least 20 days before the hearing. The notice of participation must contain the name, address, and telephone number of the employer, affected employee, or authorized employee representative requesting to participate as a party and must be mailed or personally delivered to all parties of record. Failure to give notice of participation as a party does not prevent an employer, affected employee, or authorized employee representative, from attending the hearing or testifying as a witness for a party to the hearing.

(d) A party may appear in person or through an attorney. The board may allow a person who is not an attorney to assist a party, for no compensation, in the presentation of the party's case. A Corporation may be represented by an authorized officer or agent. (Eff. 12/02/94, Register 132)

8 AAC 61.200. DISCOVERY OF INFORMATION

(a) Depositions must be taken in accordance with AS 44.62.440.

(b) The parties may undertake discovery by any other appropriate procedure, including written interrogatories, requests for production, requests for admission, or inspection of the place of employment. Discovery under this subsection must be done in accordance with the rules of civil procedure. (Eff. 01/10/75, Register 53; am 12/02/94, Register 132)

Authority: AS 18.60.020
AS 18.60.057
AS 18.60.093

Littler

Littler Mendelson P.C.
[redacted]
Tysons Corner, VA [redacted]

[redacted]
[redacted] direct
[redacted] main
[redacted] fax
[redacted] @littler.com

September 13, 2021

VIA EMAIL (ANCHORAGE.LSS-OSH@ALASKA.GOV, [redacted] @ALASKA.GOV)
& FAX [redacted]

Mr. [redacted]
Chief of Enforcement, AKOSH
[redacted]
Anchorage, AK [redacted]

Re: North Star Palmer Residential Treatment Center
Inspection No. [redacted] – NOTICE OF CONTEST

Dear Mr. Larsen:

Littler Mendelson represents North Star Palmer Residential Treatment Center ("North Star") in the above-referenced matter. North Star contests Citation 1, Items 1, 2, and 3 in the Citation and Notification of Penalty, Inspection No. [redacted] issued on August 24, 2021, as well as the penalty, abatement, and abatement date. We are filing this notice of contest to preserve all rights in this matter.

Please direct all further communications in this matter to me.

Should you have any questions regarding this Notice of Contest, please do not hesitate to contact me.

Sincerely,

[redacted]

[redacted]
Shareholder

[redacted]

Alaska Department of Labor and Workforce Development
Occupational Safety and Health
[redacted]
Anchorage, AK [redacted]
Phone: [redacted] Fax: [redacted]
Email: [redacted]

INVOICE/ DEBT COLLECTION NOTICE

Company Name: FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC dba North Star Palmer Residential Treatment Center
Inspection Site: [redacted] Palmer, AK [redacted]
Issuance Date: 08/24/2021

Summary of Penalties for Inspection Number: [redacted]

Citation 1 Item 1, Repeat-Serious	$13494.00
Citation 1 Item 2, Repeat-Serious	$13494.00
Citation 1 Item 3, Serious	$7900.00
TOTAL PROPOSED PENALTIES:	**$34888.00**

To avoid additional charges, please remit payment promptly for the total amount of the uncontested penalties summarized above. Make your check or money order payable to: "**State of Alaska**". Please send the remittance to the address listed above and indicate AKOSH's Inspection Number (indicated above) on the remittance. Return this form along with your remittance.

AKOSH does not agree to any restrictions or conditions or endorsements put on any check or money order for less than full amount due and will cash the check or money order as if these restrictions, conditions, or endorsements do not exist.

Delinquent Charges A debt is considered delinquent if it has not been paid within one month (30 calendar days) of the penalty due date or if a satisfactory payment arrangement has not been made. If the debt remains delinquent for more than 90 calendar days, the amount due will be turned over to the current state contracted collection agency for collection nationwide.

Administrative Costs Agencies of the Department of Labor are required to assess additional charges for the recovery of delinquent debts. These additional charges are administrative costs incurred by the Agency in its attempt to collect an unpaid debt. Administrative costs will be assessed for demand letters sent in an attempt to collect the unpaid debt.

[redacted]
Chief of Enforcement, AKOSH

24 Aug 2021
Date

EXHIBIT A

CONFIDENTIAL

Alaska Department of Labor and Workforce Development
Occupational Safety and Health
[redacted]
Anchorage, AK [redacted]
Phone: [redacted] Fax: [redacted]
Email: [redacted]

Citations and Notification of Penalty

To:
FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC dba North Star Palmer Residential Treatment Center and its successors
[redacted]
Anchorage, AK [redacted]

Inspection Number: [redacted]
Inspection Date(s): 04/22/2021-07/27/2021
Issuance Date: 08/24/2021

Inspection Site:
[redacted]
Palmer, AK [redacted]

The violation(s) described in this Citation and Notification of Penalty is (are) alleged to have occurred on or about the day(s) the inspection was made unless otherwise indicated within the description given below.

This Citation and Notification of Penalty (this Citation) describes alleged violations of the Alaska's occupational safety and health laws (AS 18.60.010 - AS 18.60.105) and adopted standards under the Occupational Safety and Health Act of 1970. Each alleged violation has a designated penalty outlined in the citation. Please refer to the enclosed form – *Employer Responsibilities Following an AKOSH Inspection* for additional details.

Hazards Correction/Abatement – Each alleged violation must be abated immediately to reduce the risk of an accident. You must provide proof (photos, statements, receipts, work orders, sampling results, etc.) to demonstrate that the alleged violations have been abated by the dates listed in the citation. If you file a formal notice of contest, you are not required to provide proof of abatement, but you are nevertheless required to correct hazardous conditions and provide a workplace that is free from recognized hazards.

Posting - The law (AS 18.60.091 (b)) requires that a copy of this Citation and Notification of Penalty be posted immediately in a prominent place at or near the location of the alleged violation(s). Posting is required until the alleged violations have been abated or for five working days (excluding weekends and state holidays), whichever is longer. If it is not practical to post at the worksite, due to the nature of the employer's operations, it should be posted where it can be seen by all affected employees.

EXHIBIT A

CONFIDENTIAL

Informal Conference - You may request an informal conference to discuss the alleged violations, abatement issues and associated penalties. During the informal conference you may present any evidence or views which you believe would support an adjustment to the citation(s) and/or penalty(ies). **Should you decide that you want to request an informal conference, you must submit a written request. This request must be received by AKOSH (either by mail, fax at [redacted] or e-mail to, [redacted] during the contest period.** This period extends 15 working days from the date of your receipt of this Citation.

If you are considering a request for an informal conference to discuss any issues related to this Citation and Notification of Penalty, **you make the request immediately. If you wait too long, there may not be enough time to conduct the informal conference prior to the expiration of the 15 working day contest period. (See "Right to Contest" below.)**

If you decide to request an informal conference, you must complete and post the attached *Notice to Employees of Informal Conference* next to the Citation and Notification of Penalty as soon as the time, date, and place of the informal conference have been determined. Be sure to bring to the conference any and all supporting documentation of existing conditions as well as any abatement steps taken thus far. If conditions warrant, it may be possible to enter into an informal settlement agreement to resolve this matter without litigation or contest.

Right to Contest - You have the right to formally contest this Citation and Notification of Penalty. You may contest all citation items or only individual items. You may also contest proposed penalties and/or abatement dates without contesting the underlying violations. **By law, an employer has only 15 working days (excluding weekends and state holidays) from the date citations were received to file a written notice of contest. Failure to meet this deadline will result in the alleged violations and penalties becoming a final order that is not subject to review by any court (see AS 18.60.093(a)).**

Penalty Payment – Penalties are due within 30 calendar days of receipt of this notification, unless informally settled under alternate terms or formally contested. Make your check or money order payable to "State of Alaska". Please indicate the AKOSH Inspection Number on the check.

AKOSH does not agree to any restrictions or conditions or endorsements put on any check or money order for less than the full amount due,and will cash the check or money order as if these restrictions, conditions, or endorsements do not exist.

Employer Discrimination Unlawful – The law prohibits discrimination by an employer against an employee for filing a complaint or for exercising any rights under AS 18.60.010 – AS 18.60.105 or the OSH Act of 1970. An employee who believes that he/she has been discriminated against may file a complaint within 30 days after the discrimination occurred.

Notice to Employees - The law gives an employee or his/her representative the opportunity to object to any abatement date set for a violation if he/she believes the date to be unreasonable. The contest must be mailed to the Alaska Department of Labor Office and Workforce Development at the address shown above and postmarked within 15 working days (excluding weekends and State holidays) of the receipt by the employer of this Citation and Notification of Penalty.

See pages 1 through 2 of this Citation and Notification of Penalty for information on employer and employee rights and responsibilities.

EXHIBIT A

CONFIDENTIAL UHS-FINHELP-00010956

Alaska Department of Labor and Workforce Development
Occupational Safety and Health
[redacted]
Anchorage, AK [redacted]
Phone: [redacted] Fax: [redacted]
Email: [redacted]

NOTICE TO EMPLOYEES OF INFORMAL CONFERENCE

An informal conference has been scheduled with AKOSH to discuss the Citation(s) issued on 08/24/2021. The conference will be held at the AKOSH office located at [redacted] Anchorage, AK [redacted] on _____ at _____.

Employees and/or representatives of employees have a right to attend an informal conference.

EXHIBIT A

CONFIDENTIAL UHS-FINHELP-00010957

Alaska Department of Labor and Workforce Development
Occupational Safety and Health

Inspection Number: [redacted]
Inspection Date: 04/22/2021-07/27/20.
Issuance Date: 08/24/2021

Citation and Notification of Penalty

Company Name: FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC
Inspection Site: [redacted] Palmer, AK [redacted]

Citation 1 Item 1 Type of Violation: **Repeat-Serious**

29 CFR 1910.1200(h)(1):

1910.1200 Hazard Communication.

(h) Employee information and training.

(1) Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new chemical hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (e.g., flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and safety data sheets.

EXAMPLE: Employees are exposed to health hazards due to the employer's failure to provide employees with effective information and training on hazardous chemicals in their work area whenever a new chemical hazard the employees have not previously been trained about is introduced into their work area. Chemical products used by Henry's Housekeeping (Signed service agreement 12/3/2020) called PURTABS, PEROXIDE MULTI-SURFACE CLEANER, and Spic and Span Disinfecting All-Purpose Spray and Glass Cleaner - Concentrated contained hazardous chemicals include, but are not limited to, aerosolized Hydrogen Peroxide, Diethylene glycol monobutyl ether (butyl carbitol), and 1-amino-2-propanol. The use of these chemical exposures caused North Star Palmer Residential Treatment Center employees respirable distress and hospitalization due to lack of effective communication.

REPEAT:
The Owning organization United Health Services, under North Star Behavior Health Hospital, Licensed as Frontline Residential Treatment Center, LLC, DBA North Star Palmer Residential Treatment Center was previously cited for a violation of this occupational safety and health standard or its equivalent standard 29 CFR 1910.1200(h)(1) - Employee information and training , which was contained in AKOSH inspection number 1437440, citation number 1, item number 2/c and was affirmed as a final order on (4/17/2020), with respect to a workplace located at [redacted] Anchorage, AK [redacted] A recent inspection of the same establishment revealed a violation of §29 CFR 1910.1200(h)(1) for not providing hazardous communication information and training to their employees. Although the same standard was involved, the hazardous conditions in each case are substantially similar and therefore a repeated violation would be appropriate.

Date by Which Violation Must Be Abated: **September 20, 2021**
Proposed Penalty: **$13494.00**

EXHIBIT A

CONFIDENTIAL

Alaska Department of Labor and Workforce Development
Occupational Safety and Health

Inspection Number: [redacted]
Inspection Date: 04/22/2021-07/27/20
Issuance Date: 08/24/2021

Citation and Notification of Penalty

Company Name: FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC
Inspection Site: [redacted] Palmer, AK [redacted]

Citation 1 Item 2 Type of Violation: **Repeat-Serious**

29 CFR 1910.1200(e)(1):

1910.1200 Hazard Communication.

(e) Written hazard communication program.

(1) Employers shall develop, implement, and maintain at each workplace, a written hazard communication program which at least describes how the criteria specified in paragraphs (f), (g), and (h) of this section for labels and other forms of warning, safety data sheets, and employee information and training will be met, and which also includes the following:

EXAMPLE: Employees are exposed to chemical hazards due to the employer's failure to implement their written hazard communication program that contains the criteria specified in paragraphs (h). Although employees are trained and SDS are obtained and maintained; the program is not implemented. Employees are exposed to disinfectants and cleaning agents within their work areas from an outside contractor (Henry's Janitorial Services Inc) and the employer failed to effectively communicate the hazards associated with the applications of said contractor's chemicals products to affected employees resulting in two respirable recordable illness that required medical treatment beyond first aid.

REPEAT:
The Owning organization United Health Services, under North Star Behavior Health Hospital, Licensed as Frontline Residential Treatment Center, LLC, DBA North Star Palmer Residential Treatment Center was previously cited for a violation of this occupational safety and health standard or its equivalent standard 29 CFR 1910.1200(e)(1) - Written hazard communication program, which was contained in AKOSH inspection number 1437440, citation number 1, item number 2/a and was affirmed as a final order on (4/17/2020), with respect to a workplace located at [redacted] Anchorage, AK [redacted] A recent inspection of the same establishment revealed a violation of §29 CFR 1910.1200(e)(1) for not providing hazardous communication information and training to their employees. The same standard was involved, the hazardous conditions in each case are substantially similar and therefore a repeated violation would be appropriate.

Date by Which Violation Must Be Abated: **September 20, 2021**
Proposed Penalty: **$13494.00**

Alaska Department of Labor and Workforce Development
Occupational Safety and Health

Inspection Number: [redacted]
Inspection Date: 04/22/2021-07/27/20
Issuance Date: 08/24/2021

Citation and Notification of Penalty

Company Name: FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC
Inspection Site: [redacted] Palmer, AK [redacted]

Citation 1 Item 3 Type of Violation: **Serious**

1910.22: General requirements.

(a) Surface conditions. The employer must ensure:

(1) All places of employment, passageways, storerooms, service rooms, and walking-working surfaces are kept in a clean, orderly, and sanitary condition.

EXAMPLE: Employees are exposed to the coronavirus due to the employer' failure to ensure that all places of employment are kept in a sanitary condition. Frontline Residential Treatment Center, LLC DBA North Star Palmer Residential Treatment Center uses/used to clean high touched surfaces for the protection of employees and clients from the coronavirus was not used in accordance with the manufactures directions and its limitations. Through the course of this investigation, documentation showed, the product Spic and Span® Disinfecting All-Purpose Spray and Glass Cleaner - Concentrated was used during the approximate time from December 30, 2020 through January 25, 2021 as their main means of facility disinfectant for covid in a electrostatic aerosolizer. P&G Professional at 800-332-7787, Cecily, Customer Service. Cecily stated: "We do not recommend using our product in an electrostatic sprayer due to particle size. We do not know the range of particle so there could be some respiratory concerns."

Date by Which Violation Must Be Abated: **September 20, 2021**
Proposed Penalty: **$7900.00**

[redacted]
Chief of Enforcement, AKOSH

CONFIDENTIAL UHS-FINHELP-00010960

Alaska Department of Labor and Workforce Development
Occupational Safety and Health
[redacted]
Anchorage, AK [redacted]
Phone: [redacted] Fax: [redacted]
Email: [redacted]

NOTICE OF CORRECTION

Inspection Number: [redacted] Date Issued:08/24/2021

EMPLOYER: FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC

The "ALLEGED VIOLATIONS" and the abatement dates are listed on this form in the same manner as they were on the Citation. This form is designed to help you explain how the alleged violations were corrected. Failure to correct a violation by the required date carries a penalty of up to $7,000 for each day the violation is not abated.

In order to complete this form, **you must provide an explanation of the method used to abate the violation**, fill in the date the condition was corrected and sign/initial the appropriate block. **For those citations marked with a "Y" under the heading of "Documentation Required", you must attach documentation of the method used to correct the violation.** Such documentation can be in the form of photographs and/or diagrams; an appropriate narrative of how the violation was corrected; or a written order for a part, service, or action that resulted in the correction of the violation. Please identify by violation, the attached documentation submitted as proof of correction. If insufficient documentation is provided, a representative of the Department will contact you and it may result in a follow-up inspection to verify correction of the violation(s). This form (including documentation of abatement) needs to be completed and mailed or faxed to the above address within 10 days of the last abatement date listed.

Completion of this form does not preclude the department from conducting subsequent inspections to verify that abatement has taken place. However, by providing clear explanations of the steps taken to abate a violation and documentation that the violation has been abated, your chances of receiving a follow-up inspection are reduced. Your cooperation is appreciated.

Citation # / Item	Abatement Date	Documentation Required	Correction Date	Signature
1-1	September 20, 2021			
1-2	September 20, 2021			
1-3	September 20, 2021			

EXHIBIT A

You must sign off on each individual alleged violation and provide documentation of how each alleged violation was corrected.

I _____ hereby certify under penalty of perjury that the above cited violation(s) were abated by the date(s) specified.

Name _____ Signature _____ Date _____

EXHIBIT A

CONFIDENTIAL UHS-FINHELP-00010962

UHS-FINHELP-00010963 [Redacted]

Notice of Alleged Safety or Health Hazards

April 22, 2021 11:25 AM

Complaint Number	[redacted]		
Establishment Name / DBA	FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC DBA: North Star Palmer Residential Treatment Center		
Site Address	[redacted] PALMER, AK [redacted]		
	Site Phone [redacted]	Site FAX	
Mailing Address	[redacted] Anchorage, AK [redacted]		
Management Official	[redacted]	Phone	[redacted]
Type of Business	Residential Mental Health and Substance Abuse Facilities		
Ownership	Private Sector	Site Activity NAICS	623220 -Residential Mental Health and Substance Abuse Facilities

HAZARD DESCRIPTION/LOCATION. Describe briefly the hazard(s) which you believe exist. Include the approximate number of employees exposed to or threatened by each hazard. Specify the particular building or worksite where the alleged violation exists.

Employees are exposed to health hazards to include, but not limited to:
1.) Exposure to airborne chemicals
2.) Deficient Hazard Communication

UHS-FINHELP-00010975 [Redacted]

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health
DIVISION OF BEHAVIORAL HEALTH
Director's Office
[redacted]
Anchorage, Alaska 99503-5924
Main: [redacted]
Toll Free: 800.770.3930
Fax: [redacted]

November 14, 2022

North Star RTC Palmer – The Summit
[redacted]
PO Box 1587,
Palmer, AK 99645
Redacted - PII

Attention: Utilization Review

Re: Site Review

Dear: [redacted]

The site review team would like to take the opportunity to thank the staff at North Star RTC – The Summit for the hospitality, flexibility, and willingness to accommodate our requests while on site.

As you are aware, the Code of Federal Regulations (42 CFR 456.600-614) requires State Medicaid Agencies to conduct reviews of inpatient psychiatric facilities on an annual basis. This facility was reviewed 8/29/2022 to 9/02/2022 and conducted by State of Alaska Department of Health representatives from Behavioral Health.

Type of Review: Annual

Report: Enclosed is the Site Review Summary of Findings report dated 9/23/2022. This document is also available without Medicaid numbers. This non-confidential version is submitted to residential licensing and Utilization Review.

Plan of Improvement: Plan of Improvement (POI) may be required as a result due to deficit found during the site visit and review process. If a POI is requested, your facility is expected to respond in writing to Behavioral Health within 10 business days after the site review. None requested at this time.

Should any questions arise, please do not hesitate in contacting:

[redacted]

Sincerely,

[redacted] MS, MA, RHIA
DBH Medicaid Section Manager
DBH Tribal Liaison

CC: AK Residential Licensing
North Star

State of Alaska Department of Health and Social Services
Division of Behavioral Health
Site Review Summary of Findings

Provider: North Star RTC Palmer
Provider ID: [redacted]

Start Date of Review: 8/29/2022
End Date of Review: 9/1/2022

Lead Reviewer: [redacted] RN BSN

Other Reviewers:
[redacted] LMFT
[redacted] Medicaid Program Specialist IV, Lead for Autism, PRTF & CBC
[redacted] RN BSN
[redacted] M.Ed.
[redacted] MPA
[redacted] Medicaid Program Specialist III

Date of Report: 9/23/2022

Number of Charts Reviewed: 18

ORGANIZATIONAL DESCRIPTION AND HISTORY

The "North Star Palmer RTC - Summit Program" is part of a larger company under the name of "Frontline."

Frontline operates under the parent company of Universal Health Services, Inc. and is part of the North Star Behavioral Health system. When considering this information, it is important to distinguish the different programs "Frontline" provides to Alaskans, which programs are enrolled in Alaska Medicaid, and the oversight agencies involved.

There are three types of services Frontline offers: acute psychiatric care, residential psychiatric treatment, and 1115 SUD & BH services. Within the scope of those services, there are six (6) Alaska Medicaid enrolled locations for Frontline:

Frontline – Palmer RTC - Summit Program; (DBH oversight)
Frontline – Anchorage RTC -Alpine Academy; (DBH oversight)
Frontline – North Star Hospital (Health Care Services oversight)
Frontline – DeBarr RTC HPG (Health Care Services oversight)
Frontline – North Star Hospital HPG (Health Care Services oversight)
Frontline – Arctic Recovery (Health Care Services oversight)

This report pertains solely to the audit and review of the residential psychiatric treatment facility of Frontline North Star Palmer RTC - Summit Program.

The Summit Program in Palmer (North Star Behavioral Health) provides psychiatric residential

treatment for preteen and teen boys ages 11 to 18. It is a 30-bed facility in a rural setting surrounded by natural forest.
Wilderness experiences at different levels is included in treatment for all youth:
- Hiking trails, exploring, and engaging in activities outside is a common part of the program.
- Camping opportunities are offered in all seasons.
- The program teaches competencies in wildlife and water safety, shelter-building and survival skills, as well as other education to respect and enjoy the outdoors.
- Wilderness First Responders lead camping trips.

The program utilizes the analogies of climbing a mountain in its level system and progress in treatment. "Base camp," "Approach," "Treeline," "Ridgeline," and "Summit" promote goal achievement and advancement toward graduation.

While at the Summit, youth are expected to learn healthy social, recreational and life skills, which are needed to be successful in the community and at home. The Summit is truly the halfway point of a hike up a mountain, or journey to recovery within the program, with graduation point mimicking the ultimate mountain summit youth would want to achieve at the facility.

This program relies on the following Evidence-Based Practices:
-Cognitive-Behavioral Therapy
-Dialectical Behavioral Therapy
-Solution Focused therapy
-Biofeedback
-Sensory Integration
-Leisure Ability Model
-Adventure-Based Model
-SAMHSA TRECK
-Aggression Replacement Training (ART)
-Conflict Resolution
-Managing Emotions
-SELF
-Trauma-focused CBT
-Integrative Treatment for Complex Trauma (ITCT)
-Wilderness-Based emphasis

The program has two buildings. The larger building houses two units of ten (10) youth each ("Chugach" and "Talkeetna" wings). The other building houses a unit of ten (10) boys who are at higher levels and usually transitioning home ("Alaska House"). At the time of this visit, Alaska House was closed due to capacity related with staffing concerns post COVID-19. The three units are named after mountain ranges in Alaska.

The facility has a large amount of recreational equipment, field in the back yard, and a paved court in which to play and engage in therapeutic activities. There is a Reward room with guitars, piano, and drums. There are library books filling many of the cabinets in the Alaska House. Living areas are large and well-lit by natural light and surrounded by remarkable green scenery.

Education is provided by the Mat-Su School District in a separate school building. Youth who have progressed in treatment and are identified as benefitting from practicing their skills in the public-school setting attend area schools.

The program records include paper charts for all the residents.

SITE REVIEW PURPOSE AND PROCESS
Per 42 CFR 456.606 site reviews are required to be performed yearly.

FINDINGS
Plan of Care: ***42 CFR 441.155(b)(1); 42 CFR 441.155 b(2); 42 CFR 456.609;7 AAC 140.410 (a)(3); 42 CFR 441.155(b)(3); 42 CFR 441.155 (c)(2); 42 CFR 441.156; 7 AAC 140.405(b)(5); 7 AAC 140.410 (a)(4); 7 AAC 140.410 (a)(6)***

The plans for 18 recipients of the North Star RTC Palmer - Summit program - were reviewed. All initial plans of care were based on a diagnostic evaluation signed and dated within one (1) day of admittance by the assigned psychiatrist and nursing staff.

One (1) initial plan of care was missing the child's signature. One (1) initial plan of care was missing parent/guardian signature with no follow up documentation found.

All evaluations had corresponding treatment recommendations, which formulated the master plan of care. All master plans of care were developed within fourteen (14) days of admission.

Most master plans of care were signed by the psychiatrist, child, parent/guardian, nurse, licensed social worker, mental health clinician, activity therapist and school representative. However, five (5) out eighteen (18) were missing either parent/guardian or child or both signatures with no follow-up documentation.

All plans of care reviewed prescribed an integrated program of therapies and included individual, family, group therapy, activity therapy, medication management, medical care, milieu therapy, and dietary care. All plans of care included reasons for continued stay, status of continuing care and progress per each child's treatment goals and objectives.

All plans of care were reviewed every thirty (30) days except for two (2) out of eighteen (18). Two plan of care reviews were missing child signatures. Six (6) plan of care reviews were missing parent/guardian signatures. In each of the six (6) reviews it was documented the parent/guardian was not available to participate. Documentation could not be found to indicate the clinician followed-up with offering to review the plan of care with the parent/guardian at the next family session.

The requirement of parent/guardian participation in all plans of care and their required signature was addressed at length with leadership. Leadership expressed a willingness to ensure parent/guardian participation is consistently documented in the record. The deficiency is not enough to warrant a plan of improvement currently, however the Department of Behavioral Health expects to see improvement within the 6 months following this report consistent with their upcoming DocuSign process implementation.

The clinical record review demonstrated compliance with 42 CFR 441.155(b) (2); 42 CFR 441.155(b) 42 CFR 441.156; 42 CFR 456.609; 7AAC 140.405(b) 7AAC 140.410(a) (4); 7AAC140.410(a) (6) with the exception of the findings noted above.

Progress Notes: *42 CFR 456.610 (a); 42 CFR 456.610 (b)(1); 42 CFR 456.610 (c); 42 CFR 456.610 (d)*

Psychiatrist meets with residents assessing medication every seven (7) to fourteen (14) days. Psychiatric progress notes are descriptive of clinical progress, laboratory findings, medication management, medical necessity, and response to treatment.

Redacted - PII and Redacted - PII progress notes are in-depth. Documentation of clinical sessions were clearly detailed and reviewers were able to read the notes and track the sessions having awareness of how the session met the objectives which were intended for and the interventions utilized during the same encounter. Medication management is noted in these weekly sessions as well.

One (1) out of eighteen (18) resident charts was found to have inconsistent services in the immediate follow up of emergent care for accidental injury (broken nose, following up an accident playing sports with peers), indicating staffing concerns to address this event and remain at core staffing within the facility. The nursing team was diligent and provided enough evidence of the multiple attempts made to obtain a driver and provide care. Leadership is currently addressing this incident internally and due to the excellent quality of the nursing notes, DBH will not require an improvement plan at this time.

All members of the interdisciplinary team are involved and meet in person with treatment team sitting down with child and the guardians that generally intervene via phone. The Division of Behavioral Health's review team was able to witness the above with three (3) of the residents and treatment team being led by Redacted - PII

One (1) of these residents was in Office of Children Services (OCS) custody and residential program team found themselves unable to reach and track changes within case workers and Guardians Ad Litem (GAL).This was addressed with both OCS representatives and NS leadership during the out brief meeting.

Clinical notes reviewed included individual, family, and group sessions. All clinical notes aligned to problems, goals, objectives, and modalities identified in the plan of care. Non-clinical group progress notes consistently aligned to goals, objectives, and modalities in the plan of care. Clinical progress notes documented all the required elements of a progress note. Start and end time, date, mini mental status exam, type of therapy, goals and objectives addressed in session, recipient response, assessment of progress and the plan going forward.

Regarding signatures however two (2) out of eighteen (18) clinical progress notes despite of including clinician signature and credentials were late in over one (1) month on these same signatures.

Notes are signed by licensed mental health clinicians and co-signed by the clinical supervisor for the unlicensed clinicians.

Restraint and Seclusion: *42 CFR 483.350 through 42 CFR 483.376*

The facility utilizes brief physical holds (restraints) and seclusion to manage behavioral crises that rise to the level of potential for self-harm or harm others. This program has however limited use of restraints.

The review team identified in the "North Star Behavioral Health System Philosophy regarding Emergency Interventions" language pertaining to the guardian's notification to be out of compliance with the federal regulations. Leadership promptly updated the forms for all the network facilities, and it now reads that "North Star will contact the parent or legal guardian to notify him/her of the intervention."

Physical restraints and seclusions or any outside appointment needs to be reported as per the Behavioral Health Inpatient Psychiatric Review Provider Manual, section 13, Reporting Serious Occurrences and Events using an Incident Report sent. DBH continued on-site technical assistance with explanation of reporting requirements, necessary documentation, and notification process.

Leadership promptly provided "Handle with Care" training logs for the DBH reviewers to consult.

All of the above was supported during interviews by youth, staff and parent/guardians.

All clinical record review demonstrated compliance with 42 CFR 483.350 through 42 CFR 483.376 except for the findings noted above.

Youth Interview Findings: ***42 CFR 456.608(a)(1)***

YOUTH INTERVIEWS:

Prior to conducting these interviews, a schedule was constructed, allotting each resident up to thirty (30) minutes to respond to a list of seventeen (17) questions. [redacted] Assistant Administrator (Palmer) and [redacted] Site Manager (Palmer), facilitated these interviews, bringing students into a quiet area on the unit along with a secure laptop and webcam.

Nineteen (19) of twenty (20) residents from North Star Palmer – Summit Program - were interviewed via a secure Zoom connection. The twentieth (20th) student was scheduled, however, North Star Palmer staff needed to seek emergency medical care for this youth, and he was unavailable. Two (2) interviewed residents were discharged shortly after interview, thus the number discrepancy with charts reviewed. For training purposes, three of these interviews were conducted conjointly with this reviewer and [redacted] fellow clinician of the Division of Behavioral Health.

At the start of each interview, introductions were made, and a brief explanation was offered as to the purpose and expected duration of the interview. Youth were informed that there were no correct or incorrect responses, and that their responses were confidential, with the exception of any identified safety concerns due to mandatory reporting requirement.

Youth were asked to identify themselves by name, their admission date to North Star Palmer, whether or not they had been in inpatient care elsewhere and where their home community happened to be.
Students were asked "why they were in the facility (North Star Palmer)", and eighteen (18) youth were forthright about their treatment needs, with common responses being that they had anger issues, that they were suicidal, engaged in self-harm or that they had been defiant and disrespectful. One youth sought to not answer the interview question directly and responded he

was in treatment "for a whole bunch of reasons", but he would not provide any specifics.

One youth explained, "I guess my traumas got the best of me".

The next question was "what their treatment goals were", and all nineteen (19) residents verbalized their treatment expectations, ranging from better managing their anger/defiance responses to improved communication skills.
When asked "if they helped decide the goals on their treatment plan", twelve (12) out of the nineteen (19) students affirmed that they were part of the planning process. Seven (7) youth indicated that staff provided them with "objectives" (goals), to which they agreed.

Eighteen (18) out of nineteen (19) youth reported "making progress in their treatment" while one student replied, "nothing much", but did not elaborate on his statement.

> "I think I am making great progress because I am halfway to Summit (level). I have had good peer interactions. We may not like each other (peers), but at least we can sit down at the same table and play cards."

Seventeen (17) of nineteen (19) residents were able to discuss what they had learned in treatment while the remaining two (2) children were recent admits to North Star Palmer. Thirteen (13) of those students reported improved communication and better coping skills, while one youth reported that he "had learned nothing of importance yet".

"I communicate better when I am out on pass with my parents. When I am with them, we can have a positive time".

> "I have learned to keep calm and not let the little things bother me. I have learned to be kind and considerate".

> "I learned how much I don't need to be angry to communicate my needs and wants".

Seven (7) of nineteen (19) youth had favorable comments with regards to their peers. The remaining twelve (12) students had complaints about name calling, posturing and the formation of "cliques" on the unit. These concerns were shared with management during the out brief meeting.
When asked whether they "had the opportunity to talk with other members of their treatment team", fourteen (14) residents found staff to be responsive. The remaining five (5) students made comments about staff's availability.

Nine (9) of nineteen (19) youth had positive comments regarding floor staff, often describing them as "nice". Six (6) residents either complained about "staff getting mad" or "staff having favorites" (students). Another child complained about floor staff ignoring him after he tried to apologize for an incident on the unit. One child commented that he was new to the unit and had not established trust with staff, while another complained about staff 'talking bad about kids" on the unit. Once again all these comments and concerns were shared during the out brief meeting with North Star Palmer management staff. "They are nice; they help me when frustrated!"

Seventeen (17) of nineteen (19) residents were able to recite medications that were prescribed to them and their intended purposes. One child refused to answer this question, and another did not respond when asked, instead responding to another question. Two (2) youth indicated that they had planned to talk to medical staff to get med increases, and another boy commented he would

rather use his coping skills than having to take medications. All seventeen (17) students felt that medical staff was responsive to their input.

Eighteen (18) of nineteen (19) youth indicated that they communicated with their parent/guardian on a regular basis, whether it be through passes, phone calls, visits and Zoom calls. One child indicated he had no family members with which he communicated.

Four (4) youth reported either having an Office of Children's Services case manager or a probation officer through Department of Juvenile Justice. Amongst these four (4) children, there were no complaints with regard to the amount of contact they had with these staff.

None (0) of the nineteen (19) residents had ever been restrained or had been put in seclusion while at North Star Palmer.

Sixteen (16) out of nineteen (19) students were familiar with North Star Palmer's grievance process, while the remaining three youth were later reminded of the process or were uncertain about it. Seven (7) youth indicated that they had filed grievances and the remaining nine (9) had not. Of note, several comments were made about staff changes and the residents did not know who their designed student advocate happened to be. These concerns were shared with North Star Palmer staff during the out brief meeting.

Fifteen (15) out of the nineteen (19) residents reported that they had no safety concerns for themselves or others at North Star Palmer. One (1) child responded he was fearful of his response to peers that taunted him, a second (2) student was fearful of a peer "sitting on him" if there was a conflict, and a third (3rd) resident was concerned for another resident "pushing himself" beyond his abilities to fit in the milieu.

Suggestions made to the reviewer included "having better recreational equipment and more outings", "better food and snacks" as well as more time for family outings and less group time. A couple of children responded "having better funding" so there could be some painting while one resident noted that there were nails sticking out on some of the recreational equipment outside and that the wooden picnic tables could have pieces taken off them that could be used by residents to self-harm. These concerns and suggestions were also shared with North Star Palmer staff during the out brief meeting.

PARENT INTERVIEWS:

A sample of nineteen (19) parents/guardians were contacted in the two (2) weeks following DBH's physical visit. From these, ten (10) parents answered the phone and got interviewed, whereas the remaining nine (9) parents/guardians did not answer, nor returned calls with voicemails being left if allowed to do so.

QUESTION: Were you involved in formulation of your family member's treatment plan and discharge plans?
All parents reported their involvement in both treatment and discharge planning. Here some of the answers:
"Kind of, I think. We attend the treatment team meetings monthly," except for one (1) parent who reported no involvement in the creation of the treatment and discharge plans but expressed confidence in the facility and believes the youth is making progress: "I think [the facility] is doing a real good job. He sounds better and his attitude is better when we talk." The parent

explained her work schedule and rural location has made it difficult for her to participate in the client's treatment and monthly reviews.

QUESTION: Are you aware of the psychiatric medications your child is taking and/or being prescribed while in treatment?
Most parents reported that Palmer North Star kept them abreast of any psychiatric medications prescribed as well as any changes, although some parents sounded confused:
"He is on something, but I was not sent any information. Off label, milligrams, etc." Consent was not received from the mom. "He was not on medication when he went but he asked to be on medication."
Another parent reported not being notified of a new medication prescribed to the youth. She found out about the medication when the client shared receiving new medication to treat enuresis – something else that was not shared with her. The parent cited a lack of communication from the treatment team and described feeling "left in the dark" from the first therapist not responding to any of her emails. She described the lack of communication becoming more "discombobulated" following the transfer of the client to a new therapist approximately a month ago.
One other parent/guardian expressed their concern with their child being prescribed additional medications without their consent (Melatonin, Vitamin D and Psyllium Husk). Because these were considered "natural meds," this parent did not offer any objections at the time with the psychiatrist, but they did discuss the issue with their child's clinical therapist.

QUESTION: Have you been able to communicate with members of your family member's treatment team?
Most parents affirmed that they were able to communicate with members of their child's treatment team. Some said: "We talk almost daily and have discussions with my son; Family Therapy weekly as well."
Another parent reported not receiving notification of a cancelled family session due to the new therapist calling out sick: "I waited, and he never showed up. Someone should have told me."

QUESTION: Do you know your child's treatment diagnosis, and do you understand what it means?
Most parents reported that they knew their child's diagnosis and they understood what it meant.
Another stated: "I do not know either answer. I know why we wanted him to go. I do not know really his diagnosis; I know he has behaviors and impulse problems."
One parent noted that they often "check in" with their child and note that he is learning "all the right things to say" and really does not benefit from groups as he is only required to attend them at Palmer North Star.

QUESTION: Were you informed of the facility's policy on restraint and seclusion?
Most parent/guardians recalled receiving information on Palmer North Star's policy on restraints and seclusions and most reported that this information was presented in a manner that was easily understood.
"I probably did but the packet is big, and I cannot remember – there was so much."
One parent reported receiving notification the client was placed on AWOL status due to banging his head on the wall and threatening to run. She did not know if the client had been placed in seclusion. She was not aware of a debriefing occurring after the AWOL status incident.

QUESTION: Do you have any concerns around your child feeling or being placed in an uncomfortable situation, or concerns around his/hers safety at this facility?
All parent/guardians felt their children were safe, however here are some of the comments gathered:
"I did at first, but this has been alleviated. There is some violence between the young boys out there. They assured her this is normal stuff – addressed over and over with Redacted - PII The nurse has called when he has gotten hurt. There is good communication with staff;" "They (Palmer North Star) have done a wonderful job. Our child has been in placement for six (6) years. His therapist (Redacted - PII) is wonderful. They do not push us to bring him home. They have a regimented program."

STAFF INTERVIEWS:

Two (2) full-time employees, one (1) floor staff and the other a shift floor supervisor, were interviewed conjointly with [redacted] Division of Behavioral Health, via Zoom with the assistance of [redacted] Assistant Administrator at Palmer North Star.

At the start of each interview, introductions were made, and a brief explanation was offered as to the purpose of our interview. Initially, discussion with Palmer North Star staff centered on the use of restraints and seclusions, and both staff endorsed that the use of these interventions was a rare occurrence, happening as a last resort, only after other methods of de-escalation had been exhausted. These orders would by given under the direction of the floor shift nurse because the resident was either harming themselves or others on the unit. Staff discussed their initial training in the "Handle with Care" curriculum, training materials they were given as well as opportunities to practice possible scenarios and interventions with their co-workers after their initial orientation.

With regards to suggestions, the first employee talked about promised pay raises that had not occurred yet and being short staffed, requiring them to work additional hours to provide coverage. This staff stated that having the floor shift nurse present completes the required ratio for patient to staff members on the unit, and it would be beneficial to have an additional staff person on the unit designated to field incoming phone calls or to allow other staff to take their designated breaks. Additionally, the first employee mentioned wanting to see a reduction in redundant paperwork, the incorporation of an electronic health record that is "user friendly" and the need for additional laptops for staff.
The second employee also mentioned issues with being "short staffed" and its impact not only for the staff but also for the milieu. To illustrate this point, this staff not only fixed breakfast on Saturday mornings for the residents, but they were also responsible for facilitating programming on the unit at the same time. As a suggestion, this staff wanted to see relief staff come from Anchorage as they felt that Palmer staff often had to provide relief at the Anchorage North Star facility. This staff wanted to see the return of the card game, "Magic", to the unit as they had some ideas of how this popular game could be used for therapeutic benefit with adolescent boys. This staff agreed that there needed to be a reduction in redundant paperwork, that an electronic health record would be beneficial and there was a need for additional laptops on the unit for staff.

QUALITY OF CARE

Leadership at North Star Palmer (The Summit Program) has been through a number of changes within the last year including a new CEO. It is however apparent that the core staff of the facility demonstrates retention of great professionals with emphasis on quality nursing staff. This reflects on the curriculum and overall impression of The Summit Program.

During this visit DBH's team consistently experienced the full expression of this program witnessing residents interacting outdoors in organized and well-developed activities of their core program.

Despite the environmental risk that comes with the wilderness, youth is able to therapeutically benefit from the natural environment where is inserted, helping with the overcoming of their diagnostic struggles.

After reviewing all the records, the team notices a rise in significant high trauma complexity cases for which NS Palmer is admitting, which elevates the difficulty but shows that consistency and good professionals can safely address the complex cases emerging in Alaska.

Summary of Chart Review Findings

42 CFR 441.155(a) and 456.180

16 out of 18 chart(s) met this requirement.

CA0601164807	initial plan of care review missing parent/guardian signature/ involvement with no follow-up documentation on 8/22/22
PC0601121417	initial plan of care review missing child signature/ involvement with no follow-up documentation on 8/22/22

42 CFR 441.155(b)(1)

18 out of 18 chart(s) met this requirement.

42 CFR 441.155(b)(3)

18 out of 18 chart(s) met this requirement.

42 CFR 441.155(b)(2)

13 out of 18 chart(s) met this requirement.

AAC0601204234	one plan of care review missing parent/guardian involvement/signature with no follow-up documentation on 8/17/22
AT0601106925	one plan of care review missing parent/guardian signature/ involvement with no follow-up documentation on 7/20/22
HA0601168388	one plan of care review missing child's signature on 7/27/22
LJ0601157270	three plan of care reviews missing parent/guardian signature/involvement with no follow-up documentation 11/15/21, 02/01/22,03/01/22
SG0601402842	one plan of care review missing parent/guardian signature/involvement with no follow-up documentation on 6/7/22

42 CFR 441.155(b)(4)

16 out of 18 chart(s) met this requirement.

AAC0601204234	individual therapy note week of 5/8/22-5/14/22 not signed until 7/11/22
TE0601065831	individual therapy note week of 5/19/22-5/21/22 not signed until 7/6/22

42 CFR 441.155(b)(5) and 7 AAC 140.410(6)

18 out of 18 chart(s) met this requirement.

42 CFR 441.155(c)

16 out of 18 chart(s) met this requirement.

ET0601127742	One plan of care 30 day review missing child's signature on 8/16/22

SP0601151771	one plan of care review on 5/25/22 over 60 days late with MD (signature on 8/3/22) and LCSW (signature on 7/2/22).

42 CFR 441.156 and 7 AAC 140.405(d)

18 out of 18 chart(s) met this requirement.

42 CFR 456.609(a)(b)(c)(d)

18 out of 18 chart(s) met this requirement.

42 CFR 456.610(a)

18 out of 18 chart(s) met this requirement.

42 CFR 456.610(b)(1)

18 out of 18 chart(s) met this requirement.

42 CFR 456.610(c)

18 out of 18 chart(s) met this requirement.

42 CFR 456.610(d)

18 out of 18 chart(s) met this requirement.

42 CFR 456.610(e)

17 out of 18 chart(s) met this requirement.

TE0601065831	Delayed urgent care consultation for injury (6/1/22-6/7/22)

42 CFR 483.350 through 42 CFR 483.376

18 out of 18 chart(s) met this requirement.

It should be noted that the actions described in this report, or the plan of improvement, do not limit any administrative, civil, or criminal liability of the provider either for conduct which is the subject of this report, or the plan of improvement, or other instances of provider misconduct, or noncompliance with Behavioral Health or the Alaska Medicaid Program.

UHS-FINHELP-00011003 [Redacted]

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health
DIVISION OF BEHAVIORAL HEALTH
Director's Office
3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

November 25, 2022

North Star Debarr – Alpine Academy
[redacted]
Anchorage, AK [redacted]
Redacted - PII

Re: Site Review ADDENDUM

Dear: [redacted]

The site review team would like to take the opportunity to thank the staff at North Star RTC – The Alpine Academy for the hospitality, flexibility, and willingness to accommodate our requests while on site.

As you are aware, the Code of Federal Regulations (42 CFR 456.600-614) requires State Medicaid Agencies to conduct reviews of inpatient psychiatric facilities on an annual basis. This facility was reviewed ~~8/29/2022 to 9/02/2022~~ 8-8-2022 - 8-12-2022 and conducted by State of Alaska Department of Health representatives from Behavioral Health.

Type of Review: Annual

Report: Enclosed is the Site Review Summary of Findings report dated 9/23/2022. This document is also available without Medicaid numbers. This non-confidential version is submitted to residential licensing organization.

Plan of Improvement: Plan of Improvement (POI) may be required as a result of deficits found during the site visit and review process. If a POI is requested, your facility is expected to respond in writing to Behavioral Health within 10 business days after the site review. Please review POI as described in the attached report.

Should any questions arise, please do not hesitate in contacting:

[redacted]

Sincerely,

[redacted] MS, MA, RHIA
DBH Medicaid Section Manager
DBH Tribal Liaison

CC:
AK Residential Licensing
North Star Utilization Review Team

State of Alaska Department of Health and Social Services
Division of Behavioral Health
Site Review Summary of Findings

Provider: North Star Alpine Academy PRTF
Provider ID: [redacted]

Start Date of Review: 8/8/2022
End Date of Review: 8/11/2022

Lead Reviewer: [redacted] RN BSN

Other Reviewers:
[redacted] RN BSN
[redacted] Medicaid Program Specialist IV, Lead for Autism, PRTF & CBC
[redacted] M.Ed.
[redacted] Medicaid Program Specialist 3
[redacted] MPA

Date of Report: 10/13/2022

Number of Charts Reviewed: 11

ORGANIZATIONAL DESCRIPTION AND HISTORY

This report pertains solely to the audit and review of the residential treatment of the Frontline's Alpine Academy also known and referred in this report as North Start Alpine Academy.

Alpine Academy is part of a larger company under the name of "Frontline," which operates under the parent company of Universal Health Services, Inc.

When considering this information, it is important to distinguish the different programs Frontline provides to Alaskans, which programs are enrolled in Alaska Medicaid, and the oversight agencies involved.

There are three types of services Frontline offers: 1) acute psychiatric care, 2)residential treatment, and 3) 1115 SUD & BH services. Within the scope of those services, there are 6 Alaska Medicaid enrolled locations for Frontline:

Frontline – Palmer RTC Summit Program: Behavioral Health oversight
Frontline – Anchorage RTC Alpine Academy: Behavioral Health oversight
Frontline – North Star Hospital: Health Care Services oversight
Frontline – DeBarr RTC HPG: Health Care Services oversight
Frontline – North Star Hospital HPG: Health Care Services oversight
Frontline – Arctic Recovery: Health Care Services oversight

The Alpine Academy is 30-bed residential facility in Anchorage serving female youth between the ages of 11 to 17 years of age. According with the website: "The Alpine Academy is a trauma-focused intensive therapeutic, educational, psychiatric, recreational, and nursing treatment

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program with an emphasis on instilling hope and building futures. Holistic in nature, the program is attentive to needs of the whole self—the mind, body, and spirit—and, therefore provides a variety of services that enhance the mind, strengthen the body and empower the spirit. The Alpine Academy name imparts a vision of a boundless journey-an awe inspiring trek—into a vast mountainous terrain filled with magnificent beauty, encouraging challenges, inspiring transitions, and rewarding accomplishments. The mission of the Alpine Academy is to provide therapeutic, educational, and spiritual programming to help the youth and their family along a trek toward abundant healing, abounding growth, and fruitful transition."

The program consists of three units, one secure (level 6) and two semi-secure (level 5).

Alpine Academy has a considered secured level 6 unit and a level 5 unit considered semi-secure. Residents are assessed at admission to determine which level they will start on. Parental residents are assessed every 60 days, and OCS/State custody resident are assessed every 90 days determining need for continuation of treatment in the secure unit. Residents who no longer need this secure level will be transferred to a semi-secure unit when appropriate.

The treatment program focuses on developing internal cognitive and emotional development skills as well as behavioral self-management skills based on six resiliency building blocks (i.e., insight, initiative, creativity, interrelationships, morality, and independence) through evidence-base practices such as Cognitive Behavior Therapy, Eye Movement Desensitization and Reprocessing, Biofeedback, Rational Emotive Behavior Therapy, and Dialectical Therapy.

SITE REVIEW PURPOSE AND PROCESS

Per 42 CFR 456.606 site reviews are required to be performed yearly.

FINDINGS

Plan of Care: ***42 CFR 441.155(b)(1); 42 CFR 441.155 b(2); 42 CFR 456.609;7 AAC 140.410 (a)(3); 42 CFR 441.155(b)(3); 42 CFR 441.155 (c)(2); 42 CFR 441.156; 7 AAC 140.405(b)(5); 7 AAC 140.410 (a)(4); 7 AAC 140.410 (a)(6)***

The plans for eleven (11) recipients Alpine Academy were reviewed.

Of eleven initial plans of care (POC), all were based on a diagnostic evaluation. Two (2) were missing signatures from parents/guardians; one (1) POC had past due signatures from the psychiatrist and therapist; one (1) was missing in its entirety, and Alpine Academy staff could not find or provide this initial POC

Five (5) out of eleven (11) plans of care reviewed prescribed an integrated program of therapies and included individual, family and group therapies, medication management, medical and dietary care, reasons for continued stay, status of continuing care and progress per each child's treatment goals and objectives. The remaining six (6) out of eleven (11) POC had weeks of therapy notes missing in various forms (individual, group, family); many POC had signatures missing rendering the documentation incomplete.

One (1) discharge plan of care was particularly vague and did not specify guardianship's involvement.

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One (1) chart was missing psychiatrist signature in the Certification of Need as per CFR 441.152.

All plans of care were reviewed every thirty (30) days except for one (1) out of eleven (11). Four (4) plans of care were missing parent/guardian signatures. Documentation could not be found to indicate that the clinician followed-up although there were notes indicating this would be done at the next family session.

All evaluations had corresponding treatment recommendations which formulated the master plan of care. All master plans of care were developed within fourteen (14) days of admission.

Most master plans of care were signed by the psychiatrist, child, parent/guardian, nurse, licensed social worker, mental health clinician, activity therapist and school representative. However, two (2) out eleven (11) were missing therapist signatures with no follow-up documentation. Templates, with possible copy/paste, showed inaccurate dates and signatures.

The requirement of accuracy and proper follow up with signatures in all plans of care was addressed at length with leadership prior to leaving Alpine Academy. This signature deficiency warrants a plan of improvement (POI) described in the POI section of this report.

The clinical record review demonstrated compliance with 42 CFR 441.155(b) (2); 42 CFR 441.155(b) 42 CFR 441.156; 42 CFR 456.609; 7AAC 140.405(b) 7AAC 140.410(a) (4); 7AAC140.410(a) (6) with the exception of the findings noted above.

Progress Notes: ***42 CFR 456.610 (a); 42 CFR 456.610 (b)(1); 42 CFR 456.610 (c); 42 CFR 456.610 (d)***

Medical staff reviewed prescribed medication at least every seven (7) to ten (10) days, reflected on medications that had been previously tried and provided rationale for medication changes. The progress notes from Redacted - PII and Redacted - PII were comprehensive, integrative, and demonstrated collaboration of the child's active treatment.

Nursing staff assessed the residents upon admission and completed weekly summaries. Nursing staff also documented behavioral and medical issues on a regular basis.

The Alpine Academy utilizes a charting system with paper documentation. The adoption of the checkbox forms in the Nursing Admission History seems to aid workflow, but appeared to take away from the individuality and uniqueness of these notes.

Complaints have been previously presented and brought to the forefront of this review, from Comagine (formerly known as Qualis Health) and their lead coordinators, citing the Utilization Management (UM) submissions, where most of the information extracted from progress notes and provided by the Alpine Academy, lacked sense, and appeared contradictory. The review team addressed this with leadership. [redacted] and [redacted] agreed to put in practice a training plan with Comagine for the staff responsible for these UM submissions to attend to meet the standard of "utilization review," as per the Provider Manual: Alaska Medicaid Behavioral Health Inpatient Psychiatric Review.

Progress notes seldom detailed a clear picture with correct dates and reasons for the level transition in between units, the designated level 6 or level 5.

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The review team encountered an increased number of missed parental signatures and dates on treatment plans and other important documentation. Due to this issue, Alpine Academy implemented DocuSign across disciplines. Intake has fully implemented DocuSign with consent and school enrollment forms. Per leadership DocuSign will be implemented for treatment plans for parents, doctors, and therapists. At this time DBH will request a Plan of Improvement (POI), that demonstrates the DocuSign implementation throughout the 6-month following this report.

The review team encouraged leadership to transition from paper charts to an Electronic Health Record (EHR) to improve CFR and State regulation requirement on all clinical documentation.

42CFR 456.610 (d) random audits of Q15 minute locator checks, for safe supervision of residents, compared therapy notes to locator indicators revealing missing Q15min checks and missing staff's initials conducting these checks in four (4) out eleven (11) charts in association with inaccurate, and contradictory information.

Family therapy and individual therapy notes often do not correlate with the aforementioned Q15 minute locator forms. For example: on 08/05/22 individual therapy notes show resident in therapy from 10:00 AM-to 11:00 AM whereas the Q15min locator form showed the resident in they dayroom; again, on 08/06/22, family therapy notes from 1PM-2PM show youth in therapy and but the Q15 minute indicator shows the youth at the gym.

Except for the findings noted above, all clinical record reviews demonstrated compliance with 42 CFR 483.350 through 42 CFR 483.376.

Restraint and Seclusion: ***42 CFR 483.350 through 42 CFR 483.376***

At Alpine Academy, if the patient is at imminent risk to harm self or others, seclusion or restraint may be necessary. Seclusion or restraint use is limited to emergencies in which the risk of harm is so serious that the non-physical intervention would be ineffective or not viable.

Violent behavior at the Alpine Academy that would require seclusion to prevent injury to self or others may result in a transfer to acute care, which happened in one of the cases reviewed by the team.

The Alpine Academy utilizes "Handle with Care" as their crisis intervention system when in need for brief physical holds (restraints) to manage behavioral crises that pose a threat to harm to themselves and/or others.

At the time of this visit and after review of training records, The Alpine Academy was found to have two (2) staff out-of-compliance for "Handle with Care" training. This issue was discussed with leadership which promptly pulled the mentioned staff off the work schedule until further training occurred. All staff is currently trained, and certifications are in place.

The facility has limited use of brief physical holds.

The clinical team reviewed all restraint events including one (1) youth that had discharged prior to the visit and found these to be compliant with Center for Medicare & Medicaid Services (CMS) regulations.

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There was no indication during the review that restraints are inappropriately used. These interventions had a physician's order, were time limited and discontinued as early as possible. The residents were continuously assessed and assisted during the intervention and in-person monitoring took place.

The incident reports pertaining to the above-mentioned restraints were reviewed prior to the site visit, and during the review, and with North Start's Chief Executive Officer, [redacted] who provided evidence of proper follow up with the residents at the time of these incidents.

Except for the findings noted above, all clinical record reviews demonstrated compliance with 42 CFR 483.350 through 42 CFR 483.376.

Youth Interview Findings: ***42 CFR 456.608(a)(1)***

YOUTH INTERVIEWS

Eleven (11) residents from Alpine Academy were interviewed via a secure Zoom connection. Prior to conducting these interviews, a schedule was constructed, allotting each girl up to thirty (30) minutes to respond to a list of seventeen (17) questions [redacted] Compliance Director for Alpine Academy facilitated these interviews, bringing students into a quiet area on the unit along with a Webcam equipped laptop.

At the start of each interview, introductions were made, and a brief explanation was offered as to the purpose and expected duration of the interview. Youth were informed that there were no correct or incorrect responses, and that their responses were confidential with the exception of any identified safety concerns due to mandatory reporting requirement.

Youth were asked to identify themselves by name, their admission date to the Alpine Academy, whether or not they had been in inpatient care elsewhere and where their home community happened to be.

Students were asked "why they were in the facility (Alpine Academy)", and all eleven (11) youth were forthright about their treatment needs, with common responses such as "I was suicidal" or "family problems".

The next question was "what their treatment goals were", and ten (10) out of eleven (11) residents verbalized their treatment expectations, ranging from learning coping skills to repairing relationships with family members.

When asked "if they helped decide the goals on their treatment plan", nine (9) out of eleven (11) students affirmed that they were part of the planning process.

Eleven (11) youth reported making progress in their treatment" though one student felt that she was now "flat-lining", as the treatment curriculum was "beginning to be repetitive". Another student commented on her newly learned skills.

> "I have gotten further than I have expected, and I have only been here two months."
>
> "I stopped doing behaviors that were no longer healthy…I am moving forward."

> "Just because you make a mistake, move forward…there are a lot of hiccups in life."

Eleven (11) residents were able to discuss what they had learned in treatment. One (1) student suggested that the curriculum itself should be different for a "seventeen-year-old versus an eleven-year-old".

Nine (9) youth had favorable comments with regards to their peers. Of note, complaints were about gossiping, "drama", fat shaming, arguments, and boundary issues amongst the residents on the unit.

> "I get along with them, but we are on different paths…its not like I am going to be in their weddings or anything like that."

In the out brief meeting with Alpine Academy staff, all of the above-mentioned concerns were shared.

When asked whether they "had the opportunity to talk with other members of their treatment team", nine (9) residents responded that they could.

> "Lately they have been busy, and I have to cope with things. I realize that it's not always about me."

> "Their responsiveness depends…things get put off, but eventually they get around to it."

In the out brief meeting with North Star staff, these concerns were shared.

Eleven (11) residents had positive comments regarding floor staff…" you can talk to them one on one". One (1) student stated, "staff come and go, there's a lot of turnover" while another made remarks about staff shortages at Alpine Academy…" sometimes I get angry when there is one (1) staff on the unit and there's supposed to be two (2)", referring to the staff ratio.
Two (2) youth reported a male staff who frequently talks about religion while on the unit, which made them uncomfortable. These comments and concerns were shared during the out brief meeting with North Star Alpine Academy staff.
Eleven (11) residents were able to recite medications that were prescribed to them and their intended purposes. Amongst this group, almost all of them reported that they were able to discuss their concerns with the doctor as well as with nursing staff. One (1) student complained that her diagnosis was supposed to be changed and it has remained unchanged despite the doctor agreeing to do so earlier.
Nine (9) youth indicated that they communicated with their parent/guardian on a regular basis. Two (2) residents reported some difficulty connecting with their supports because either they did not pick up the phone when they called or come by for visitation. These students reported having feelings of homesickness and these concerns were addressed with North Star staff during the out brief meeting.
Two (2) youth reported having an Office of Children's Services case manager. One (1) youth provided further detail stating that there was weekly contact, while the other youth declined to discuss this matter further when questioned.

None (0) of the interviewed residents had ever been restrained or put in seclusion while at

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Alpine Academy. When explored further, one youth described an incident on the unit months earlier she self-described as a "riot", after a fire alarm had been pulled on a couple of occasions. She detailed other youth being given emergency meds and herself being in her room for three (3) hours while staff managed the incident.
This was discussed with North Star staff at the out brief meeting and DBH comparatively reviewed incident reports, chart notes and medication records to further explore these incidents. At present though, there are no immediate safety concerns as this is within DBH's role as an oversight agency.

Ten (10) out of eleven (11) students were familiar with North Star Alpine Academy's grievance process; one (1) youth claimed to not be familiar with this process. Ten (10) youth had filed grievances on "having things (privileges) taken away" or program rule changes, such as their clothing allowance on the unit, being able to have makeup and being able to crochet. Some of these grievances were directly related to the "riots" mentioned above.

> "The CEOs are not flexible. They don't come in on the unit and instead watch us from the
> staff area. They talk to admin but not to us."

All eleven (11) residents reported that they had no safety concerns at North Star's Alpine Academy. When asked for complaints/suggestions, an often-heard reply was that there was a lack of communication amongst staff…"one person will say one thing (about the rules), while another person will say something else". Another topic was the belief that girls "coming directly from (the) acute (unit)" destabilizing the milieu on Redwood, "that they had not earned the privileges" of others on the unit. One (1) youth wanted staff to consider age differences amongst the residents on the unit when assigning roommates, while two (2) residents verbalizing wanting "Janet U.", a former clinician at Alpine Academy, come back to the unit.

PARENT INTERVIEWS

A sample of nine (9) parents/guardians were contacted in the two (2) weeks following DBH's physical visit. From these, seven (7) parents answered the phone and were interviewed, whereas the remainder did not answer, nor returned calls with voicemails being left if allowed to do so. Given the severity of the concerns of one (1) of the parents/guardians, DBH followed up with a separate interview and treatment team participation request denied by North Star.

QUESTION: Were you involved in formulation of your family member's treatment plan and discharge plans?

All parents reported they were involved at some point in the formulation or at least informed monthly of any updates to the treatment plans. One (1) parent indicated that they were involved in the beginning. Another parent stated: "Some of it, most of it was done by the doctor and counselors, they notify every month." One (1) parent/guardian initially commented "What is a discharge plan?", once clarification was provided, they affirmed that a discharge plan had been initiated during their intake.

QUESTION: Are you aware of the psychiatric medications your child is taking and/or being prescribed while in treatment?

All parents reported they were aware of the medications prescribed to their children. One (1)

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parent indicated he did not agree with all the medications prescribed. All the interviewed parent/guardians reported that North Star Alpine Academy kept them abreast of any psychiatric medications prescribed as well as any changes.

QUESTION: Have you been able to communicate with members of your family member's treatment team?

One (1) parent stated, "Yes, sometimes it takes a little longer than I'd like. They've got a lot going on at the facility because of the shortage of staffing." Two (2) parents indicated "yes and no". One of these two (2) parents stated she is informed when the team meeting takes place and have contacted her for it, but she is at work, and they do not provide her with the treatment plan updates; she does meet with the counselor weekly over the phone for Family Therapy. The other parent indicated she had requested to speak to the director, was told she was busy, and never received a call back. Other comments worth noting: "They are pretty good at keeping us informed via phone calls and email".
One (1) parent expressed difficulty contacting their child at times:

> "I know they're short-staffed, but there have been times the phone has rang for twenty (20) minutes…"

QUESTION: Do you know your child's treatment diagnosis, and do you understand what it means?

One (1) parent stated she did not know if they added more diagnoses since her child has been at the facility. Another parent stated, "Yes and no. It isn't my child's first time there and each time there's a different diagnosis and it changes." Another parent stated, "I do not know if all the diagnoses is being handled; it doesn't feel like there's any follow through and consistency." Other said: "And I've done my fair share of research of her dx and understand."
Other comments:

"I have been shut down many times by the counselors, except for one (Redacted - PII) who nailed her down her behavior (consequences matched with her actions). Brought in contraband, stole staff member's ID and went through staff's drawer. They are the professionals and should be able to identify her behaviors and know how to fix it. Youth stated it does not matter whether they transfer her to a reduced security facility or not because she can break out of Alpine Academy at any time. She stole a phone and facility stated they will investigate and return, but never returned. You asked to speak to the director, but never got a call back."

QUESTION: Were you informed of the facility's policy on restraint and seclusion?

One (1) parent indicated she was not given information regarding their policy. Another parent indicated she was given the information and understood it. Another parent did not think the information was provided or could not remember. "I don't recall, it's probably there. It was a mess when she got there." One (1) parent/guardian added "I am sure they had gone over it, but conflicting information has been given".

QUESTION: Do you have any concerns around your child feeling or being placed in an uncomfortable situation, or concerns around his/hers safety at this facility?

Two (2) parents indicated they did not have any concerns regarding the safety of their children

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in the facility. Another parent had a concern about the security of the facility since contraband items were able to be sneaked into the facility.
One (1) parent/guardian complained about her child having access to hand sanitizer (which she could drink, and allegedly other peers had), but not have shampoo. This parent also complained about her daughter's art supplies were stolen and never replaced. Additionally, this parent/guardian complained about purchasing a home COVID test, only to find out that she needed to have this done at a hospital (so she could visit her child) despite being instructed to just provide a negative test result. The other parent/guardian complained about staffing shortages at Alpine Academy, sharing that this was also a concern of her daughter.

Additional Comments:

One (1) parent indicated a concern over lack of recreation and indoor activities and her child is bored. The parent stated, "They used to play games, puzzles and crochet; the only watch tv every day and watch the same movie." Parent understands if activities are taken away as punishment, but how long are they penalized and will the activities be brought back.
One (1) parent stated she was "Concerned about staffing shortages."; "It would be nice if the counselors were consistent, she's had four (4) counselor changes since she's been at Alpine." Parent asked the current counselor if he/she had read her child's entire file, the counselor stated that he/she had not; concerned that the counselor had not read the file to know what was going on with her child. Parent also stated that it was ridiculous that they only had one (1) phone for all the kids to use at night to call family considering how much they charge for the child to be in the facility.

Several stated there is not a lot of consistency due to staffing issues and they were not satisfied with the service. One (1) parent claims the facility is pushing to discharge her child, but they had not addressed one of the main issues she was admitted for. Parent also feels that proper documentation was not done in the case of her child's file to document communication efforts.

One (1) parent/guardian states their child went in with issues of being abused, no documentation of her experience and it has not been addressed. Last counselor ([Redacted - PII]) finally documented that in her chart and that it had not been addressed. This is one of the main issues that should be addressed while she was in the treatment center, but it kept getting deferred in therapy. Resident's counselors keep changing; resident expressed her frustration to her dad because she has to repeat herself, be reintroduced and adjust to the new counselor's philosophy and have to rebuild the trust and rapport with a new counselor. "There is a stigma with Natives, and this little Native girl is just going to get pushed through the system. He asked her if she had dealt with some of her core issues; she panicked with fear in her eyes and was speechless. Not fair to her or parents that her core issues have not been addressed or dealt with. There should have been documentation that these issues were addressed, and the coping skills taught to her. Facility wants to discharge her, but she's still dealing with an unhealthy mindset and no coping skills. I do not want to discredit the facility. They have done some good things and made some headway. I have heard of people who have left the program and have done great, but I feel in this case there has been inconsistencies in the care and treatment she is receiving."

STAFF INTERVIEWS

Two (2) full-time employees, one (1) floor staff and the other (1) a registered nurse, were interviewed via Zoom with the assistance of [redacted] the Compliance Director at North Star Alpine Academy.

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At the start of each interview, introductions were made, and a brief explanation was offered as to the purpose of our interview. Both staff were able to confirm that restraints and seclusions are used as the last resort when verbal de-escalation techniques and providing the resident with space are unsuccessful. Restraints and seclusions are only warranted when either the youth is harming themselves or is attempting to hurt others on the unit. Both staff talked about how their responses to such situations are also dictated by what is written on their individualized treatment plans by the therapist. One (1) staff added, "it's pretty kid specific" as there may be interventions tailored to the youth.

With regards to suggestions, the first employee talked about the need for pay increases in the hopes to retain staff as there had been a lot of turnover. As a comparison, this employee claimed that other providers in the community paid more than Alpine Academy currently does and this would alleviate some of the stress that co-workers experienced. Additionally, the suggestion was made as to the need for greater communication between staff via email and faster internet connection speed at the facility.

The second employee thought that having nursing staff and the floor staff on the same twelve-hour shifts would greatly improve communication across shifts. This staff pointed out that while nursing staff works twelve-hour shifts, floor staff works eight-hour shifts and there is often information lost between different schedules. Additionally, this employee talked about the need to go to an electronic records system as opposed to paper charts, along with the difficulties in administering emergency meds on the unit, if needed immediately. Another area for improvement would be better staff to patient ratios on the unit, as this was an area of ethical and professional concern…" I want to write good quality notes and pass meds" (in addition to other responsibilities). Finally, this employee talked about changes within the organization that bring with "inconsistency for the staff as well as the kids" (patients).

QUALITY OF CARE

During site visit and in the follow up contacts with leadership after interviews were conducted, the Division of Behavioral Health staff expressed concerns regarding safe supervision of the children during their treatment stay.

All documentation requires immediate attention for improvement. Quality assurance is needed to assess accuracy of notes and guarantee signatures are in place to fully qualify for Medicaid payment.

Quality Management is required to provide DBH with reports conducted quarterly that assess for missing signatures. DBH request these reports to be shared with the division to ensure quality assurance on medical records.

COMAGINE TRAINING: DBH recommends all staff involved in Utilization Reviews to receive and obtain comprehensive training and technical assistance with Comagine. Utilization Review input is to be evaluated by North Star Quality Management quarterly and these reports to be shared with DBH.

Based on the Q15 minute locators, incongruences with locations, and staff, parent and children's complaints about safety, DBH recommends that Alpine Academy to hire additional staff to ensure services are being rendered safety and with quality of care. It is of the utmost importance that North Star recruit and retain qualified staff in order to improve clinician to client ratios, as well as the mental health specialist to client ratios.

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DBH recommends that an internal review be done with North Star Corporate due to the local operation concerns of professional liability. When complete, DBH requests this report to be shared with DBH.

PLAN OF IMPROVEMENT (POI)
Provide a POI that addresses how you will correct the following deficiency/s:

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(a) and 42 CFR 456.180
Findings: Missing and /or late signatures from parents/guardians, and psychiatrists, in the Plans of Care.

POI: Alpine Academy - Quality Management is required to provide DBH with internal audit reports conducted monthly* from the receipt of this request that assess for missing signatures on Plans of Care;

POI: as discussed with leadership, please demonstrate the DocuSign implementation throughout the 6-month following this report.

*11/23/2022 addendum changed to monthly due dates of: December 30, 2022, January 31, 2023, February 28, 2023.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(b)(4)
Findings:
a) resident's records were missing and showed inaccurate Q15 min checks

b) Multiple records were missing weeks of therapy notes or inaccurate documentation

POI:
a) Provide a monthly (11/23/2022 addendum due: December 2022, January 2023, February 2023) plan that identifies how your organization will ensure Alpine Academy's Q15min checks are accurately completed and documented.

b) Provide DBH with monthly* internal audit reports conducted that assess for completion and accuracy of Alpine Academy's therapy notes.

*11/23/2022 addendum changed to monthly due dates of: December 30, 2022, January 31, 2023, February 28, 2023.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(c)
Findings:
30-day-review of the POC was missing multiple treatment team member signatures and/or showed inaccurate documentation

POI: Provide DBH with internal audit reports conducted monthly* that assess for missing

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signatures.

*11/23/2022 addendum changed to monthly due dates of: December 30, 2022, January 31, 2023, February 28, 2023.

Submit POI by:

Mail To:
State of Alaska
Department of Health and Social Services
Division of Behavioral Health
Attn: [redacted] RN BSN
[redacted]
Anchorage, AK [redacted]

Or
E- Mail To: [redacted]
Or
Fax POI To: [redacted] RN BSN

Summary of Chart Review Findings

42 CFR 441.155(a) and 456.180

7 out of 11 chart(s) met this requirement.

0601164168 KIBA	initial plan of care review missing on 03/25/22 with no follow-up documentation found
0601068949 MATI	initial plan of care review (09/23/21) signatures for psychiatrist (10/19/21) and therapist (10/12/21) past due by multiple days
0601109599 BRBR	missing parent/guardian signatures on initial treatment plan;
0601314134 DAJU	missing parent/guardian signatures on initial treatment plan;

42 CFR 441.155(b)(1)

11 out of 11 chart(s) met this requirement.

42 CFR 441.155(b)(3)

11 out of 11 chart(s) met this requirement.

42 CFR 441.155(b)(2)

11 out of 11 chart(s) met this requirement.

42 CFR 441.155(b)(4)

4 out of 11 chart(s) met this requirement.

0601164168 KIBA	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures; inaccurate Q15min locators contradicting these notes
0601080343 ISHA	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures
0601068949 MATI	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures; inaccurate Q15 missing youth's whereabouts on 06/07/22.
0601109599 BRBR	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures
0601222919 ABJO	inaccurate Q15min locators contradicting therapy notes (examples:08/05/22 & 08/06/22)
0601095426 GRNA	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures, with inaccurate Q15min locators contradicting these notes (07/05/22)
0601314134 DAJU	missing weeks of therapy notes (individual, group, family)

42 CFR 441.155(b)(5) and 7 AAC 140.410(6)

10 out of 11 chart(s) met this requirement.

0601250346 KAMO	Discharge Plan language vague - OCS involvement not clearly

	noted

42 CFR 441.155(c)

6 out of 11 chart(s) met this requirement.

0601068949 MATI	one plan of care 30 day review missing therapist signature on 06/02/22
0601150629 HECH	CFR 441.152 Certification of Need missing signature by psychiatrist
0601109599 BRBR	6/9/2022 signature sheet date/time review note not updated - possibly a copy paste; 07/07/2022 parent not available, reviewed at FT but no date specified.
0601095426 GRNA	one plan of care 30 day review missing parent/guardian signature on 12/23/21; Several missing signatures on plan of care for 03/17/22 and 09/30/21
2006912333 DEPELE	one plan of care 30-day review missing for 05/26/22

42 CFR 441.156 and 7 AAC 140.405(d)

11 out of 11 chart(s) met this requirement.

42 CFR 456.609(a)(b)(c)(d)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(a)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(b)(1)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(c)

9 out of 11 chart(s) met this requirement.

2004260101 GILIBO	MAR missing signatures for Trazadone on 07/10/22
0601109599 BRBR	MAR missing signatures for Concerta + Effexor on 07/29/22; Missing dietitian assessment documentation

42 CFR 456.610(d)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(e)

11 out of 11 chart(s) met this requirement.

42 CFR 483.350 through 42 CFR 483.376

11 out of 11 chart(s) met this requirement.

It should be noted that the actions described in this report, or the plan of improvement, do not limit any administrative,

civil, or criminal liability of the provider either for conduct which is the subject of this report, or the plan of improvement, or other instances of provider misconduct, or noncompliance with Behavioral Health or the Alaska Medicaid Program.

UHS-FINHELP-00011037 [Redacted]

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health
DIVISION OF BEHAVIORAL HEALTH
Director's Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

November 25, 2022

North Star Debarr – Alpine Academy
[redacted]
Anchorage, AK [redacted]
Redacted - PII

Re: Site Review ADDENDUM

Dear: Ann Marie Lynch,

The site review team would like to take the opportunity to thank the staff at North Star RTC – The Alpine Academy for the hospitality, flexibility, and willingness to accommodate our requests while on site.

As you are aware, the Code of Federal Regulations (42 CFR 456.600-614) requires State Medicaid Agencies to conduct reviews of inpatient psychiatric facilities on an annual basis. This facility was reviewed ~~8/29/2022 to 9/02/2022~~ 8-8-2022 - 8-12-2022 and conducted by State of Alaska Department of Health representatives from Behavioral Health.

Type of Review: Annual

Report: Enclosed is the Site Review Summary of Findings report dated 9/23/2022. This document is also available without Medicaid numbers. This non-confidential version is submitted to residential licensing organization.

Plan of Improvement: Plan of Improvement (POI) may be required as a result of deficits found during the site visit and review process. If a POI is requested, your facility is expected to respond in writing to Behavioral Health within 10 business days after the site review. Please review POI as described in the attached report.

Should any questions arise, please do not hesitate in contacting:

[redacted]

Sincerely,

[redacted] MS, MA, RHIA
DBH Medicaid Section Manager
DBH Tribal Liaison

CC:
AK Residential Licensing
North Star Utilization Review Team

State of Alaska Department of Health and Social Services
Division of Behavioral Health
Site Review Summary of Findings

Provider: North Star Alpine Academy PRTF
Provider ID: [redacted]

Start Date of Review: 8/8/2022
End Date of Review: 8/11/2022

Lead Reviewer: [redacted] RN BSN

Other Reviewers:
[redacted], RN BSN
[redacted] Medicaid Program Specialist IV, Lead for Autism, PRTF & CBC
[redacted] M.Ed.
[redacted] Medicaid Program Specialist 3
[redacted] MPA

Date of Report: 10/13/2022

Number of Charts Reviewed: 11

ORGANIZATIONAL DESCRIPTION AND HISTORY

This report pertains solely to the audit and review of the residential treatment of the Frontline's Alpine Academy also known and referred in this report as North Start Alpine Academy.

Alpine Academy is part of a larger company under the name of "Frontline," which operates under the parent company of Universal Health Services, Inc.

When considering this information, it is important to distinguish the different programs Frontline provides to Alaskans, which programs are enrolled in Alaska Medicaid, and the oversight agencies involved.

There are three types of services Frontline offers: 1) acute psychiatric care, 2)residential treatment, and 3) 1115 SUD & BH services. Within the scope of those services, there are 6 Alaska Medicaid enrolled locations for Frontline:

Frontline – Palmer RTC Summit Program: Behavioral Health oversight
Frontline – Anchorage RTC Alpine Academy: Behavioral Health oversight
Frontline – North Star Hospital: Health Care Services oversight
Frontline – DeBarr RTC HPG: Health Care Services oversight
Frontline – North Star Hospital HPG: Health Care Services oversight
Frontline – Arctic Recovery: Health Care Services oversight

The Alpine Academy is 30-bed residential facility in Anchorage serving female youth between the ages of 11 to 17 years of age. According with the website: "The Alpine Academy is a trauma-focused intensive therapeutic, educational, psychiatric, recreational, and nursing treatment

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program with an emphasis on instilling hope and building futures. Holistic in nature, the program is attentive to needs of the whole self—the mind, body, and spirit—and, therefore provides a variety of services that enhance the mind, strengthen the body and empower the spirit. The Alpine Academy name imparts a vision of a boundless journey-an awe inspiring trek—into a vast mountainous terrain filled with magnificent beauty, encouraging challenges, inspiring transitions, and rewarding accomplishments. The mission of the Alpine Academy is to provide therapeutic, educational, and spiritual programming to help the youth and their family along a trek toward abundant healing, abounding growth, and fruitful transition."

The program consists of three units, one secure (level 6) and two semi-secure (level 5).

Alpine Academy has a considered secured level 6 unit and a level 5 unit considered semi-secure. Residents are assessed at admission to determine which level they will start on. Parental residents are assessed every 60 days, and OCS/State custody resident are assessed every 90 days determining need for continuation of treatment in the secure unit. Residents who no longer need this secure level will be transferred to a semi-secure unit when appropriate.

The treatment program focuses on developing internal cognitive and emotional development skills as well as behavioral self-management skills based on six resiliency building blocks (i.e., insight, initiative, creativity, interrelationships, morality, and independence) through evidence-base practices such as Cognitive Behavior Therapy, Eye Movement Desensitization and Reprocessing, Biofeedback, Rational Emotive Behavior Therapy, and Dialectical Therapy.

SITE REVIEW PURPOSE AND PROCESS

Per 42 CFR 456.606 site reviews are required to be performed yearly.

FINDINGS

Plan of Care: ***42 CFR 441.155(b)(1); 42 CFR 441.155 b(2); 42 CFR 456.609;7 AAC 140.410 (a)(3); 42 CFR 441.155(b)(3); 42 CFR 441.155 (c)(2); 42 CFR 441.156; 7 AAC 140.405(b)(5); 7 AAC 140.410 (a)(4); 7 AAC 140.410 (a)(6)***

The plans for eleven (11) recipients Alpine Academy were reviewed.

Of eleven initial plans of care (POC), all were based on a diagnostic evaluation. Two (2) were missing signatures from parents/guardians; one (1) POC had past due signatures from the psychiatrist and therapist; one (1) was missing in its entirety, and Alpine Academy staff could not find or provide this initial POC

Five (5) out of eleven (11) plans of care reviewed prescribed an integrated program of therapies and included individual, family and group therapies, medication management, medical and dietary care, reasons for continued stay, status of continuing care and progress per each child's treatment goals and objectives. The remaining six (6) out of eleven (11) POC had weeks of therapy notes missing in various forms (individual, group, family); many POC had signatures missing rendering the documentation incomplete.

One (1) discharge plan of care was particularly vague and did not specify guardianship's involvement.

One (1) chart was missing psychiatrist signature in the Certification of Need as per CFR 441.152.

All plans of care were reviewed every thirty (30) days except for one (1) out of eleven (11). Four (4) plans of care were missing parent/guardian signatures. Documentation could not be found to indicate that the clinician followed-up although there were notes indicating this would be done at the next family session.

All evaluations had corresponding treatment recommendations which formulated the master plan of care. All master plans of care were developed within fourteen (14) days of admission.

Most master plans of care were signed by the psychiatrist, child, parent/guardian, nurse, licensed social worker, mental health clinician, activity therapist and school representative. However, two (2) out eleven (11) were missing therapist signatures with no follow-up documentation. Templates, with possible copy/paste, showed inaccurate dates and signatures.

The requirement of accuracy and proper follow up with signatures in all plans of care was addressed at length with leadership prior to leaving Alpine Academy. This signature deficiency warrants a plan of improvement (POI) described in the POI section of this report.

The clinical record review demonstrated compliance with 42 CFR 441.155(b) (2); 42 CFR 441.155(b) 42 CFR 441.156; 42 CFR 456.609; 7AAC 140.405(b) 7AAC 140.410(a) (4); 7AAC140.410(a) (6) with the exception of the findings noted above.

Progress Notes: ***42 CFR 456.610 (a); 42 CFR 456.610 (b)(1); 42 CFR 456.610 (c); 42 CFR 456.610 (d)***

Medical staff reviewed prescribed medication at least every seven (7) to ten (10) days, reflected on medications that had been previously tried and provided rationale for medication changes. The progress notes from Redacted - PII and **Redacted - PII** were comprehensive, integrative, and demonstrated collaboration of the child's active treatment.

Nursing staff assessed the residents upon admission and completed weekly summaries. Nursing staff also documented behavioral and medical issues on a regular basis.

The Alpine Academy utilizes a charting system with paper documentation. The adoption of the checkbox forms in the Nursing Admission History seems to aid workflow, but appeared to take away from the individuality and uniqueness of these notes.

Complaints have been previously presented and brought to the forefront of this review, from Comagine (formerly known as Qualis Health) and their lead coordinators, citing the Utilization Management (UM) submissions, where most of the information extracted from progress notes and provided by the Alpine Academy, lacked sense, and appeared contradictory. The review team addressed this with leadership. [redacted] agreed to put in practice a training plan with Comagine for the staff responsible for these UM submissions to attend to meet the standard of "utilization review," as per the Provider Manual: Alaska Medicaid Behavioral Health Inpatient Psychiatric Review.

Progress notes seldom detailed a clear picture with correct dates and reasons for the level transition in between units, the designated level 6 or level 5.

The review team encountered an increased number of missed parental signatures and dates on treatment plans and other important documentation. Due to this issue, Alpine Academy implemented DocuSign across disciplines. Intake has fully implemented DocuSign with consent and school enrollment forms. Per leadership DocuSign will be implemented for treatment plans for parents, doctors, and therapists. At this time DBH will request a Plan of Improvement (POI), that demonstrates the DocuSign implementation throughout the 6-month following this report.

The review team encouraged leadership to transition from paper charts to an Electronic Health Record (EHR) to improve CFR and State regulation requirement on all clinical documentation.

42CFR 456.610 (d) random audits of Q15 minute locator checks, for safe supervision of residents, compared therapy notes to locator indicators revealing missing Q15min checks and missing staff's initials conducting these checks in four (4) out eleven (11) charts in association with inaccurate, and contradictory information.

Family therapy and individual therapy notes often do not correlate with the aforementioned Q15 minute locator forms. For example: on 08/05/22 individual therapy notes show resident in therapy from 10:00 AM-to 11:00 AM whereas the Q15min locator form showed the resident in they dayroom; again, on 08/06/22, family therapy notes from 1PM-2PM show youth in therapy and but the Q15 minute indicator shows the youth at the gym.

Except for the findings noted above, all clinical record reviews demonstrated compliance with 42 CFR 483.350 through 42 CFR 483.376.

Restraint and Seclusion: ***42 CFR 483.350 through 42 CFR 483.376***

At Alpine Academy, if the patient is at imminent risk to harm self or others, seclusion or restraint may be necessary. Seclusion or restraint use is limited to emergencies in which the risk of harm is so serious that the non-physical intervention would be ineffective or not viable.

Violent behavior at the Alpine Academy that would require seclusion to prevent injury to self or others may result in a transfer to acute care, which happened in one of the cases reviewed by the team.

The Alpine Academy utilizes "Handle with Care" as their crisis intervention system when in need for brief physical holds (restraints) to manage behavioral crises that pose a threat to harm to themselves and/or others.

At the time of this visit and after review of training records, The Alpine Academy was found to have two (2) staff out-of-compliance for "Handle with Care" training. This issue was discussed with leadership which promptly pulled the mentioned staff off the work schedule until further training occurred. All staff is currently trained, and certifications are in place.

The facility has limited use of brief physical holds.

The clinical team reviewed all restraint events including one (1) youth that had discharged prior to the visit and found these to be compliant with Center for Medicare & Medicaid Services (CMS) regulations.

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There was no indication during the review that restraints are inappropriately used. These interventions had a physician's order, were time limited and discontinued as early as possible. The residents were continuously assessed and assisted during the intervention and in-person monitoring took place.

The incident reports pertaining to the above-mentioned restraints were reviewed prior to the site visit, and during the review, and with North Start's Chief Executive Officer, [redacted] who provided evidence of proper follow up with the residents at the time of these incidents.

Except for the findings noted above, all clinical record reviews demonstrated compliance with 42 CFR 483.350 through 42 CFR 483.376.

Youth Interview Findings: ***42 CFR 456.608(a)(1)***

YOUTH INTERVIEWS

Eleven (11) residents from Alpine Academy were interviewed via a secure Zoom connection. Prior to conducting these interviews, a schedule was constructed, allotting each girl up to thirty (30) minutes to respond to a list of seventeen (17) questions. [redacted] Compliance Director for Alpine Academy facilitated these interviews, bringing students into a quiet area on the unit along with a Webcam equipped laptop.

At the start of each interview, introductions were made, and a brief explanation was offered as to the purpose and expected duration of the interview. Youth were informed that there were no correct or incorrect responses, and that their responses were confidential with the exception of any identified safety concerns due to mandatory reporting requirement.

Youth were asked to identify themselves by name, their admission date to the Alpine Academy, whether or not they had been in inpatient care elsewhere and where their home community happened to be.

Students were asked "why they were in the facility (Alpine Academy)", and all eleven (11) youth were forthright about their treatment needs, with common responses such as "I was suicidal" or "family problems".

The next question was "what their treatment goals were", and ten (10) out of eleven (11) residents verbalized their treatment expectations, ranging from learning coping skills to repairing relationships with family members.

When asked "if they helped decide the goals on their treatment plan", nine (9) out of eleven (11) students affirmed that they were part of the planning process.

Eleven (11) youth reported making progress in their treatment" though one student felt that she was now "flat-lining", as the treatment curriculum was "beginning to be repetitive". Another student commented on her newly learned skills.

> "I have gotten further than I have expected, and I have only been here two months."
>
> "I stopped doing behaviors that were no longer healthy…I am moving forward."

> "Just because you make a mistake, move forward…there are a lot of hiccups in life."

Eleven (11) residents were able to discuss what they had learned in treatment. One (1) student suggested that the curriculum itself should be different for a "seventeen-year-old versus an eleven-year-old".

Nine (9) youth had favorable comments with regards to their peers. Of note, complaints were about gossiping, "drama", fat shaming, arguments, and boundary issues amongst the residents on the unit.

> "I get along with them, but we are on different paths…its not like I am going to be in their weddings or anything like that."

In the out brief meeting with Alpine Academy staff, all of the above-mentioned concerns were shared.

When asked whether they "had the opportunity to talk with other members of their treatment team", nine (9) residents responded that they could.

> "Lately they have been busy, and I have to cope with things. I realize that it's not always about me."

> "Their responsiveness depends…things get put off, but eventually they get around to it."

In the out brief meeting with North Star staff, these concerns were shared.

Eleven (11) residents had positive comments regarding floor staff…" you can talk to them one on one". One (1) student stated, "staff come and go, there's a lot of turnover" while another made remarks about staff shortages at Alpine Academy…" sometimes I get angry when there is one (1) staff on the unit and there's supposed to be two (2)", referring to the staff ratio.
Two (2) youth reported a male staff who frequently talks about religion while on the unit, which made them uncomfortable. These comments and concerns were shared during the out brief meeting with North Star Alpine Academy staff.
Eleven (11) residents were able to recite medications that were prescribed to them and their intended purposes. Amongst this group, almost all of them reported that they were able to discuss their concerns with the doctor as well as with nursing staff. One (1) student complained that her diagnosis was supposed to be changed and it has remained unchanged despite the doctor agreeing to do so earlier.
Nine (9) youth indicated that they communicated with their parent/guardian on a regular basis.
Two (2) residents reported some difficulty connecting with their supports because either they did not pick up the phone when they called or come by for visitation. These students reported having feelings of homesickness and these concerns were addressed with North Star staff during the out brief meeting.
Two (2) youth reported having an Office of Children's Services case manager. One (1) youth provided further detail stating that there was weekly contact, while the other youth declined to discuss this matter further when questioned.

None (0) of the interviewed residents had ever been restrained or put in seclusion while at

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Alpine Academy. When explored further, one youth described an incident on the unit months earlier she self-described as a "riot", after a fire alarm had been pulled on a couple of occasions. She detailed other youth being given emergency meds and herself being in her room for three (3) hours while staff managed the incident.
This was discussed with North Star staff at the out brief meeting and DBH comparatively reviewed incident reports, chart notes and medication records to further explore these incidents. At present though, there are no immediate safety concerns as this is within DBH's role as an oversight agency.

Ten (10) out of eleven (11) students were familiar with North Star Alpine Academy's grievance process; one (1) youth claimed to not be familiar with this process. Ten (10) youth had filed grievances on "having things (privileges) taken away" or program rule changes, such as their clothing allowance on the unit, being able to have makeup and being able to crochet. Some of these grievances were directly related to the "riots" mentioned above.

"The CEOs are not flexible. They don't come in on the unit and instead watch us from the

staff area. They talk to admin but not to us."

All eleven (11) residents reported that they had no safety concerns at North Star's Alpine Academy. When asked for complaints/suggestions, an often-heard reply was that there was a lack of communication amongst staff…"one person will say one thing (about the rules), while another person will say something else". Another topic was the belief that girls "coming directly from (the) acute (unit)" destabilizing the milieu on Redwood, "that they had not earned the privileges" of others on the unit. One (1) youth wanted staff to consider age differences amongst the residents on the unit when assigning roommates, while two (2) residents verbalizing wanting "Redacted - PII", a former clinician at Alpine Academy, come back to the unit.

PARENT INTERVIEWS

A sample of nine (9) parents/guardians were contacted in the two (2) weeks following DBH's physical visit. From these, seven (7) parents answered the phone and were interviewed, whereas the remainder did not answer, nor returned calls with voicemails being left if allowed to do so. Given the severity of the concerns of one (1) of the parents/guardians, DBH followed up with a separate interview and treatment team participation request denied by North Star.

QUESTION: Were you involved in formulation of your family member's treatment plan and discharge plans?

All parents reported they were involved at some point in the formulation or at least informed monthly of any updates to the treatment plans. One (1) parent indicated that they were involved in the beginning. Another parent stated: "Some of it, most of it was done by the doctor and counselors, they notify every month." One (1) parent/guardian initially commented "What is a discharge plan?", once clarification was provided, they affirmed that a discharge plan had been initiated during their intake.

QUESTION: Are you aware of the psychiatric medications your child is taking and/or being prescribed while in treatment?

All parents reported they were aware of the medications prescribed to their children. One (1)

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parent indicated he did not agree with all the medications prescribed. All the interviewed parent/guardians reported that North Star Alpine Academy kept them abreast of any psychiatric medications prescribed as well as any changes.

QUESTION: Have you been able to communicate with members of your family member's treatment team?

One (1) parent stated, "Yes, sometimes it takes a little longer than I'd like. They've got a lot going on at the facility because of the shortage of staffing." Two (2) parents indicated "yes and no". One of these two (2) parents stated she is informed when the team meeting takes place and have contacted her for it, but she is at work, and they do not provide her with the treatment plan updates; she does meet with the counselor weekly over the phone for Family Therapy. The other parent indicated she had requested to speak to the director, was told she was busy, and never received a call back. Other comments worth noting: "They are pretty good at keeping us informed via phone calls and email".
One (1) parent expressed difficulty contacting their child at times:

> "I know they're short-staffed, but there have been times the phone has rang for twenty (20) minutes…"

QUESTION: Do you know your child's treatment diagnosis, and do you understand what it means?

One (1) parent stated she did not know if they added more diagnoses since her child has been at the facility. Another parent stated, "Yes and no. It isn't my child's first time there and each time there's a different diagnosis and it changes." Another parent stated, "I do not know if all the diagnoses is being handled; it doesn't feel like there's any follow through and consistency." Other said: "And I've done my fair share of research of her dx and understand."
Other comments:

"I have been shut down many times by the counselors, except for one (Redacted - PII) who nailed her down her behavior (consequences matched with her actions). Brought in contraband, stole staff member's ID and went through staff's drawer. They are the professionals and should be able to identify her behaviors and know how to fix it. Youth stated it does not matter whether they transfer her to a reduced security facility or not because she can break out of Alpine Academy at any time. She stole a phone and facility stated they will investigate and return, but never returned. You asked to speak to the director, but never got a call back."

QUESTION: Were you informed of the facility's policy on restraint and seclusion?

One (1) parent indicated she was not given information regarding their policy. Another parent indicated she was given the information and understood it. Another parent did not think the information was provided or could not remember. "I don't recall, it's probably there. It was a mess when she got there." One (1) parent/guardian added "I am sure they had gone over it, but conflicting information has been given".

QUESTION: Do you have any concerns around your child feeling or being placed in an uncomfortable situation, or concerns around his/hers safety at this facility?

Two (2) parents indicated they did not have any concerns regarding the safety of their children

in the facility. Another parent had a concern about the security of the facility since contraband items were able to be sneaked into the facility.
One (1) parent/guardian complained about her child having access to hand sanitizer (which she could drink, and allegedly other peers had), but not have shampoo. This parent also complained about her daughter's art supplies were stolen and never replaced. Additionally, this parent/guardian complained about purchasing a home COVID test, only to find out that she needed to have this done at a hospital (so she could visit her child) despite being instructed to just provide a negative test result. The other parent/guardian complained about staffing shortages at Alpine Academy, sharing that this was also a concern of her daughter.

Additional Comments:

One (1) parent indicated a concern over lack of recreation and indoor activities and her child is bored. The parent stated, "They used to play games, puzzles and crochet; the only watch tv every day and watch the same movie." Parent understands if activities are taken away as punishment, but how long are they penalized and will the activities be brought back.
One (1) parent stated she was "Concerned about staffing shortages."; "It would be nice if the counselors were consistent, she's had four (4) counselor changes since she's been at Alpine." Parent asked the current counselor if he/she had read her child's entire file, the counselor stated that he/she had not; concerned that the counselor had not read the file to know what was going on with her child. Parent also stated that it was ridiculous that they only had one (1) phone for all the kids to use at night to call family considering how much they charge for the child to be in the facility.

Several stated there is not a lot of consistency due to staffing issues and they were not satisfied with the service. One (1) parent claims the facility is pushing to discharge her child, but they had not addressed one of the main issues she was admitted for. Parent also feels that proper documentation was not done in the case of her child's file to document communication efforts.

One (1) parent/guardian states their child went in with issues of being abused, no documentation of her experience and it has not been addressed. Last counselor (Redacted - PII) finally documented that in her chart and that it had not been addressed. This is one of the main issues that should be addressed while she was in the treatment center, but it kept getting deferred in therapy. Resident's counselors keep changing; resident expressed her frustration to her dad because she has to repeat herself, be reintroduced and adjust to the new counselor's philosophy and have to rebuild the trust and rapport with a new counselor. "There is a stigma with Natives, and this little Native girl is just going to get pushed through the system. He asked her if she had dealt with some of her core issues; she panicked with fear in her eyes and was speechless. Not fair to her or parents that her core issues have not been addressed or dealt with. There should have been documentation that these issues were addressed, and the coping skills taught to her. Facility wants to discharge her, but she's still dealing with an unhealthy mindset and no coping skills. I do not want to discredit the facility. They have done some good things and made some headway. I have heard of people who have left the program and have done great, but I feel in this case there has been inconsistencies in the care and treatment she is receiving."

STAFF INTERVIEWS

Two (2) full-time employees, one (1) floor staff and the other (1) a registered nurse, were interviewed via Zoom with the assistance of [redacted] he Compliance Director at North Star Alpine Academy.

At the start of each interview, introductions were made, and a brief explanation was offered as to the purpose of our interview. Both staff were able to confirm that restraints and seclusions are used as the last resort when verbal de-escalation techniques and providing the resident with space are unsuccessful. Restraints and seclusions are only warranted when either the youth is harming themselves or is attempting to hurt others on the unit. Both staff talked about how their responses to such situations are also dictated by what is written on their individualized treatment plans by the therapist. One (1) staff added, "it's pretty kid specific" as there may be interventions tailored to the youth.

With regards to suggestions, the first employee talked about the need for pay increases in the hopes to retain staff as there had been a lot of turnover. As a comparison, this employee claimed that other providers in the community paid more than Alpine Academy currently does and this would alleviate some of the stress that co-workers experienced. Additionally, the suggestion was made as to the need for greater communication between staff via email and faster internet connection speed at the facility.

The second employee thought that having nursing staff and the floor staff on the same twelve-hour shifts would greatly improve communication across shifts. This staff pointed out that while nursing staff works twelve-hour shifts, floor staff works eight-hour shifts and there is often information lost between different schedules. Additionally, this employee talked about the need to go to an electronic records system as opposed to paper charts, along with the difficulties in administering emergency meds on the unit, if needed immediately. Another area for improvement would be better staff to patient ratios on the unit, as this was an area of ethical and professional concern…" I want to write good quality notes and pass meds" (in addition to other responsibilities). Finally, this employee talked about changes within the organization that bring with "inconsistency for the staff as well as the kids" (patients).

QUALITY OF CARE

During site visit and in the follow up contacts with leadership after interviews were conducted, the Division of Behavioral Health staff expressed concerns regarding safe supervision of the children during their treatment stay.

All documentation requires immediate attention for improvement. Quality assurance is needed to assess accuracy of notes and guarantee signatures are in place to fully qualify for Medicaid payment.

Quality Management is required to provide DBH with reports conducted quarterly that assess for missing signatures. DBH request these reports to be shared with the division to ensure quality assurance on medical records.

COMAGINE TRAINING: DBH recommends all staff involved in Utilization Reviews to receive and obtain comprehensive training and technical assistance with Comagine. Utilization Review input is to be evaluated by North Star Quality Management quarterly and these reports to be shared with DBH.

Based on the Q15 minute locators, incongruences with locations, and staff, parent and children's complaints about safety, DBH recommends that Alpine Academy to hire additional staff to ensure services are being rendered safety and with quality of care. It is of the utmost importance that North Star recruit and retain qualified staff in order to improve clinician to client ratios, as well as the mental health specialist to client ratios.

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DBH recommends that an internal review be done with North Star Corporate due to the local operation concerns of professional liability. When complete, DBH requests this report to be shared with DBH.

PLAN OF IMPROVEMENT (POI)
Provide a POI that addresses how you will correct the following deficiency/s:

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(a) and 42 CFR 456.180
Findings: Missing and /or late signatures from parents/guardians, and psychiatrists, in the Plans of Care.

POI: Alpine Academy - Quality Management is required to provide DBH with internal audit reports conducted monthly* from the receipt of this request that assess for missing signatures on Plans of Care;

POI: as discussed with leadership, please demonstrate the DocuSign implementation throughout the 6-month following this report.

*11/23/2022 addendum changed to monthly due dates of: December 30, 2022, January 31, 2023, February 28, 2023.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(b)(4)
Findings:
a) resident's records were missing and showed inaccurate Q15 min checks

b) Multiple records were missing weeks of therapy notes or inaccurate documentation

POI:
a) Provide a monthly (11/23/2022 addendum due: December 2022, January 2023, February 2023) plan that identifies how your organization will ensure Alpine Academy's Q15min checks are accurately completed and documented.

b) Provide DBH with monthly* internal audit reports conducted that assess for completion and accuracy of Alpine Academy's therapy notes.

*11/23/2022 addendum changed to monthly due dates of: December 30, 2022, January 31, 2023, February 28, 2023.

Identified CFR / State of Alaska Regulation and Deficiency
42 CFR 441.155(c)
Findings:
30-day-review of the POC was missing multiple treatment team member signatures and/or showed inaccurate documentation

POI: Provide DBH with internal audit reports conducted monthly* that assess for missing

signatures.

*11/23/2022 addendum changed to monthly due dates of: December 30, 2022, January 31, 2023, February 28, 2023.

Submit POI by:

Mail To:
State of Alaska
Department of Health and Social Services
Division of Behavioral Health
Attn: [redacted] RN BSN
[redacted]
Anchorage, AK [redacted]

Or
E- Mail To: [redacted]@alaska.gov
Or
Fax POI To: [redacted] attention [redacted] RN BSN

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Summary of Chart Review Findings

42 CFR 441.155(a) and 456.180

7 out of 11 chart(s) met this requirement.

0601164168 KIBA	initial plan of care review missing on 03/25/22 with no follow-up documentation found
0601068949 MATI	initial plan of care review (09/23/21) signatures for psychiatrist (10/19/21) and therapist (10/12/21) past due by multiple days
0601109599 BRBR	missing parent/guardian signatures on initial treatment plan;
0601314134 DAJU	missing parent/guardian signatures on initial treatment plan;

42 CFR 441.155(b)(1)

11 out of 11 chart(s) met this requirement.

42 CFR 441.155(b)(3)

11 out of 11 chart(s) met this requirement.

42 CFR 441.155(b)(2)

11 out of 11 chart(s) met this requirement.

42 CFR 441.155(b)(4)

4 out of 11 chart(s) met this requirement.

0601164168 KIBA	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures; inaccurate Q15min locators contradicting these notes
0601080343 ISHA	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures
0601068949 MATI	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures; inaccurate Q15 missing youth's whereabouts on 06/07/22.
0601109599 BRBR	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures
0601222919 ABJO	inaccurate Q15min locators contradicting therapy notes (examples:08/05/22 & 08/06/22)
0601095426 GRNA	missing weeks of therapy notes (individual, group, family), and therapy documentation missing signatures, with inaccurate Q15min locators contradicting these notes (07/05/22)
0601314134 DAJU	missing weeks of therapy notes (individual, group, family)

42 CFR 441.155(b)(5) and 7 AAC 140.410(6)

10 out of 11 chart(s) met this requirement.

0601250346 KAMO	Discharge Plan language vague - OCS involvement not clearly

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	noted

42 CFR 441.155(c)

6 out of 11 chart(s) met this requirement.

0601068949 MATI	one plan of care 30 day review missing therapist signature on 06/02/22
0601150629 HECH	CFR 441.152 Certification of Need missing signature by psychiatrist
0601109599 BRBR	6/9/2022 signature sheet date/time review note not updated - possibly a copy paste; 07/07/2022 parent not available, reviewed at FT but no date specified.
0601095426 GRNA	one plan of care 30 day review missing parent/guardian signature on 12/23/21; Several missing signatures on plan of care for 03/17/22 and 09/30/21
2006912333 DEPELE	one plan of care 30-day review missing for 05/26/22

42 CFR 441.156 and 7 AAC 140.405(d)

11 out of 11 chart(s) met this requirement.

42 CFR 456.609(a)(b)(c)(d)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(a)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(b)(1)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(c)

9 out of 11 chart(s) met this requirement.

2004260101 GILIBO	MAR missing signatures for Trazadone on 07/10/22
0601109599 BRBR	MAR missing signatures for Concerta + Effexor on 07/29/22; Missing dietitian assessment documentation

42 CFR 456.610(d)

11 out of 11 chart(s) met this requirement.

42 CFR 456.610(e)

11 out of 11 chart(s) met this requirement.

42 CFR 483.350 through 42 CFR 483.376

11 out of 11 chart(s) met this requirement.

It should be noted that the actions described in this report, or the plan of improvement, do not limit any administrative,

civil, or criminal liability of the provider either for conduct which is the subject of this report, or the plan of improvement, or other instances of provider misconduct, or noncompliance with Behavioral Health or the Alaska Medicaid Program.

Northstar Behavioral Health: Alpine Academy -Department of Health Plan of Improvement
December 30, 2022.

CFR/STATE REGULATION DEFICIENCY	FINDINGS	POI	Monthly Audits		
			December 30, 2022	January 31, 2022	February 28, 2023
42 CFR 441.155(a) 42 CFR 456.180	Missing and/or late signatures from parents/ guardians, and psychiatrists, in the Plans of Care.	Due to leadership turnover, Docusign was not implemented as planned initially. NSBH will confirm a training date with Docusign by 1/31/23. After training, NSBH will determine a realistic rollout date. The PI Director will assume the lead role in making arrangements for training and the DCS/designee will assume the lead in implementing the system for clinical services. The DCS/designee will audit treatment plans monthly for signatures of parents/guardians and team members. When parents/guardians were unable to attend in person, it is documented how and when they participated/approved of the plan by the clinical therapist on the treatment plan, with a double witness if verbal. It is expected that NSBH-Alpine Academy will maintain a monthly rate of at least 90% accuracy.	100%		
42 CFR 441.155 (b)(4)	a) Resident's records were missing and showed inaccurate Q 15 checks	MHS and nursing staff received training on Q15s and patient monitoring. Post-tests verified competency. Beginning January 1, RNs will review Q15s at least twice per shift and sign the Q 15 to verify that they have monitored completion of the form and MHS supervision of residents. At least twice a week Senior Leaders/designees will conduct rounds to ensure policies are followed. Weekly, Medical Records will review all Q 15's for completion and report to the CNO any incomplete incidents for follow-up. NSBH will expect at least a 90% completion/accuracy rate sustained. Senior Leadership may audit video files to ensure patient monitoring has occurred per policy.	Training completed on 12/30/22.		

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	b) Multiple records were missing weeks of therapy notes or inaccurate documentation	CT's received training and signed attestations verifying an understanding of documentation requirements. CT's and AT's are responsible for documenting groups and placing the signed documentation into the chart per documentation policy. Auditing will begin January 1, 2023 with an expectation of 90% accuracy of therapy notes incorporated in the file.	Training completed on 12/30/22.		
42 CFR 441.155 (c)	30-day-review of the POC was missing multiple treatment team member signatures and/or showed inaccurate documentation	The DCS/designee will audit charts on a weekly basis for signatures of parents/guardians and team members. In the event that signatures are missing, the DCS/Designee will e-mail the appropriate manager of missing signatures and that manager is responsible for follow-up to ensure policies and procedures are being followed. NSBH is pursuing Docusign as a means of obtaining signatures when team members are not able to attend in person. It is expected that NSBH-Alpine Academy will maintain a monthly rate of at least 90% accuracy.	91% all signatures present.		

Submitted by [redacted] Date: December 30, 2022

[redacted] MS
Performance Improvement Director
[redacted]

North Star Behavioral Health: Alpine Academy -Department of Health Plan of Improvement
February 28, 2023.

CFR/STATE REGULATION DEFICIENCY	FINDINGS	POI	Monthly Audits		
			December 30, 2022	January 31, 2022	February 28, 2023
42 CFR 441.155(a) 42 CFR 456.180	Missing and/or late signatures from parents/ guardians, and psychiatrists, in the Plans of Care.	Due to leadership turnover, Docusign was not implemented as planned initially. NSBH will confirm a training date with Docusign by 1/31/23. After training, NSBH will determine a realistic rollout date. The PI Director will assume the lead role in making arrangements for training and the DCS/designee will assume the lead in implementing the system for clinical services. The DCS/designee will audit treatment plans monthly for signatures of parents/guardians and team members. When parents/guardians were unable to attend in person, it is documented how and when they participated/approved of the plan by the clinical therapist on the treatment plan, with a double witness if verbal. It is expected that NSBH-Alpine Academy will maintain a monthly rate of at least 90% accuracy.	100%	90% Follow up with one missing parent/guardian signature was completed by CT	84.6% 13 treatment plans for the month of February were audited. All but two had indication of guardian knowledge and signatures. This will continue to be addressed in the POI dated 3/6/23.
42 CFR 441.155 (b)(4)	a) Resident's records were missing and showed inaccurate Q 15 checks	MHS and nursing staff received training on Q15s and patient monitoring. Post-tests verified competency. Beginning January 1, RNs will review Q15s at least twice per shift and sign the Q 15 to verify that they have monitored completion of the form and MHS supervision of residents. At least twice a week Senior Leaders/designees will conduct rounds to ensure policies are followed. Weekly, Medical Records will review all Q 15's for completion and report to the CNO any incomplete	Training completed on 12/30/22.	9 3.9% 415 days of Q 15s were reviewed, of those, 3 dates had one blank time entry and 22 dates were missing a shift	95.7% 676 days of Q 15s were audited, of those, only 2 blank entries were noted.

		incidents for follow-up. NSBH will expect at least a 90% completion/accuracy rate sustained. Senior Leadership may audit video files to ensure patient monitoring has occurred per policy.		manager signature. Total completion 93.9%	Of the 676 days, there were 2028 opportunities to have shift manager/RN signatures. 87 signatures were missing, leaving a 95.7% compliance rate
	b) Multiple records were missing weeks of therapy notes or inaccurate documentation	CT's received training and signed attestations verifying an understanding of documentation requirements. CT's and AT's are responsible for documenting groups and placing the signed documentation into the chart per documentation policy. Auditing will begin January 1, 2023 with an expectation of 90% accuracy of therapy notes incorporated in the file.	Training completed on 12/30/22.	83.8% Of a possible 210 notes required, 176 were included in the active chart and completed appropriately. DCS notified	43.8% CT individual and family therapy, group therapies and AT therapies were audited for the month of February, of possible 925 notes, 406 were present and signed. DCS was notified.

					This will continue to be addressed in the POI dated 3/6/23.
42 CFR 441.155 (c)	30-day-review of the POC was missing multiple treatment team member signatures and/or showed inaccurate documentation	The DCS/designee will audit charts on a weekly basis for signatures of parents/guardians and team members. In the event that signatures are missing, the DCS/Designee will e-mail the appropriate manager of missing signatures and that manager is responsible for follow-up to ensure policies and procedures are being followed. NSBH is pursuing Docusign as a means of obtaining signatures when team members are not able to attend in person. It is expected that NSBH-Alpine Academy will maintain a monthly rate of at least 90% accuracy.	91% signatures present.	90 % Follow up with CT was completed	84.6% 13 charts with February treatment plans were audited. Of those, 1 chart was missing a signature page and one was missing a CT signature. This will continue to be addressed in the POI dated 3/6/23.

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February 28, 2023.

Submitted by _____ Date: February 28, 2023

[redacted]MS
Performance Improvement Director
[redacted]