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
	054083	A. BUILDING _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
B 000	INITIAL COMMENTS An unannounced recertification survey was conducted by federal consultant surveyors from 7/30/18 to 8/1/2018. The census on the first day of the survey was 47. The sample of active patients was eight (8). Two (2) discharged patients and one (1) death patient were added to review a critical incident and discharge summaries.	B 000		
B 103	SPEC MEDICAL RECORD REQS FOR PSYCH HOSPITALS CFR(s): 482.61 The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. This Condition is not met as evidenced by: Based on record review and interview, the facility failed to: I. Ensure the psychosocial assessments include the conclusions and recommendations related to the anticipated social work role(s) in treatment and discharge planning for eight (8) out of eight (8) active sample patients (1, 2, 3, 4, 5, 6, 7, and 8) did not have the anticipated role(s) of the social worker. As a result, critical and professional patient psychosocial information necessary for informed treatment planning decisions was not available. (Refer to B108) II. Ensure that Psychiatric Evaluations: A. Were performed in a timely manner for two (2) of two (2) discharged patients (N1 and N2) added to review a critical incident. There were no	B 103	The Chief of Social Services reviewed the Bio-psychosocial assessment currently used with each of the affected patients identified (Patients 1, 2, 3, 4, 5, 6, 7 and 8). Kedren is currently using the Askesis PsychConsult EHR system & Biopsychosocial assessment (Attachment # 02) which is less comprehensive than the Netsmart MyAvatar EHR system & Psychosocial assessment. Kedren is currently in the process of transitioning from Askesis to Netsmart which is set to launch on 11/13/2018. The Chief of Social Services reviewed the Netsmart MyAvatar Psychosocial Assessment which will be used by the Social Workers to complete a comprehensive assessment of the patient (Attachment # 01). The Chief of Social Services determined that the Netsmart document allows for more information to be gathered at the time of assessment which will be used to formulate a clear social work goals related to their role in treatment, information that can assist in formulating a treatment plan and discharge plan. The Chief of Social Services will conduct an in-service training on 10/24/2018 (Attachment # 03) to review Standards listed by the State Operations Manual (Attachment # 04) to ensure that Social Workers collect and properly document the necessary information about home plans, family attitudes, community resource and social history and understand where the information should be filled in on the current Askesis Biopsychosocial assessment during this interim period of transition to the Netsmart Psychosocial assessment which has clear areas in which the above information will be collected. Netsmart will launch on 11/13/2018. (Refer to B108)	11/13/2018

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

[signature] President & CEO 10-19-18

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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B 103	Continued From page 1 psychiatric assessments completed on these patients prior to their discharge from the facility. This failure delays the treatment of acute symptoms with psychotropic medications and professional therapies. (Refer to B110) B. Included an estimation of patients' memory with supporting clinical evidence for six (6) of eight (8) active sample patients This deficiency compromises the database from which diagnoses are determined and from which changes in response to treatment interventions may be measured. (Refer to B110) III. Provide adequate treatment and monitoring for one (1) of three (3) discharged patients (N1) who subsequently assaulted and murdered his/her roommate (E1). In addition, the facility failed to ensure that an adequate root cause analysis and a prompt review by their Morbidity and Mortality Board of the circumstances surrounding this event were completed to implement corrective actions. Without taking appropriate and immediate actions to mitigate risks and prevent future recurrence of these unsafe practices, the health and safety of all newly admitted patients may be jeopardized. (Refer to B125) IV. Ensure the discharge summaries are completed in a timely manner and signed by the physician within 14 days of discharge for three (3) of five (5) discharged patients (D1, D3, and D4) and for three (3) of three (3) added patients to review summaries (N1, N2, and E1). This deficiency results in a failure to communicate in a timely manner final diagnosis, current medications, the course of treatment, a summary of relevant labs and testing, anticipated problems and discharge plan with outpatient providers. (Refer to B133)	B 103		

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B 108	Continued From page 2	B 108	Chief of Social Services will conduct an in-service training on 10/24/2018 with all Inpatient Social Service staff (Attachment # 03) to review the Standards clearly defined by the State Operations Manual (Attachment # 04). Chief of Social Services will train Social Workers on where on their current Askesis PsychConsult Biopsychosocial Assessment document (Attachment # 02) they will include specific information related to home plans, family attitudes, community resource contacts and social history. Chief of Social Services will also review and train the Social Workers on the new Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) that will be launched on 11/13/2018 and which clearly identifies the specific areas that Social Service will capture the standard information that we are required to have (home plans, family attitudes, community resource contacts & social history).	11/13/2018
B 108	DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA CFR(s): 482.61(a)(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history. This Standard is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure that the Psychosocial Assessments for eight (8) out of eight (8) active sample patients (1, 2, 3, 4, 5, 6, 7, and 8) included anticipated Social Work roles in treatment. As a result, critical and professional patient psychosocial information necessary for informed treatment planning decisions was not available to the treatment teams. Findings include: A. Record Review 1. Patient 1 was admitted for "danger to others and gravely disabled" on 6/25/18. The Psychosocial Assessment completed on 6/25/18 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. 2. Patient 2 was admitted for "danger to others and gravely disabled" on 7/13/18. The Psychosocial Assessment completed on 7/13/18 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. 3. Patient 3 was admitted for "gravely disabled"	B 108	This documentation will be monitored weekly by the Chief of Social Services and the Director of Quality Management through the Utilization Review process. Plan of Correction for each deficiency cited under CFR(s): 482.61 (a)(4) is the following: (1-8) On page 27 of the Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) the Social Work staff will identify problems, determine short/long term goals, determine Social/Clinical work goals for the Social Worker, identify current psychological issues that need interventions and provide a clinical summary/ impression. During interim transition before 11/13/2018 Netsmart launch, Social Work staff will manually write in the above information collected onto page 5 of the Askesis PsychConsult Biopsychosocial Assessment (Attachment # 02) in the "Evaluation & Initial Discharge Summary" section.	11/13/2018

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B 108	Continued From page 3 on 12/13/17. The Psychosocial Assessment completed on 12/14/17 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. 4. Patient 4 was admitted for "danger to self and danger to others" on 7/7/18. The Psychosocial Assessment completed on 7/10/18 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. 5. Patient 5 was admitted for "danger to others " on 7/21/18. The Psychosocial Assessment completed on 7/21/18 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. 6. Patient 6 was admitted for " gravely disabled" on 7/8/18. The Psychosocial Assessment completed on 7/9/18 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. 7. Patient 7 was admitted for "danger to self and danger to others" on 7/23/18. The Psychosocial Assessment completed on 7/24/18 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. 8. Patient 8 was admitted for "danger to self and danger to others" on 7/25/18. The Psychosocial Assessment completed on 7/26/18 did not identify anticipated roles for social work staff in formulating interventions for inpatient treatment. B. Staff Interview In a meeting with the acting Director of Social Services on 7/31/18 at 1:00 p.m., the above deficiencies were reviewed. She agreed with the	B 108	On page 27 of the Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) the Social Work staff will identify problems, determine short/long term goals, determine Social/Clinical work goals for the Social Worker, identify current psychological issues that need interventions and provide a clinical summary/impression. During interim transition before 11/13/2018 Netsmart launch, Social Work staff will manually write in the above information collected onto page 5 of the Askesis PsychConsult Biopsychosocial Assessment (Attachment # 02) in the "Evaluation & Initial Discharge Summary" section. On page 27 of the Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) the Social Work staff will identify problems, determine short/long term goals, determine Social/Clinical work goals for the Social Worker, identify current psychological issues that need interventions and provide a clinical summary/impression. During interim transition before 11/13/2018 Netsmart launch, Social Work staff will manually write in the above information collected onto page 5 of the Askesis PsychConsult Biopsychosocial Assessment (Attachment # 02) in the "Evaluation & Initial Discharge Summary" section. On page 27 of the Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) the Social Work staff will identify problems, determine short/long term goals, determine Social/Clinical work goals for the Social Worker, identify current psychological issues that need interventions and provide a clinical summary/impression. During interim transition before 11/13/2018 Netsmart launch, Social Work staff will manually write in the above information collected onto page 5 of the Askesis PsychConsult Biopsychosocial Assessment (Attachment # 02) in the "Evaluation & Initial Discharge Summary" section.	11/13/2018 11/13/2018 11/13/2018

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B 108	Continued From page 4 above findings and further stated, "Social work has a critical role in the treatment of patients."	B 108	On page 27 of the Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) the Social Work staff will identify problems, determine short/long term goals, determine Social/Clinical work goals for the Social Worker, identify current psychological issues that need interventions and provide a clinical summary/impression. During interim transition before 11/13/2018 Netsmart launch, Social Work staff will manually write in the above information collected onto page 5 of the Askesis PsychConsult Biopsychosocial Assessment (Attachment # 02) in the "Evaluation & Initial Discharge Summary" section. Psychiatric Evaluation CFR(s): 482.61(b) this standard was not met as the Psychiatric Evaluation reviewed had no assessments than include member functioning there by compromising the data base from which diagnosis are determined and treatment interventions measured. Correction Action Plan The Physician involved has been subjected to disciplinary action pending peer review. The Board of Directors has appointed a Medical Director Inpatient Psychiatry who will work with the Director of Quality Management to implement a monitoring tracking system to include tracers to track, trend and redirect Physicians on a daily basis to ensure that all the required diagnostic fields are completed and in addition the tracking will address timely completion of the Psychiatric Evaluations to ensure that patient care is expeditiously delivered. Delinquent deficiencies before they leave the	11/13/2018
B 110	PSYCHIATRIC EVALUATION CFR(s): 482.61(b) Each patient must receive a psychiatric evaluation. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to: I. Provide comprehensive and complete psychiatric evaluations. Specifically, the psychiatric evaluations had no assessments that included memory functioning for six (6) of eight (8) active sample patients (2, 3, 5, 6, 7 and 8). This deficiency compromises the database from which diagnoses are determined and from which changes in response to treatment interventions may be measured. Findings include: I. Lack of timely psychiatric evaluations A. Record Review 1. Patient N1 was admitted on 11/2/17 at 3:30 p.m. for "Psychosis NOS [not otherwise specified] and danger to self." The Root Cause Analysis (undated) stated, "Client was brought in by [spouse] to urgent care clinic for psychiatric evaluation due to increasingly unpredictable behavior. Client stated hearing voices telling [him/her] to harm [himself/herself] and [spouse] reported client was found with a knife attempting to [self-mutilate his/her genitals]." There was no psychiatric assessment completed prior to the	B 110		

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B 110	Continued From page 5 patient being taken by police for allegations of murder on the evening of 11/2/17. 2. Patient N2 was admitted on 11/2/17 at 4:00 p.m. for Unspecified Mood Disorder and danger to self." The Root Cause Analysis (undated) stated, "[S/he] expressed feeling depressed, felt like hurting [himself/herself] with plans to stab [himself/herself] with pencils." There was no psychiatric assessment completed prior to the patient being transferred to another facility on 11/3/17 at 2:30 p.m. B. Interview On 8/1/18 at 10:15 a.m., the Medical Director agreed that the psychiatric assessments were not completed and that the facility does not have psychiatrists on duty after hours. II. Lack of comprehensive and complete psychiatric evaluations A. Record Review 1. Patient 2's Psychiatric Evaluation (dated 7/14/18) did not include any assessment of the patient's memory. 2. Patient 3's Psychiatric Evaluation (dated 12/14/17) did not include any assessment of the patient's memory. 3. Patient 5's Psychiatric Evaluation (dated 7/22/17) did not include any assessment of the patient's memory. 4. Patient 6's Psychiatric Evaluation (dated 7/8/17) did not include any assessment of the patient's memory.	B 110	hospital on that day. In addition data arrived from QAPI will be presented at the Medical Executive Committee Meeting and the committee will determine the necessity for Peer Review. An administrative discharge note has been placed on all three of the records of the patients involved in the sentinel event. Competently medical records would audit records on a daily basis for accuracy and completion and will notify the delinquent Physicians of their deficiencies. The Medial Director of Inpatient Services is responsible for the enforcement of these rules. To ensure that all patients are expeditiously seen and evaluated the hospital has engaged a physician and a psychiatric practitioner to admit and evaluate patients between 6:00 pm and 11:00 pm to support the physician providing admission coverage between 7:00 am and 6:00 pm. Any admissions arriving between 11:00 pm and 7:00 am admission orders to include 1:1 observation. Such admissions will be fully evaluated by the psychiatric team at 7:00 am the following day. 1. Appropriate disciplinary action will be taken pending peer review. 2. Appropriate disciplinary action will be taken pending peer review. 3. Appropriate disciplinary action will be taken pending peer review.	

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B 110	Continued From page 6 5. Patient 7's Psychiatric Evaluation (dated 7/24/17) did not include any assessment of the patient's memory. 6. Patient 8's Psychiatric Evaluation (dated 7/25/17) did not include any assessment of the patient's memory. B. Interview On 7/31/18 at 10:10 a.m., the Medical Director agreed that memory was not assessed in the Psychiatric Evaluation.	B 110	4. Appropriate disciplinary action will be taken pending peer review. 5. Appropriate disciplinary action will be taken pending peer review. 6. Appropriate disciplinary action will be taken pending peer review.	
B 125	TREATMENT PLAN CFR(s): 482.61(c)(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included. This Standard is not met as evidenced by: Based on record review, document review, and interviews, the facility failed to provide adequate treatment and monitoring for one (1) of three (3) discharged patients (N1) who subsequently assaulted and murdered his/her roommate (E1). In addition, the facility failed to ensure that an adequate root.cause analysis and a prompt review by their Morbidity and Mortality Board were completed to address the circumstances surrounding this event and to implement corrective actions. Without taking appropriate and immediate actions to mitigate risks and prevent future recurrence of unsafe practices, the health and safety of all newly admitted patients may be jeopardized. Findings include:	B 125	The rounding policy procedure has been revised to ensure consistence rounding in the hospital in addition a separate policy denoting that all new patients will be placed on a SPCIII (level 1:1) when admitted and will remain on this level of precaution until evaluated by attending Psychiatrist or Clinical Psychologist. (Attachment 10)	10/23/2018

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B 125	Continued From page 7 A. Record Review Patient N1 was admitted on 11/2/17 at 3:30 p.m. for "Psychosis NOS and danger to self." The undated Root Cause Analysis stated "Client was brought in by [spouse] to urgent care clinic for psychiatric evaluation due to increasingly unpredictable behavior. Client stated hearing voices telling [him/her] to harm [himself/herself] and [spouse] reported client was found with a knife attempting to ... [self-mutilate his/her genitals]." There was not a psychiatric assessment completed prior to the patient being taken by police for allegations of murder the evening of 11/2/17. In addition, there was a significant discrepancy in how often N1 was to be monitored by staff. The nursing assessment noted 30 minute checks, the rounds sheet indicated that the patient was monitored every 20 minutes, and the facility policy stated that all patients were to be monitored every 15 minutes. Furthermore, there was not a progress note or discharge summary documenting the time of discharge to the police. These failures delayed the treatment of acute symptoms with psychotropic medication and assessment of the patient condition by a qualified psychiatrist. In fact, the patient was not evaluated by a psychiatrist during the hospital stay and no antipsychotic medications were ordered. B. Document Review 1. The facility provided the surveyors with a copy of the undated Root Cause Analysis titled "Sentinel Event." This document did not include dates when meetings occurred, analysis of contributing factors such as human and environmental. There was no mention of a failure	B 125	1. At the time of the Sentinel Event, there were key positions that were vacant at the facility (i.e. CQI Director, Risk Manager, and Patient Safety Manager. This played a role in the thoroughness of the documentation as there was no one who was familiar with the RCA process in the position	06/18/2018, 08/24/2018 & 10/15/2018

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B 125	Continued From page 8 to monitor, evaluate or medicate the patients in the document. Therefore, there were no corrective actions identified to address these issues to prevent further reoccurrences. 2. The medical staff did not review this death and there were no minutes from the Mortality and Morbidity Board as of August 1, 2018. 3. Patients N1 was placed on every 30-minute observation per the "RN's Mental Health Nursing History and Assessment" dated 11/2/17 at 5:00 p.m. However, there was no physician order denoting "Precautions" on the "Physician Admission Orders" dated 11/2/17 at 5:45 p.m. These orders were telephone orders and were not signed by a physician until 3/15/18. In addition, the patient, according to the rounds sheet, was monitored every 20 minutes. The facility policy, "Rounds for Patient Observation" and reviewed/revised 12/2017, stated, "Every patient must be seen/located by the staff member every fifteen minutes with documentation as to patient location/activity on the Rounds form according to the location code." 4. The facility did not have a Death Review Policy or Procedure and used the undated Sentential Event Procedure # 6009 [no date] which did not address homicides in the procedure. The procedure also did not address the management and review of expected and unexpected deaths by medical staff or mortality review board. 5. There were no documents to review to determine that the facility took actions to mitigate the risks to prevent recurrence. C. Staff Interviews	B 125	at that time. There is now a CQI Director as of 06/18/2018 and Patient Safety Manager as of 8/24/2018 with several years experience with patient safety, risk management, and the RCA process. There is now a very robust RCA process in place and staff are initially trained on this process prior to starting an RCA (Attachment 6). In addition, our Sentinel Event policy was updated on 10/15 2018 Attachment 7). 2. Per our updated Sentinel Event policy a Mortality and Morbidity (M&M) review will be conducted on all deaths and presented to the MEC and the Governing Board. (Attachment 7) 4. The Sentinel Event (SE) policy was updated to include the M&M standard operating procedure on 10/15/2018. This was distributed to staff on 10/19/2018. 5. Immediately after the SE the following processes were changed to prevent re-occurrence in the facility (Attachment 8): The Chief of Staff appointed a Process Improvement Team to perform a RCA related to the SE; all admitted patients were placed on one-to-one observation until they were seen by an admitting physician. The CNO will be responsible for ensuring that all one-to-one orders are enforced.;	10/15/2018 10/15/2018

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B 125	Continued From page 9 1. On 8/1/18 at 10:15 a.m., the surveyors interviewed the CEO and Medical Director and they agreed that they had not taken actions to mitigate risk to the patient. The CEO explained he is trying to have the unit remodeled, replace the patient room doors with flexi glass windows but this has not been completed. Furthermore, the CEO reported he had not reviewed the root-cause-analysis. The CEO state, "Things could have been managed much better. 2. On 8/1/18 at 11:00 a.m., the surveyor interviewed the Director of Quality Improvement and he/she agreed the root-cause-analysis was vague and did not provide an in-depth analysis of the event including the analysis of contributing factors such as human and environmental. 3. On 8/1/18 at 10:00 a.m., the Director of Nursing stated, "You are correct. The observation documents do not agree with the policy."	B 125	discussions took place regarding the redesign of the unit to ensure greater visibility of the patients in their rooms which resulted in the upgrade to an electronic monitoring rounding system being adopted by the facility. In addition, mirrors will be strategically placed in the rooms enabling staff to have full view of the patients in each bed at all times. (Attachment 9). 1. discussions took place regarding the redesign of the unit to ensure greater visibility of the patients in their rooms which resulted in the upgrade to an electronic monitoring rounding system being adopted by the facility. In addition, mirrors will be strategically placed in the rooms enabling staff to have full view of the patients in each bed at all times. (Attachment 9). 2. There is now a very robust RCA process in place and staff are initially trained on this process prior to starting an RCA (Attachment 6). In addition, our Sentinel Event policy was updated on 10/15 2018 (Attachment 7).	
B 133	DISCHARGE PLANNING CFR(s): 482.61(e) The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization. This Standard is not met as evidenced by: Based on record review, document review, and interview, the facility failed to ensure that discharge summaries were dictated, transcribed and signed within 14 days of discharge for three (3) of five (5) sample discharged patients (D1, D3, and D4) and for two (2) of two (2) added discharged patients (N1 and N2) and one (1) death (E1). This deficiency results in a failure to communicate in a timely manner final diagnosis,	B 133	The Chief of Social Services will conduct an in-service training on 10/24/18 with all Inpatient Social Service staff (Attachment #03) to review the standards for discharge summaries as documented by the State Operations Manual (Attachment # 04). The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged charts weekly to ensure that the document is completed and filed in the chart within the standard of 14-days of discharge for all patients. The Chief of Social Services will use the Social Service Aftercare & Discharge Summary Review tool (Attachment # 05) do document discrepancies and provide necessary feedback to Social Service staff immediately. Social Services Staff will be required to make corrections to deficiencies before 14-day due date.	10/24/2018

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B 133	Continued From page 10 current medications, the course of treatment, summary of relevant labs and testing, anticipated problems and discharge plan with outpatient providers. Findings include: A. Record Review 1. D1's discharge summary (discharge dated 6/11/18 with discharge summary dated 6/29/11) was not completed within 14 days and was not signed by the physician. 2. D3's discharge summary (discharge dated 6/15/18 with discharge summary dated 7/2/18) was not completed within 14 days and was not signed by the physician. 3. D4's discharge summary (discharge dated 6/17/18 with discharge summary dated 7/2/18) was not completed within 14 days and was not signed by the physician. 4. N1 (discharged 11/2/17) had no discharge summary. 5. N2 (discharged 11/3/17) had no discharge summary. 6. E1 (death 11/2/17) had no discharge summary. B. Document Review An undated facility document titled "Discharge Summaries" stated, "Entire chart to be fully completed by 14 days from discharge." [Note: This document had no date.] C. Interview	B 133	Signature by a physician: A glitch in the current Askesis PsychConsult system does allow the Psychiatrist to co-sign the discharge document. The new Netsmart MyAvatar has the functionality to route the discharge summary to the Psychiatrist for co-signature upon completion. Kedren is scheduled to begin using the Netsmart MyAvatar system on 11/13/2018. 1. The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged charts weekly to ensure that the document is completed and filed in the chart within the standard of 14-days of discharge for all patients. 2. The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged charts weekly to ensure that the document is completed and filed in the chart within the standard of 14-days of discharge for all patients. 3. The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged charts weekly to ensure that the document is completed and filed in the chart within the standard of 14-days of discharge for all patients. 4. The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged charts weekly to ensure that the document is completed and filed in the chart within the standard of 14-days of discharge for all patients. 5. The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged charts weekly to ensure that the document is completed and filed in the chart within the standard of 14-days of discharge for all patients. 6. The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged charts weekly to ensure that the document is completed and filed in the chart within the standard of 14-days of discharge for all patients.	11/13/2018

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B 133	Continued From page 11 On 7/31/18 at 10:10 a.m., the Medical Director agreed that the discharge summaries were missing, late or not signed by the physician. He stated, "This should have been done."	B 133		
B 142	MEDICAL STAFF CFR(s): 482.62(b) The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services. This Standard is not met as evidenced by: Based on record review and staff interviews the facility failed to deploy psychiatrists to ensure psychiatric assessments were completed for two (2) of two (2) added patients (N1 and N2) admitted after hours. Specifically, the facility failed to provide 24-hour psychiatric coverage when the facility admits acutely and unstable mentally ill patients without a qualified psychiatrist assessment to provide appropriated psychotropic medications, observations and monitoring of patient's condition. This failure delays the treatment of acutely mentally ill patients with psychotropic medications and potentially dangerous behaviors without being properly medicated with antipsychotic or other psychiatric medications. Findings include: A. Record Review 1. Patient N1 was admitted on 11/2/17 at 3:30 p.m. for "Psychosis NOS and danger to self." The Root Cause Analysis (undated) stated, "Client was brought in by [spouse] to urgent care clinic for psychiatric evaluation due to increasingly	B 142	MEDICAL STAFF CFR(s): 482.62(b) POC: The Board of Directors has appointed a Medical Director Inpatient Psychiatry who will work with the Director of Quality Management to implement a monitoring tracking system to include tracers to track, trend and redirect Physicians on a daily basis to ensure that all the required diagnostic fields are completed and in addition the tracking will address timely completion of the Psychiatric Evaluations to ensure that patient care is expeditiously delivered. Delinquent deficiencies before they leave the hospital on that day. In addition data arrived from QAPI will be presented at the Medical Executive Committee Meeting and the committee will determine the necessity for Peer Review. An administrative discharge note has been placed on all three of the records of the patients involved in the sentinel event. Competently medical records would audit records on a daily basis for accuracy and completion and will notify the delinquent Physicians of their deficiencies. The Medial Director of Inpatient Services is responsible for the enforcement of these rules.	

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B 142	Continued From page 12 unpredictable behavior. Client stated hearing voices telling [him\her] to harm [himself/herself] and [spouse] reported client was found with a knife attempting to [self-mutilate his/her genitals]." There was no psychiatric assessment completed prior to patient taken by police for allegations of murder the evening of 11/2/17. There was not a progress note or discharge summary documenting the time of discharge to police. This failure delays the treatment of acute symptoms with psychotropic medication and assessment of patient condition by a qualified psychiatrist. 2. Patient N2 was admitted on 11/2/17 at 4:00 p.m. for Unspecified Mood Disorder and danger to self." The Root Cause Analysis (undated) stated "[S/he] expressed feeling depressed, felt like hurting [himself/herself] with plans to stab [himself/herself] with pencils." There was no psychiatric assessment completed prior to patient transferred to another facility on 11/3/17 at 2:30 p.m. This failure delays the treatment of acute symptoms with psychotropic medication and assessment of patient condition by a qualified psychiatrist. B. Document Review The CEO provided to the surveyors the Board of Directors Meeting minutes dated November 17, 2017. The minutes stated: "The Board suggested: there needs to be a psychiatrist present. Need to have someone there that can adjust the medication immediately." C. Staff Interview On 8/1/18 at 10:15 a.m., the Medical Director agreed the psychiatric assessments were not completed and that the facility does not have	B 142	To ensure that all patients are expeditiously seen and evaluated the hospital has engaged a physician and a psychiatric practitioner to admit and evaluate patients between 6:00 pm and 11:00 pm to support the physician providing admission coverage between 7:00 am and 6:00 pm. Any admissions arriving between 11:00 pm and 7:00 am admission orders to include 1:1 observation. Individual Responsible: Director of Psychiatry for Inpatient Services	

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B 142	Continued From page 13 psychiatrists on duty after hours.	B 142		
B 144	MEDICAL STAFF CFR(s): 482.62(b)(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff. This Standard is not met as evidenced by: Based on record review and interview, the Medical Director failed to: I. Ensure that: Psychiatric Evaluations: A. Included an estimation of patients' memory with supporting clinical evidence for six (6) of eight (8) active sample patients This deficiency compromises the database from which diagnoses are determined and from which changes in response to treatment interventions may be measured. (Refer to B110) II. Provide adequate treatment and monitoring for one (1) of three (3) discharged patients (N1) who subsequently assaulted and murdered his/her roommate (E1). In addition, the facility failed to ensure that an adequate root cause analysis and a prompt review by their Morbidity and Mortality Board of the circumstances surrounding this event were completed to implement corrective actions. Without taking appropriate and immediate actions to mitigate risks and prevent future recurrence of these unsafe practices, the health and safety of all newly admitted patients may be jeopardized. (Refer to B125) III. Ensure the discharge summaries are completed in a timely manner and signed by the physician within 14 days of discharge for three (3)	B 144	MEDICAL STAFF CFR(s): 482.62(b)(2): POC The Board of Directors has appointed a Medical Director Inpatient Psychiatry who will work with the Director of Quality Management to implement a monitoring tracking system to include tracers to track, trend and redirect Physicians on a daily basis to ensure that all the required diagnostic fields are completed and in addition the tracking will address timely completion of the Psychiatric Evaluations to ensure that patient care is expeditiously delivered. Delinquent deficiencies before they leave the hospital on that day. In addition data arrived from QAPI will be presented at the Medical Executive Committee Meeting and the committee will determine the necessity for Peer Review. An administrative discharge note has been placed on all three of the records of the patients involved in the sentinel event. Competently medical records would audit records on a daily basis for accuracy and completion and will notify the delinquent Physicians of their deficiencies. The Medial Director of Inpatient Services is responsible for the enforcement of these rules. To ensure that all patients are expeditiously seen and evaluated the hospital has engaged a physician and a psychiatric practitioner to admit	

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B 144	Continued From page 14 of five (5) discharged patients (D1, D3, and D4) and for (3) of (3) added patients to review summaries (N1, N2, and E1). This deficiency results in a failure to communicate in a timely manner final diagnosis, current medications, the course of treatment, a summary of relevant labs and testing, anticipated problems and discharge plan with outpatient providers. (Refer to B133) IV. Ensure adequate deployment of psychiatrists so that psychiatric assessments were completed for two (2) of two (2) added patients (N1 and N2) admitted after hours. Specifically, the facility failed to provide 24-hour psychiatric coverage when the facility admits acutely and unstable mentally ill patients without a qualified psychiatrist assessment to provide appropriated psychotropic medications, observations and monitoring of patient's condition. This failure delays the treatment of acutely mentally ill patients with psychotropic medications and potentially dangerous behaviors without being properly medicated with antipsychotic or other psychiatric medications. (Refer to B142)	B 144	and evaluate patients between 6:00 pm and 11:00 pm to support the physician providing admission coverage between 7:00 am and 6:00 pm. Any admissions arriving between 11:00 pm and 7:00 am admission orders to include 1:1 observation. Individual Responsible: Director of Psychiatry for Inpatient Services	
B 148	NURSING SERVICES CFR(s): 482.62(d)(1) The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. This Standard is not met as evidenced by: Based on document review and interview, the Director of Nursing failed to ensure that Patient N1 was monitored according to policy and that monitoring documents were consistent with the policy. This deficiency resulted in the patient	B 148		

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B 148	Continued From page 15 being monitored inappropriately and potentially compromising his/her safety. (Refer to B125)	B 148		
B 152	SOCIAL SERVICES CFR(s): 482.62(f) There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. This Standard is not met as evidenced by: The Director of Social Work failed to ensure the quality and appropriateness of services provided by the social work staff. Specifically, the Director failed to assure that the Psychosocial Assessments included the anticipated social work roles in treatment for eight (8) of eight (8) (1, 2, 3, 4, 5, 6, 7, and 8) active sample patients. This failure results in a lack of professional social work information in treatment planning. (Refer to B108)	B 152	Chief of Social Services will conduct an in-service 11/13/2018 training on 10/24/2018 with all Inpatient Social Service staff (Attachment # 03) to review the Standards clearly defined by the State Operations Manual (Attachment # 04). Chief of Social Services will train Social Workers on where on their current Askesis PsychConsult Biopsychosocial Assessment document (Attachment # 02) they will include specific information related to home plans, family attitudes, community resource contacts and social history. Chief of Social Services will also review and train the Social Workers on the new Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) that will be launched on 11/13/2018 and which clearly identifies the specific areas that Social Service will capture the standard information that we are required to have (home plans, family attitudes, community resource contacts & social history).	