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	054055	A. BUILDING _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 000	INITIAL COMMENTS	A 000		

AMENDED 2567 2.14.2025

The following reflects the findings of the California Department of Public Health during a Complaint Validation survey, authorized by the Center for Medicare and Medicaid Services, conducted on January 21, 2025 through January 24. 2025.

Complaint Validation Intake Number:
CA00931732

Patient Census: 182
Sample Size: 30

The following Conditions of Participation (CoPs) were investigated:
482.13 Patient Rights

The inspection was limited to the specific Conditions of Participation investigated and does not represent the finding of a full inspection of the facility.

The facility was found not to be in compliance with the following Condition of Participation:
482.13 Patient Rights

A 115 PATIENT RIGHTS — A 115
CFR(s): 482.13

A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the Condition of Participation for Patient Rights was met as

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President (CEO) — (X6) DATE: 2/25/2025

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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A 115	Continued From page 1 evidenced by: 1. The facility failed to provide information about conditions of admission (COA, legal agreement between the patient and the hospital consenting to treatment, assignment of insurance benefits and accepting financial responsibility for their medical service) to the legal guardian for five of 30 sampled patients (Patients 2, 3, 10, 11 and 14), who were identified as a minor (children under age of 18) upon admission, in accordance with the facility's policy and procedure regarding admitting procedures. This deficient practice resulted in the legal guardians for Patients 2, 3, 10, 11 and 14 not receiving information regarding conditions of admission, and not knowing their patient rights including arbitration (a procedure in which a dispute is submitted), billing, release of information, and financial responsibilities during hospitalization which may negatively affect the patients' involvement in their care and treatment. (Refer to A-0117). 2. The facility failed to inform family members of the use of restraints (chemical restraints, a medication that is not being used as a standard treatment for the patient's medical or psychiatric condition and that results in restriction of the patient's freedom of moment) for one of 30 sampled patients (Patient 18), in accordance with the facility's policy and procedure regarding restraints use. This deficient practice resulted in family members not being informed of the treatment provided at the facility including understanding the risks and benefits of the treatment (use of chemical	A 115		

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restraint on Patient 18) and being able to help make informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered). (Refer to A-0131)

3. The facility failed to ensure the medication informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was completed prior to medication administration for one of 30 sampled patients (Patient 10), in accordance with the facility's policy and procedure regarding medication consent, when the consent for prescribed Melatonin (medication that helps to regulate sleep and other bodily function) was missing the psychiatrist (physician who specializes in mental health) information.

This deficient practice resulted in Patient 10 receiving Melatonin without a complete consent. It also had the potential to result in Patient 10's parent not being fully informed of the risks and benefits, of Patient 10 taking Melatonin, before giving consent for the treatment. (Refer to A-0131)

4. The facility failed to ensure its nursing staff obtained a complete seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving)/restraint (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body) order for seclusion/ restraint use for each of three of 30 sampled patients (Patient 10, 14 and 15), in accordance with facility's policy and

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procedure regarding seclusion and restraints when:

4.a. Patient 10 was placed in seclusion without a seclusion order for three hours and five minutes and was placed on 5-point restraints (restraints applied to patient's bilateral wrists, ankles, and chest) without a renewal order for one hour and five minutes on 6/15/2024.

4.b. Patient 14 was placed in seclusion and restrained for three hours and fifty minutes without a physician order on 3/5/2024.

4.c. Nursing staff initiated seclusion for Patient 15 without a physician order on 4/19/2024 at 5:45 p.m. and the renewal seclusion/restraint order was also incomplete on 4/20/2024 at 1:45 a.m.

These deficient practices resulted in Patients 10, 14 and 15 being placed in seclusion and restrained without a proper physician order, which had the potential of placing the patients (Patients 10, 14 and 15) at risk for unnecessary and inappropriate seclusion/restraint use and at risk for injury. (Refer to A-0168)

5. The facility failed to ensure physician orders included the indication for restraints (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body) use for one of 30 sampled patients (Patient 16), in accordance with the facility's policy regarding restraints use.

This deficient practice had the potential for restraints to be applied unnecessarily, thus putting Patient 16 at risk for injury. (Refer to

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A 115	Continued From page 4 A-0168)	A 115		

6. The facility failed to ensure its nursing staff assessed and monitored three of 30 sampled patients (Patient 11, 13, and 16) for behavior, circulation (flow of fluid, blood in the body), sensation (seeing, hearing, or smelling), movement, or were offered range of motion (movement of a joint), toileting, fluids, food, or hygiene, while placed on restraints (a device attached to the patient's body that restricts freedom of movement), in accordance with the facility's policy and procedures regarding seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and restraints (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body), when the assigned Registered Nurse for each respective patient:

6.a. did not perform hourly assessment for Patient 11, who was placed in walking restraints (restraint applied to patient's ankles to prevent patient from AWOL [absent without official leave, leaving the hospital without discharge order from physician]), on 2/13/2024 from 4:30 p.m. to 10:55 p.m. (10 hours 25 mins).

6.b. did not perform hourly assessment for Patient 13, who was placed in walking restraints on 2/28/2024, from 12:15 a.m. to 8:49 a.m. (8 hours 34 mins).

6.c. did not perform assessment for Patient 16, who was placed in ankle restraints, from 9:30 a.m. to 2:45 p.m., on 1/21/2025 (5 hours and 15 minutes).

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These deficient practices had the potential for the inability of staff to identify complications of restraints use for Patients 11, 13 and 16, and placed the patients (Patients 11, 13, and 16) at risk for injury such as loss of circulation or sensation to limbs, skin breakdown, and needs including hydration, toileting and hygiene not being met as needed. (Refer to A-0175)

7. The facility failed to ensure two of two sampled Qualified Registered Nurse (QRN, trained Registered Nurse) completed the face-to-face assessment (an in person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body], within one hour of initiation to evaluate patient's medical condition and response to intervention) within an hour after the initiation of seclusion/restraint for two of 30 sampled patients (Patients 1 and 13), in accordance with the facility's policy and procedure regarding seclusion and restraint when:

7.a. The QRN (QRN 3) did not take vital signs (measurements of the body's most basic function including body temperature, heart rate, blood pressure, respirations and pain level) during the face-to-face assessment of Patient 1 on 5/13/2023.

This deficient practice had the potential for QRN

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not accurately identifying Patient 1's response to the treatment (chemical restraint, a medication that is not being used as a standard treatment for the patient's medical or psychiatric condition and that results in restriction of the patient's freedom of moment) and put Patient 1 at risk for respiratory distress (difficulty breathing) and/or other complications. (Refer to A-0179)

7.b. The QRN did not perform face-to-face assessment for Patient 13 when Patient 13 was placed in walking restraint (restraint applied to patient's ankles to prevent patient from AWOL [absent without official leave, leaving the hospital without discharge order from physician]) on 2/28/2024.

This deficient practice had the potential for Patient 13 not being properly assessed if the restraint (walking restraint/ankle restraint) was applied appropriately or if there is a need for the restraint use, which may put Patient 13 at risk for injury such as skin breakdown, compromised circulation (the flow of blood in the body), etc. (Refer to A-0179)

8. The facility failed to ensure two of two qualified Registered Nurses (QRN, trained Registered Nurse- QRN 2 and QRN 5) communicated with/notified the physician after face-to-face assessment (an in person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access

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any part of his/her body] within one hour of initiation to evaluation patient's medical condition and response to intervention) was completed for two of 30 sampled patients (Patients 14 and 15), in accordance with the facility's policy and procedure regarding seclusion and restraint.

This deficient practice had the potential to put Patients 14 and 15 at risk for unnecessary seclusion and restraint as well as delay of care when the physicians are not informed by the QRN regarding the outcome of the face-to-face evaluation of Patients 14 and Patient 15's appropriateness for seclusion/restraint and need for other treatment or intervention. (Refer to A-0182)

9. The facility failed to ensure one of three sampled Qualified Registered Nurses (QRN 3) was currently certified to perform face-to face-evaluations (determines if use of restraints is justified to prevent the patient from causing harm to self or others) for patients who were placed on restraints (a device attached to the patient's body that restricts freedom of movement), in accordance with the facility's "Seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and Restraint Physical Hold Policy," and the policy and procedure regarding "Qualified Registered Nurse Training for Seclusion & Restraint."

This deficient practice had the potential for inaccurate face-to-face evaluations performed, which may result in harm committed by patients to themselves or to others. (Refer to A-0208)

The cumulative effect of these deficient practices

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A 115	Continued From page 8 resulted in the facility's inability to provide quality healthcare in a safe environment.	A 115		
A 117	PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide information about conditions of admission (COA, legal agreement between the patient and the hospital consenting to treatment, assignment of insurance benefits and accepting financial responsibility for their medical service) to the legal guardian for five of 30 sampled patients (Patients 2, 3, 10, 11 and 14), who were identified as a minor (children under age of 18) upon admission, in accordance with the facility's policy and procedure regarding admitting procedures. This deficient practice resulted in the legal guardians for Patients 2, 3, 10, 11 and 14 not receiving information regarding conditions of admission, and not knowing their patient rights including arbitration (a procedure in which a dispute is submitted), billing, release of information, and financial responsibilities during hospitalization which may negatively affect the patients' involvement in their care and treatment. Findings: 1. During a review of Patient 2's "Psychiatric and Mental Status Examination (Psych Eval, a formal	A 117		

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and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 12/10/2024, the Psych Eval indicated, Patient 2, a 15-year-old, was admitted to the facility on a 5585-hold (allows a minor experiencing a mental health crisis to be involuntary detained for a 72-hour psychiatric [a branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotion, and behavioral disorders] evaluation and treatment) with diagnoses including but not limited to bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration), depressed (mood disorder that causes a persistent feeling of sadness and loss of interest in life), severe with psychotic (a severe mental disorder with hallucinations [an experience involving the apparent perception of something not present]) features.

During a review of Patient 2's "Integrated Admission Assessment (patient data collected by the facility upon admission)," dated 12/10/2024, the "Integrated Admission Assessment" indicated, Patient 2 was under Department of Child, Family and Adult Services (DCFS, service and system that protects children from abuse and neglect, and provides services to children and families in need) custody (the legal right of care for and control a person or property).

During an interview on 1/23/2025 at 2:13 p.m. with the Admitting Representative (AR), AR stated the following: the conditions of admission (COA, legal agreement between the patient and the hospital consenting to treatment, assignment of insurance benefits and accepting financial responsibility for their medical service) forms consisted of information including consent for

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treatment and patient's financial responsibilities. The COA forms were given to patient to sign upon admission. If a patient was below 18 years old, the legal guardian or parent would be the one signing the COA forms. If the legal guardian or parent were not available upon admission, admitting staff would present the COA forms to the legal guardian or parent at discharge. It was important to provide the COA forms so the signer would know the rights (Patient Rights) and allow him or her to ask questions.

During an interview on 1/24/2025 at 8:53 a.m. with the Patient Admitting Supervisor (PAS), PAS stated the following: the COA forms talked about arbitration (a procedure in which a dispute is submitted), consent to treat, billing insurance and physician relationship with the hospital. The COA forms were given upon admission to the patient or the legal guardian if patient was a minor. If the COA forms were not signed upon admission, the admitting staff would obtain the signatures from the legal guardian upon discharge when the legal guardian or parent picked up the patient. Currently there was no process in place to make any attempts to deliver the COA information or obtain signature by admitting department during patient's stay. PAS stated, "that is something we can work on."

During a concurrent interview and record review on 1/24/2025 at 11 a.m. with the Nurse Manager (NM 4) of Developmental Delay/ Disable and Mentally Ill Services (DDMI, hospital wing services patients with development disabilities, autism spectrum disorders [ASD, a developmental disability caused by differences in the brain] and mental health issues), Patient 2's "Conditions of Admission (COA)" forms, dated

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12/9/2024, was reviewed. The COA forms indicated, "General Admission Consent to Care ... Legal Relationship Between Hospital and Physician ... Release of Information ... Financial Agreement ... Assignment of Insurance Benefits ... Third Party Liability and Billing ... Personal Valuables ... Consent to Photograph ... Discharge ... Arbitration ... the undersigned certifies that he/she has read the foregoing conditions of admission, received a copy thereof, clarified any doubts as to its meaning and accepts its terms, and is the patient, the patients legal representatives, or duly authorized by the patient as the patient's general; agent to execute the conditions of admissions." The COA forms also indicated, "Parent unavailable" under the signature of patient/guardian/conservator section. NM 4 stated Patient 2 was under the custody of DCFS and the facility should have contacted DCFS and gave DCFS the COA forms for signature.

During a review of the facility's policy and procedure (P&P) titled, "Patient Admitting Checklist of Legal Documentation," dated 11/2023, the P&P indicated, "All patient admitting representatives are to ensure that any patient admitting to [the facility] receives and/ or signs for receipt of all legal documentation ... Upon admission, the following items must be given to the patient and/ or signature must be obtained: Conditions of Admission: This document outlines [the facility] general consent to care; legal relationship between hospital and physician; release of information; financial agreement; assignment of insurance benefits; third party liability and billing; personal valuables; consent to photograph; and discharge ... Adolescent or Adult Checklist: with every admission a checklist is

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generated to ensure that all of the above mentioned forms or handouts are properly delivered to a patient. The patient or parent acknowledge receipt of these items of signing the checklist. The patient admitting representative is required witnessing the patient's or parent's signature ... if minor patient arrives without parent/legal guardian, unit is to contact the Admitting Department when the parent/legal guardian is visiting or is picking patient up upon discharge."

2. During a review of Patient 3's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 5/2/2024, Patient 3, a 16-year-old, was admitted to the facility on a 5585-hold (allows a minor experiencing a mental health crisis to be involuntary detained for a 72-hour psychiatric [a branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotion, and behavioral disorders] evaluation and treatment) with diagnoses including but not limited to bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration), depressed (mood disorder that causes a persistent feeling of sadness and loss of interest in life), severe with psychotic (a severe mental disorder with hallucinations [an experience involving the apparent perception of something not present]) features.

During a review of Patient 3's "face sheet (face sheet, document provides patient's demographic data including name, date of birth, emergency contact, admitting diagnosis and health insurance)," dated 5/1/2024, the face sheet

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indicated, Patient 3 had a guardian with a listed phone number."

During a review of Patient 3's "Conditions of Admission (COA, legal agreement between the patient and the hospital consenting to treatment, assignment of insurance benefits and accepting financial responsibility for their medical service)," dated 5/1/2024, the COA forms indicated, "General Admission Consent to Care ... Legal Relationship Between Hospital and Physician ... Release of Information ... Financial Agreement ... Assignment of Insurance Benefits ... Third Party Liability and Billing ... Personal Valuables ... Consent to Photograph ... Discharge ... Arbitration ... the undersigned certifies that he/she has read the foregoing conditions of admission, received a copy thereof, clarified any doubts as to its meaning and accepts its terms, and is the patient, the patients legal representatives, or duly authorized by the patient as the patient's general; agent to execute the conditions of admissions." The COA forms also indicated, "Guardian unavailable" under the signature of patient/guardian/conservator section.

During an interview on 1/23/2025 at 2:13 p.m. with the Admitting Representative (AR), AR stated the following: the conditions of admission (COA) forms consisted of information including consent for treatment and patient's financial responsibilities. The COA forms were given to patient to sign upon admission. If a patient was below 18 years old, the legal guardian or parent would be the one signing the COA forms. If the legal guardian or parent were not available upon admission, admitting staff would present the COA forms to the legal guardian or parent at discharge. It was important to provide the COA

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forms so the signer would know the Patient rights and allow him or her to ask questions.

During an interview on 1/24/2025 at 8:53 a.m. with the Patient Admitting Supervisor (PAS), PAS stated the following: the COA forms talked about arbitration, consent to treat, billing insurance and physician relationship with the hospital. The COA forms were given upon admission to the patient or the legal guardian if patient was a minor. If the COA forms were not signed upon admission, the admitting staff would obtain the signatures from the legal guardian upon discharge when the legal guardian or parent picked up the patient. Currently there was no process in place to make any attempts to deliver the COA information or obtain signature by admitting department during patient's stay. PAS stated, "that is something we can work on."

During a review of the facility's policy and procedure (P&P) titled, "Patient Admitting Checklist of Legal Documentation," dated 11/2023, the P&P indicated, "All patient admitting representatives are to ensure that any patient admitting to [the facility] receives and/ or signs for receipt of all legal documentation ... Upon admission, the following items must be given to the patient and/ or signature must be obtained: Conditions of Admission: This document outlines [the facility] general consent to care; legal relationship between hospital and physician; release of information; financial agreement; assignment of insurance benefits; third party liability and billing; personal valuables; consent to photograph; and discharge ... Adolescent or Adult Checklist: with every admission a checklist is generated to ensure that all of the above mentioned forms or handouts are properly

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delivered to a patient. The patient or parent acknowledge receipt of these items of signing the checklist. The patient admitting representative is required witnessing the patient's or parent's signature ... if minor patient arrives without parent/legal guardian, unit is to contact the Admitting Department when the parent/legal guardian is visiting or is picking patient up upon discharge."

3. During a review of Patient 10's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 2/24/2024, the Psych Eval indicated, Patient 10, a 14-year-old, was admitted to the facility with diagnosis of disruptive mood dysregulation disorder (a mental health condition characterized by persistent irritability, anger, and frequent intense temper outbursts).

During a review of Patient 10's "face sheet (face sheet, document provides patient's demographic data including name, date of birth, emergency contact, admitting diagnosis and health insurance)," dated 2/24/2024, the face sheet indicated, Patient 10's parent was listed as the emergency contact with phone number.

During an interview on 1/23/2025 at 2:13 p.m. with the Admitting Representative (AR), AR stated the following: the conditions of admission (COA, legal agreement between the patient and the hospital consenting to treatment, assignment of insurance benefits and accepting financial responsibility for their medical service) forms consisted of information including consent for treatment and patient's financial responsibilities.

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The COA forms were given to patient to sign upon admission. If a patient was below 18 years old, the legal guardian or parent would be the one signing the COA forms. If the legal guardian or parent were not available upon admission, admitting staff would present the COA forms to the legal guardian or parent at discharge. It was important to provide the COA forms so the signer would know the Patient rights and allow him or her to ask questions.

During an interview on 1/24/2025 at 8:53 a.m. with the Patient Admitting Supervisor (PAS), PAS stated the following: the COA forms talked about arbitration, consent to treat, billing insurance and physician relationship with the hospital. The COA forms were given upon admission to the patient or the legal guardian if patient was a minor. If the COA forms were not signed upon admission, the admitting staff would obtain the signatures from the legal guardian upon discharge when the legal guardian or parent picked up the patient. Currently there was no process in place to make any attempts to deliver the COA information or obtain signature by admitting department during patient's stay. PAS stated, "that is something we can work on."

During a concurrent interview and record review on 1/24/2025 at 1:46 p.m. with the Nurse Manager (NM 3), Patient 10's "Conditions of admission (COA)" forms, dated 2/24/2024, was reviewed. The COA forms indicated, "General Admission Consent to Care ... Legal Relationship Between Hospital and Physician ... Release of Information ... Financial Agreement ... Assignment of Insurance Benefits ... Third Party Liability and Billing ... Personal Valuables ... Consent to Photograph ... Discharge ...

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A 117	Continued From page 17 Arbitration ... the undersigned certifies that he/she has read the foregoing conditions of admission, received a copy thereof, clarified any doubts as to its meaning and accepts its terms, and is the patient, the patients legal representatives, or duly authorized by the patient as the patient's general; agent to execute the conditions of admissions." The COA forms also indicated, "Parent unavailable" under the signature of patient/guardian/conservator section. NM 3 stated there was no signature from Patient 10's parent upon admission and discharge on the COA forms. During a review of the facility's policy and procedure (P&P) titled, "Patient Admitting Checklist of Legal Documentation," dated 11/2023, the P&P indicated, "All patient admitting representatives are to ensure that any patient admitting to [the facility] receives and/ or signs for receipt of all legal documentation ... Upon admission, the following items must be given to the patient and/ or signature must be obtained: Conditions of Admission: This document outlines [the facility] general consent to care; legal relationship between hospital and physician; release of information; financial agreement; assignment of insurance benefits; third party liability and billing; personal valuables; consent to photograph; and discharge ... Adolescent or Adult Checklist: with every admission a checklist is generated to ensure that all of the above mentioned forms or handouts are properly delivered to a patient. The patient or parent acknowledge receipt of these items of signing the checklist. The patient admitting representative is required witnessing the patient's or parent's signature ... if minor patient arrives without parent/legal guardian, unit is to contact the	A 117		

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Admitting Department when the parent/legal guardian is visiting or is picking patient up upon discharge."

4. During a review of Patient 11's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 1/22/2024, Patient 11, a 16-year-old, was admitted to the facility with diagnoses including but not limited to major depression (MDD - a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) with psychotic features (delusions and hallucinations), anxiety disorder (a group of mental disorders characterized by significant feelings of fear) and autistic spectrum disorders (a developmental disability caused by differences in the brain).

During a review of Patient 11's "Integrated Admission Assessment (patient data collected by the facility upon admission)," dated 1/23/2024, the Integrated Admission Assessment indicated, Patient 11's parent was the custodial (the legal right of care for and control a person or property) parent.

During an interview on 1/23/2025 at 2:13 p.m. with the Admitting Representative (AR), AR stated the following: the conditions of admission (COA, legal agreement between the patient and the hospital consenting to treatment, assignment of insurance benefits and accepting financial responsibility for their medical service) forms consisted of information including consent for treatment and patient's financial responsibilities. The COA forms were given to patient to sign

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upon admission. If a patient was below 18 years old, the legal guardian or parent would be the one signing the COA forms. If the legal guardian or parent were not available upon admission, admitting staff would present the COA forms to the legal guardian or parent at discharge. It was important to provide the COA forms so the signer would know the rights and allow he or she to ask questions.

During a concurrent interview and record review on 1/23/2025 at 2:18 p.m. with the Admitting Representative (AR), Patient 11's "Conditions of Admission (COA)" forms, dated 1/22/2024, was reviewed. The COA forms indicated, "General Admission Consent to Care ... Legal Relationship Between Hospital and Physician ... Release of Information ... Financial Agreement ... Assignment of Insurance Benefits ... Third Party Liability and Billing ... Personal Valuables ... Consent to Photograph ... Discharge ... Arbitration ... the undersigned certifies that he/she has read the foregoing conditions of admission, received a copy thereof, clarified any doubts as to its meaning and accepts its terms, and is the patient, the patients legal representatives, or duly authorized by the patient as the patient's general; agent to execute the conditions of admissions." The COA forms also indicated, "Parent unavailable" under the signature of patient/guardian/conservator section.
AR stated Patient 11's parent was not available upon admission to sign the COA forms. AR also stated there was no attempt documented in obtaining Patient 11's parent signature during hospitalization and upon discharge.

During an interview on 1/24/2025 at 8:53 a.m. with the Patient Admitting Supervisor (PAS), PAS

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stated the following: the COA forms talked about arbitration, consent to treat, billing insurance and physician relationship with the hospital. The COA forms were given upon admission to the patient or the legal guardian if patient was a minor. If the COA forms were not signed upon admission, the admitting staff would obtain the signatures from the legal guardian upon discharge when the legal guardian or parent picked up the patient. Currently there was no process in place to make any attempts to deliver the COA information or obtain signature by admitting department during patient's stay. PAS stated, "that is something we can work on."

During a review of the facility's policy and procedure (P&P) titled, "Patient Admitting Checklist of Legal Documentation," dated 11/2023, the P&P indicated, "All patient admitting representatives are to ensure that any patient admitting to [the facility] receives and/ or signs for receipt of all legal documentation ... Upon admission, the following items must be given to the patient and/ or signature must be obtained: Conditions of Admission: This document outlines [the facility] general consent to care; legal relationship between hospital and physician; release of information; financial agreement; assignment of insurance benefits; third party liability and billing; personal valuables; consent to photograph; and discharge ... Adolescent or Adult Checklist: with every admission a checklist is generated to ensure that all of the above mentioned forms or handouts are properly delivered to a patient. The patient or parent acknowledge receipt of these items of signing the checklist. The patient admitting representative is required witnessing the patient's or parent's signature ... if minor patient arrives without

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parent/legal guardian, unit is to contact the Admitting Department when the parent/legal guardian is visiting or is picking patient up upon discharge."

5. During a review of Patient 14's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 3/3/2024, the Psych Eval indicated, Patient 14, a 17-year-old, was admitted to the facility with diagnosis of psychosis (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality).

During a review of Patient 14's "Integrated Admission Assessment (patient data collected by the facility upon admission)," dated 3/5/2024, the Integrated Admission Assessment indicated, Patient 14's parent was the custodial parent with full custody (the legal right of care for and control a person or property).

During an interview on 1/23/2025 at 2:13 p.m. with the Admitting Representative (AR), AR stated the following: the conditions of admission (COA, legal agreement between the patient and the hospital consenting to treatment, assignment of insurance benefits and accepting financial responsibility for their medical service) forms consisted of information including consent for treatment and patient's financial responsibilities. The COA forms were given to patient to sign upon admission. If a patient was below 18 years old, the legal guardian or parent would be the one signing the COA forms. If the legal guardian or parent were not available upon admission, admitting staff would present the COA forms to

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the legal guardian or parent at discharge. It was important to provide the COA forms so the signer would know the rights and allow he or she to ask questions.

During an interview on 1/24/2025 at 8:53 a.m. with the Patient Admitting Supervisor (PAS), PAS stated the following: the COA forms talked about arbitration, consent to treat, billing insurance and physician relationship with the hospital. The COA forms were given upon admission to the patient or the legal guardian if patient was a minor. If the COA forms were not signed upon admission, the admitting staff would obtain the signatures from the legal guardian upon discharge when the legal guardian or parent picked up the patient. Currently there was no process in place to make any attempts to deliver the COA information or obtain signature by admitting department during patient's stay. PAS stated, "that is something we can work on."

During a concurrent interview and record review on 1/24/2025 at 9:10 a.m. with the Patient Admitting supervisor (PAS), Patient 14's "Conditions of Admission (COA)" forms, dated 3/2/2024, was reviewed. The COA forms indicated, "General Admission Consent to Care ... Legal Relationship Between Hospital and Physician ... Release of Information ... Financial Agreement ... Assignment of Insurance Benefits ... Third Party Liability and Billing ... Personal Valuables ... Consent to Photograph ... Discharge ... Arbitration ... the undersigned certifies that he/she has read the foregoing conditions of admission, received a copy thereof, clarified any doubts as to its meaning and accepts its terms, and is the patient, the patients legal representatives, or duly authorized by the patient

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as the patient's general; agent to execute the conditions of admissions." The COA forms also indicated, "Parent unavailable" under the signature of patient/guardian/conservator section.

During the same interview on 1/24/2025 at 9:10 a.m. with the Patient Admitting Supervisor (PAS), PAS stated there was no signature obtained from Patient 14's parent upon admission and discharge. PAS also stated there was no attempt made to deliver the information and obtain the signature when Patient 14 was hospitalized.

During a review of the facility's policy and procedure (P&P) titled, "Patient Admitting Checklist of Legal Documentation," dated 11/2023, the P&P indicated, "All patient admitting representatives are to ensure that any patient admitting to [the facility] receives and/ or signs for receipt of all legal documentation ... Upon admission, the following items must be given to the patient and/ or signature must be obtained: Conditions of Admission: This document outlines [the facility] general consent to care; legal relationship between hospital and physician; release of information; financial agreement; assignment of insurance benefits; third party liability and billing; personal valuables; consent to photograph; and discharge ... Adolescent or Adult Checklist: with every admission a checklist is generated to ensure that all of the above mentioned forms or handouts are properly delivered to a patient. The patient or parent acknowledge receipt of these items of signing the checklist. The patient admitting representative is required witnessing the patient's or parent's signature ... if minor patient arrives without parent/legal guardian, unit is to contact the Admitting Department when the parent/legal

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A 117	Continued From page 24 guardian is visiting or is picking patient up upon discharge."	A 117		
A 131	PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Inform family members of the use of restraints (chemical restraints, a medication that is not being used as a standard treatment for the patient's medical or psychiatric condition and that results in restriction of the patient's freedom of moment) for one of 30 sampled patients (Patient 18), in accordance with the facility's policy and procedure regarding restraints. This deficient practice resulted in family members not being informed of the treatment provided at the facility including understanding the risks and benefits of the treatment (use of chemical restraint on Patient 18) and being able to help make informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits,	A 131		

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and alternatives offered).

2. Ensure the medication informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was completed prior to medication administration for one of 30 sampled patients (Patient 10), in accordance with the facility's policy and procedure regarding medication consent, when the consent for prescribed Melatonin (medication that helps to regulate sleep and other bodily function) was missing the psychiatrist (physician who specializes in mental health) information.

This deficient practice resulted in Patient 10 receiving Melatonin without a complete consent. It also had the potential to result in Patient 10's parent not being fully informed of the risks and benefits, of Patient 10 taking Melatonin, before giving consent for the treatment.

Findings:

1. During a concurrent interview and record review on 1/22/2025 at 9:38 a.m., with Nurse Managers (NM) 3 and 4. NM 3 and NM 4 stated the following: Patient 18 was admitted on 1/8/2024 on a 5150 hold (72-hour involuntary hold at a psychiatric [focuses on the diagnosis, treatment, and prevention of mental health disorders] facility for someone experiencing a mental health crisis) for being a danger to others. Patient 18 requested that his (Patient 18) mother be notified if Patient 18 was placed on restraints or seclusion (involuntary confinement of patient alone in a room or area from which the patient is physically prevented from leaving). Restraints, included chemical restraints (a medication that is

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not being used as a standard treatment for the patient's medical or psychiatric condition and that results in restriction of the patient's freedom of moment) or emergency medications. Patient 18 was given Thorazine (treats behavior disorders, reduces anxiety [excessive and persistent worry]) 50 milligrams (mg, a unit of measurement) IM (in the muscle) for agitation (a feeling of irritability or restlessness), paranoia (persistent and irrational feelings of suspicion, mistrust, and persecution), and provoking peers on 1/19/2024 at 1:40 p.m. NM 3 and NM 4 stated that Patient 18's mother had not been notified of the chemical restraint (Thorazine medication), despite Patient 18's request to inform Patient 18's mother.

During a review of Patient 18's "Integrated Admission Assessment," dated 1/08/2024, the assessment indicated Patient 18 wished for the facility to contact his (Patient 18) mother if the facility required the use of seclusion or restraints for Patient 18.

During a review of Patient 18's "Psychiatric and Mental Status Examination," dated 4/16/2024, the Examination indicated the following: Patient 18 was admitted on 1/08/2024. According to the report, Patient 18 was running into traffic, stranger attempted to save him (Patient 18) from getting hurt. Patient 18 ended up fighting the individual ...subsequently placed on a 5150 hold. "Transferred to this facility for stabilization of behavior."

During a review of Patient 18's physician's order dated 1/19/2024 at 1:37 p.m., the order indicated to give chlorpromazine (Thorazine, treats behavior disorders, reduces anxiety) 50 mg IM (in the muscle), once for psychosis (a mental

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disorder characterized by a disconnection from reality).

During a review of Patient 18's flow sheet (a tool that clinicians use to document patient care) titled, "6793 Emergency Use of Medications Assessment Flowsheet," dated 1/19/2024 at 1:40 p.m., the flow sheet indicated the results of Patient 18's physical assessment, fall (an unintentional event that results in a person coming to rest on the ground or another lower level) risk, vital signs (blood pressure, pulse, respiratory rate and temperature) and mental status exam after the intervention (administration of Thorazine) dated 1/19/2024 at 1:40 p.m. The flow sheet did not include notification of Patient 18's mother on the use of a chemical restraint.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated the following: Registered Nurse (RN)/designee notifies the patient's legal guardian/parent, as applicable, as soon as possible and documents the notification in the patient's chart.

During a review of the facility's policy and procedure (P&P) titled, "Patient's Rights/Philosophy," dated 10/2023, the P&P indicated the following: "Each patient shall receive a reasonable response to his/her request for treatment and /or services within the hospital's capacity, stated mission, and applicable law and regulations. The basic patient's rights for voluntary and involuntary patients are as follows ...Patient, conservator, parent, and/or anyone designated by the patient shall be informed of the following as appropriate ...b. The plan of

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treatment while in the hospital and the staff providing care; c. The risk and side effects of medication and treatment procedures and any alternatives ..."

2. During a review of Patient 10's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician who specializes in mental health])," dated 2/24/2024, the Psych Eval indicated, Patient 10, a 14-year-old, was admitted to the facility with diagnosis of disruptive mood dysregulation disorder (a mental health condition characterized by persistent irritability, anger, and frequent intense temper outbursts).

During a concurrent interview and record review on 1/24/2025 at 2:42 p.m. with the Nurse Manager (NM 1), Patient 10's "General Medication Consent (medication consent form, a consent form indicating a psychiatrist had discussed the risk and benefits of the medications being prescribed and the patient or patient's legal representative gave consent to take the medication)," dated 3/2/2024, was reviewed. The medication consent form indicated, Melatonin (medication that helps to regulate sleep and other bodily function) was listed on the consent form with verbal consent given by Patient 10's parent and witnessed by Registered Nurse (RN) 3. The medication consent form also indicated, "Psychiatrist Signature" section that required the name of the psychiatrist, date and time of signature, were left blank.

During the same interview on 1/24/2025 at 2:42 p.m. with Nurse Manager (NM) 1, NM 1 stated the following: Melatonin had hypnotic (produce

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drowsiness) effect and would require consent from Patient 10's parent when it was prescribed to be taken daily. It was the psychiatrist's responsibility to discuss the risks and benefits, dosage, alternatives of treatment and answer all questions when obtaining the medication consent. Without the psychiatrist's name and signature, it was unknown of who had discussed the Melatonin use with Patient 10's parent to make sure Patient 10's parent was fully informed of the medication's purpose, risk and benefits, and side effects before giving the consent. NM 1 also said that RN 3 should not sign as a witness the medication consent because it was incomplete. NM 1 further stated Melatonin should not be given to Patient 10 without a complete consent.

During a review of Patient 10's "Order Chronology (list of physician order [orders written by physicians to direct care and treatment])," dated from 4/9/2024 to 5/7/2024, the "Order Chronology" indicated, Melatonin 3 milligrams (mg, a unit of measure) orally to start on 4/9/2024 and stop on 5/7/2024. The "Order Chronology" also indicated Patient 10 received Melatonin 3 mg daily from 4/9/2024 to 5/7/2024.

During a review of the facility's policy and procedure (P&P) titled, "Consent Procedures for Medications," dated 11/2023, the P&P indicated, "To ensure that all patients (voluntary and involuntary) are fully informed regarding the risks, side effects, and benefits of certain psychotropic (medications that affect a person's mental state, emotions, and behavior) medications and their rights to refuse medication ... if the patient is a minor, the parent or legal guardian will be informed prior to administration and asked to sign

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A 131	Continued From page 30 the consent form ... Patient (guardian, conservator) consent is required for medications prescribed to affect the central nervous system (CNS, the primary control center of the body, consisting of the brain and spinal cord) to treat psychiatric disorders (medical condition that significantly affects a person's thinking, mood and behavior) or illness including, but not limited to anti-depressants (medications helps to relieve symptoms of depression [mood disorder that causes a persistent feeling of sadness and loss of interest in life] and anxiety [a group of mental disorders characterized by significant feelings of fear]), mood stabilizing (medications to regulate mood, reducing mood swings and stabilizing emotions) and antipsychotics (medications to treat mental health conditions) ... the physician will explain to the patient, parent or legal guardian: nature of the patient's mental condition; reason for taking such medication ... the type of medication, range of frequency of administration and dosage amount ...probable side effects of the medication ... a licensed nursing staff member will witness, as appropriate, the signature of the patient, parent, or legal guardian. This applies to situations where the consent is obtained over the phone ... medication will not be ordered if the consent form has not been completed."	A 131		
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) §§482.13(e)(5) - The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law.	A 168		

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This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to:

1. Ensure its nursing staff obtained a complete seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving)/restraint (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body) order for each seclusion/restraint use for each of three of 30 sampled patients (Patient 10, 14 and 15), in accordance with facility's policy and procedure regarding seclusion and restraints when:

1.a. Patient 10 was placed in seclusion without a seclusion order for three hours and five minutes and was placed on 5-point restraints (restraints applied to patient's bilateral wrists, ankles, and chest) without a renewal order for one hour and five minutes on 6/15/2024.

1.b. Patient 14 was placed in seclusion and restrained for three hours and fifty minutes without a physician order on 3/5/2024.

1.c. Nursing staff initiated seclusion for Patient 15 without a physician order on 4/19/2024 at 5:45 p.m. and the renewal seclusion/restraint order was incomplete on 4/20/2024 at 1:45 a.m.

These deficient practices resulted in Patients 10, 14 and 15 being placed in seclusion and restrained without a proper physician order and had the potential of placing the patients (Patients 10, 14 and 15) at risk for unnecessary and inappropriate seclusion/restraint use and at risk

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for injury.

2. Ensure physician orders included the indication for restraints (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body) for one of 30 sampled patients (Patient 16), in accordance with the facility's policy regarding restraints.

This deficient practice had the potential for restraints to be applied unnecessarily, thus putting Patient 16 at risk for injury.

Findings:

1.a. During a review of Patient 10's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 2/24/2024, the Psych Eval indicated, Patient 10, a 14-year-old, was admitted to the facility with diagnosis of disruptive mood dysregulation disorder (a mental health condition characterized by persistent irritability, anger, and frequent intense temper outbursts).

During an interview on 1/22/2025 at 10:49 a.m. with the Shift Supervisor (QRN 2), QRN 2 stated a physician order was required for seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and restraint (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body). QRN 2 also stated each

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seclusion/restraint order was good for two (2) hours for youth (9-17 years old) patients.

During a concurrent interview and record review on 1/24/2025 at 1:46 p.m. with Nurse Manager (NM) 3, Patient 10's "Seclusion and Restraints Assessment Packet (S&R Assessment)," dated 6/15/2024, was reviewed. The S&R Assessment indicated, Patient 10 was placed in seclusion and restraint on 6/15/2024 at 9:35 p.m. The S&R Assessment also indicated Patient 10 was released from restraint and seclusion on 6/16/2024 at 12:40 a.m. NM 3 stated Patient 10 was in seclusion and restraint for three (3) hours and five (5) minutes. NM 3 stated there should be physician order for seclusion and restraints during the start and another seclusion and restraint renewal order two (2) hours after the initiation of seclusion and restraint.

During a concurrent interview and record review on 1/24/2025 at 2:10 p.m. with NM 3, Patient 10's physician orders, dated on 6/15/2024, was reviewed. The physician orders indicated the following:

-"On 6/15/2024 at 9:38 p.m.: initial order: time limited order 2 hours for age 9 - 17;
initial order: the patient needs to be released from seclusion/restraints by 11:35 p.m. or a new order to be obtained;
-type of seclusion/restraints: 5 points restraint (restraints applied to a patient's both wrist, ankles, and chest);
-describe the precipitating incident: patient (Patient 10) biting left forearm, pulling own teeth off own mouth. Not following any redirection from staff."

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During the same interview on 1/24/2025 at 2:10 p.m., NM 3 stated the following: each restraint order should specify the type of restraint. There was no seclusion order when Patient 10 was placed in a seclusion room on 6/15/2024 at 9:35 p.m. It would be considered as restraining patient without a physician order. Nursing staff should contact physician to obtain restraints renewal order by 11:35 p.m. because each restraint order was only good for two (2) hours for youth patients. Patient 10 was restrained without renewal order for one (1) hour and five (5) minutes (from 11:35 p.m. to 12:40 a.m.).

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "The physician or Registered Nurse (RN) can initiate the need for restrictive intervention, obtain a written or telephonic order from the physician for the seclusion/restraints (S/R), and document on the Seclusion/Restraint Order form as follows: A. Time Limits: 1) Adults 18 and older up to four (4) hours; 2) Youth 9 - 17 up to two (2) hours ... B. The physician's orders specify the reason for restraint and seclusion usage, the type of restraint, and their duration. The S/R can be ordered for less than above stated maximum. The length of the S/R is limited by the continued need for the intervention rather than the length of the order ... In an emergency, the Nursing Supervisor, Shift Supervisor, or a trained Registered Nurse may initiate a S/R as a protective measure provided that a physician order is obtained immediately within minutes."

1.b. During a review of Patient 14's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient

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and the problem done by Psychiatrist [physician specializes in mental health])," dated 3/3/2024, the Psych Eval indicated, Patient 14, a 17-year-old, was admitted to the facility with diagnosis of psychosis (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality).

During an interview on 1/22/2025 at 10:49 a.m. with the Shift Supervisor (QRN 2), QRN 2 stated a physician order was required for seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and restraint (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body). QRN 2 also stated each seclusion/restraint order was good for two hours for youth (9-17 years old) patients.

During a concurrent interview and record review on 1/23/2025 at 11:40 a.m. with the Nurse Manager (NM 2), Patient 14's "Seclusion and Restraints Assessment Packet (S&R Assessment)," dated 3/5/2024, was reviewed. The S&R Assessment indicated, Patient 14 was placed on physical hold (any manual and physical method of holding a patient against patient's will that restricts freedom of movement or normal access to one's body) and seclusion on 3/5/2024 at 6:22 p.m. and restrained on 3/5/2024 at 7:35 p.m. Patient 14 was released from seclusion and restraint on 3/5/2024 at 10:10 p.m.

During the same interview on 1/23/2025 at 11:40 a.m. with the Nurse Manager (NM) 2, NM 2 stated Patient 14 was on seclusion and was restrained for three (3) hours and fifty (50)

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minutes.

During a concurrent interview and record review on 1/23/2025 at 11:50 a.m. with NM 3, Patient 14's physician orders, dated 3/5/2024 was reviewed. The physician order indicated the following:

-On 3/5/2024 at 6:25 p.m.: Physical Hold ordered: yes;
To prevent imminent (about to happen) physical or emotional harm to others because of threats, attempts, or other acts the patient overly or continually makes or commits.
-On 3/5/2024 at 8:22 p.m.: Renewal Order #1: time limited ordered: 2 hours for ages 9 - 17; specific behavior or requiring restraints/seclusion: danger to others, patient continues to scream, cursing at staff, unable to make a safety plan for when patient (Patient 14) is released.

During the same interview on 1/23/2025, at 11:50 a.m. with Nurse Manager (NM) 2, NM 2 stated that there was no physician order when seclusion and a restraint were initiated at 6:22 p.m. and at 7:35 p.m., respectively. NM 2 also stated there was the renewal order at 8:22 p.m. but it did not indicate what type of restraints to be continued. NM 2 stated Patient 14 was on seclusion and restrained from 6:22 p.m. to 10:10 p.m. (3hour 50 min) without a physician order. NM 2 stated nursing staff could not restrain without physician orders. NM 2 stated physician orders should be obtained within minutes upon seclusion and restraint initiation.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P

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indicated, "The physician or Registered Nurse (RN) can initiate the need for restrictive intervention, obtain a written or telephonic order from the physician for the seclusion/restraints (S/R), and document on the Seclusion/Restraint Order form as follows: A. Time Limits: 1) Adults 18 and older up to four (4) hours; 2) Youth 9 - 17 up to two (2) hours ... B. The physician's orders specify the reason for restraint and seclusion usage, the type of restraint, and their duration. The S/R can be ordered for less than above stated maximum. The length of the S/R is limited by the continued need for the intervention rather than the length of the order ... In an emergency, the Nursing Supervisor, Shift Supervisor, or a trained Registered Nurse may initiate a S/R as a protective measure provided that a physician order is obtained immediately within minutes."

1.c. During a review of Patient 15's Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 4/17/2024, the Psych Eval indicated, Patient 15 was admitted to the facility with diagnosis of bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration), mixed with psychotic (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality) features.

During an interview on 1/21/2025 at 1:52 p.m. with the Nurse Manager (NM 1), NM 1 stated a physician order was required for any seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and restraint (any method, physical or chemical, or mechanical

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device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body). NM 1 also stated each restraint order was good for four (4) hours for adult patients (18 and older).

During a concurrent interview and record review on 1/23/2025 at 3:22 p.m. with Nurse Manger (NM) 3, Patient 15's "Seclusion and Restraints Assessment Packet (S&R Assessment)," dated 4/19/2024, was reviewed. The S&R Assessment indicated, Patient 15 was placed in physical hold, seclusion and restraints on 4/19/2024 at 5:45 p.m., released from restraints on 4/20/2024 at 2:45 a.m. and seclusion on 4/20/2024 at 3:45 a.m. NM 3 stated Patient 15 was in restraints for nine (9) hours and seclusion for ten (10) hours.

During a concurrent interview and record review on 1/24/2025 at 2:56 p.m. with NM 3, Patient 15's physician orders, dated 4/19/2024, was reviewed. The physician orders indicated the following:

-"On 4/19/2024 at 5:45 p.m.: initial order: time limited order: 4 hours for age 18 or older; type of seclusion/restraint: therapeutic/physical hold (any manual and physical method of holding a patient against patient's will that restricts freedom of movement or normal access to one's body); type of seclusion/restraint: 5 points restraints (restraints applied to a patient's both wrist, ankles, and chest); specific behavior or requiring restraints/seclusion: danger to others, Patient (Patient 15) attacked 1:1 staff and continued to attack staff that arrived at the code grey (hospital emergency response when someone is acting violently, aggressively or threateningly), patient (Patient 15) continued made threats throughout whole interaction."

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-"On 4/19/2024 at 9:45 p.m.: renewal order #1: time limited order: 4 hours for age 18 or older; type of seclusion/restraint: 5 points restraints; type of seclusion/restraint: seclusion; specific behavior or requiring restraint/seclusion: danger to others ..."

-"On 4/20/2024 at 1:45 a.m.: renewal order #2: time limited order: 4 hours for age 18 or older; specific behavior or requiring restraint/seclusion: danger to others ..."

During the same interview on 1/24/2025 at 2:56 p.m. with Nurse Manager (NM) 3, NM 3 stated the following: there was no seclusion order when Patient 15 was placed in seclusion on 4/19/2024 at 5:45 p.m. Also, the renewal order #2 on 4/20/2024 at 1:45 a.m. was missing the type of restraint/seclusion.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "The physician or Registered Nurse (RN) can initiate the need for restrictive intervention, obtain a written or telephonic order from the physician for the seclusion/restraints (S/R), and document on the Seclusion/Restraint Order form as follows: A. Time Limits: 1) Adults 18 and older up to four (4) hours; 2) Youth 9 - 17 up to two (2) hours ... B. The physician's orders specify the reason for restraint and seclusion usage, the type of restraint, and their duration. The S/R can be ordered for less than above stated maximum. The length of the S/R is limited by the continued need for the intervention rather than the length of the order ... In an emergency, the Nursing Supervisor, Shift Supervisor, or a

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trained Registered Nurse may initiate a S/R as a protective measure provided that a physician order is obtained immediately within minutes."

2. During a concurrent observation and interview on 1/21/2025 at 2:54 p.m., in the DDMI Youth Unit (unit for minors who are developmentally delayed with mental illness), Patient 16 walked into the unit wearing restraints to both ankles. Nurse Manager (NM) 3 stated Patient 16 returned from a doctor's appointment and had been placed on restraints due to Patient 16's high AWOL (absent without leave, a mental health patient leaves a facility without permission) risk.

During an interview on 1/22/2025 at 4:10 p.m. with the Chief Nursing Officer (CNO), the CNO stated that restraint orders should include the type of restraints to be used and the indications or reasons for the restraints. Each restraint order should stand alone.

During a concurrent interview and record review on 1/22/2025 at 4:18 p.m. with Nurse Managers (NM) 3 and 4. NM 3 and NM 4 stated the following: Patient 16 was 17 years old. Patient 16 was placed in ankle restraints on 1/21/2025 from 9:30 a.m. to 2:45 p.m. during transportation to a clinic appointment because Patient 16 was an AWOL (absent without leave, a mental health patient leaves a facility without permission) risk. Restraint orders for minors (ages 9 - 17) expire in 2 hours and require a new physician's order. The physician ordered restraints on 1/21/2025 at 9:13 a.m., 11:23 a.m., and 1:12 p.m. NM 3 and NM 4 verified that orders written at 9:13 a.m. and 11:12 a.m. did not have an indication or reason for the ankle restraints.

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During a review of Patient 16's "Psychiatric and Mental Status Examination," dated 11/29/2023, the Examination indicated the following: Patient 16 was admitted on involuntary status (against ones will) for danger to self, danger to others, and gravely disabled (a person is unable to meet their basic needs) on 11/27/2023. Patient 16 was 15 years old (in 2023).

During a review of Patient 16's physician's order dated 1/21/2025 at 9:13 am, the physician's order indicated the following: Type of Seclusion/Restraint: Walking Restraints/ -Transport. Associated problems: Blank (no documentation of problems).

During a review of Patient 16's physician's order dated 1/21/2025 at 11:23 a.m., the physician's order indicated the following: Type of Seclusion/Restraint: Walking Restraints/Transport. Associated problems: Blank (no documentation of problems).

During a review of Patient 16's physician's order dated 1/21/2025 at 1:53 p.m., the physician's order indicated the following: Type of Seclusion/Restraint: Walking Restraints/Transport. High AWOL risk.

During a review of Patient 16's "Seclusion & Restraints Flow Sheet," dated 1/21/2025, the Flow Sheet indicated Patient 16 was placed on ankle (walking) restraints from 9:12 a.m. to 2:42 p.m., during transport.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated the following: The Hospital considers a

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A 168	Continued From page 42 patient a high risk for AWOL during transportation outside of the facility to be an imminent risk for harm to self or others (community). In this situation, with a physician's order, the patient may be placed in transport restraints while outside the facility ...The same procedure ...will be used for transport restraints including but not limited to: obtaining MD (physician) order ...The physician or Registered Nurse can initiate the need for restrictive intervention, obtain a written or telephonic order for the restraints / Seclusion (S/R). Time Limits: ...Youth 9 - 17 (years of age) up to two (2) hours. The physician's orders specify the reason for restraint and seclusion usage, the type of restraint, and their duration ...Reassessment / Continuation Protocol. Physician / Qualified Registered Nurse (RN) reassesses patients for continuation of S/R ...as followings ... Youth 9 - 17 (of age) at two (2) hours ...Ensures a new order is written on the Seclusion Restraint Continuation Order justifying continuation of S/R.	A 168		
A 175	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure its nursing staff assessed and monitored three of 30 sampled patients (Patient 11, 13, and 16) for behavior, circulation (flow of fluid, blood in the body), sensation (seeing,	A 175		

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hearing, or smelling), movement, or were offered range of motion (movement of a joint), toileting, fluids, food, or hygiene, while placed on restraints (a device attached to the patient's body that restricts freedom of movement), in accordance with the facility's policy and procedures regarding seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and restraints (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body), when the assigned Registered Nurse for each respective patient:

1. did not perform hourly assessment for Patient 11, who was placed in walking restraints (restraint applied to patient's ankles to prevent patient from AWOL [absent without official leave, leaving the hospital without discharge order from physician]), on 2/13/2024 from 4:30 p.m. to 10:55 p.m. (10 hours 25 mins).

2. did not perform hourly assessment for Patient 13, who was placed in walking restraints on 2/28/2024, from 12:15 a.m. to 8:49 a.m. (8 hours 34 mins).

3. did not perform assessment for Patient 16, who was placed in ankle restraints, from 9:30 a.m. to 2:45 p.m., on 1/21/2025 (5 hours and 15 minutes).

These deficient practices had the potential for the inability of staff to identify complications of restraints use for Patients 11, 13 and 16, and placed the patients (Patients 11, 13, and 16) at risk for injury such as loss of circulation or sensation to limbs, skin breakdown, and needs

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including hydration, toileting and hygiene not being met as needed.

Findings:

1. During a review of Patient 11's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician who specializes in mental health])," dated 1/22/2024, the psych eval indicated Patient 11 was admitted to the facility with diagnoses including but not limited to major depression (MDD - a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) with psychotic features (delusions [a false or fixed belief that persists despite overwhelming evidence to the contrary] and hallucinations [a false perception of objects or events]), anxiety disorder (a group of mental disorders characterized by significant feelings of fear) and autistic spectrum disorders (a developmental disability caused by differences in the brain).

During a review of Patient 11's physician order, dated 2/13/2024, the physician order indicated, "transport/ transfer via ambulance to emergency room in walking restraints (restraint applied to patient's ankles to prevent patient from AWOL [absent without official leave, leaving the hospital without discharge order from physician]) with a Registered Nurse (RN)."

During a concurrent interview and record review on 1/23/2025 at 2:39 p.m. with the Nurse Manager (NM 2), Patient 11's "Seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically

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prevented from leaving) and Restraints (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body) Assessment Packet (S&R Assessment)," dated 2/13/2024, was reviewed. The S&R Assessment indicated, Patient 11 was placed in walking restraint on 2/13/2024 at 4: 30 p.m. and released from restraint on 2/13/2024 at 10:55 p.m. (10 hours 25 mins).

During the same interview on 1/23/2025 at 2:39 p.m. with Nurse Manager (NM) 2, NM 2 stated the following: Patient 11 was sent to an emergency room for a medical evaluation and was placed in walking restraints due to high AWOL (absent without official leave, leaving the hospital without discharge order from physician) risk. A Registered Nurse (RN 4) was assigned to accompany Patient 11 and was responsible to perform assessment and monitoring every hour to check for range of motion (movement of a joint), hydration, hygiene and toileting to make sure Patient 11 was safe and Patient 11's needs were met while in restraint.

During a concurrent interview and record review on 1/23/2024 at 2:45 p.m. with NM 2, Patient 11's "Seclusion & Restraints Flow Sheet," dated 2/13/2024, was reviewed. The S/R flowsheet indicated, the section for checking range of motion, toileting, fluids, food and hygiene from 4:30 p.m. to 11p.m., was blank. NM 2 stated RN 4 did not document any assessment and monitoring every hour on 2/13/2024 from 4:30 p.m. to 10:55 p.m. (10 hours 25 mins).

During a review of the facility's policy and

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procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "Use of mechanical restraint during transport: [the facility] consider a patient at high risk for AWOL [absent without official leave, leaving the hospital without discharge order from physician] during transportation outside of the facility to be at imminent (about to happen) risk of harm to self and others (community). This is situation, with a physician's order, the patient may be placed in transport restraints while outside the facility ... Patient placed in transport restraints outside the facility will be sent with a Registered Nurse (RN) to ensure the patient is continuously monitored and assessed ... The same procedure listed below will be used for transport restraints including but not limited to face to face assessment, monitoring, debriefing, etc ... Assigned staff conducts 15-minute patient observation on the Seclusion & Restraint Flow Sheet that includes the following: A. Review for signs of injury related to restraint application; B. evaluate patient behavior, staff interventions and patient responses; C. evaluate for breathing; D. monitor for circulation and skin integrity; E. perform range of motion exercise ... F. offer food during meal times using paper products; G. Offers fluid or upon request; H. assist with toileting; I. assists with personal hygiene ... RN assesses the patient's medical and psychological status and readiness for discontinuation every hour and documents ..."

2. During a review of Patient 13's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 8/23/2024, the Psych Eval indicated, Patient 13 was admitted

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to the facility with diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought), and autism (a developmental disorder that affects a person's communication, behavior, and social interaction). The Psych Eval also indicated, Patient 13 had episodes of attempting to AWOL (absent without official leave, leaving the hospital without discharge order from physician).

During a review of Patient 13's physician orders, dated 2/27/2024, the physician order indicated, "transport/ transfer with ambulance to [an acute care facility] emergency room with walking restraint (restraint applied to patient's ankles to prevent patient from AWOL) with Registered Nurse staff and 1:1 (a type of care where a patient is under constant observation by a single staff member) Mental Health Worker."

During a review of Patient 13's "Seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and Restraints (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body) Assessment Packet (S&R Assessment)," dated 2/28/2024, the S&R Assessment indicated, Patient 13 was placed in walking restraint on 2/28/2024 at 12:15 a.m. and released from restraint on 2/28/2024 at 8:49 a.m. (8 hours and 34 mins).

During an interview on 1/24/2025 at 3:55 p.m. with the Nurse Manager (NM) 1, NM 1 stated there was no Registered Nurse hourly assessment found in Patient 13's medical record for the restraint episode on 2/28/2024 from 12:15

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am to 8:49 a.m. NM 1 stated, "It was not done."

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "Use of mechanical restraint during transport: [the facility] consider a patient at high risk for AWOL [absent without official leave, leaving the hospital without discharge order from physician] during transportation outside of the facility to be at imminent (about to happen) risk of harm to self and others (community). This is situation, with a physician's order, the patient may be placed in transport restraints while outside the facility ... Patient placed in transport restraints outside the facility will be sent with a Registered Nurse (RN) to ensure the patient is continuously monitored and assessed ... The same procedure listed below will be used for transport restraints including but not limited to face to face assessment, monitoring, debriefing, etc ... Assigned staff conducts 15-minute patient observation on the Seclusion & Restraint Flow Sheet that includes the following: A. Review for signs of injury related to restraint application; B. evaluate patient behavior, staff interventions and patient responses; C. evaluate for breathing; D. monitor for circulation and skin integrity; E. perform range of motion exercise ... F. offer food during meal times using paper products; G. Offers fluid or upon request; H. assist with toileting; I. assists with personal hygiene ... RN assesses the patient's medical and psychological status and readiness for discontinuation every hour and documents ..."

3. During a concurrent interview and record review on 1/22/2025 at 4:18 p.m. with Nurse Managers (NM) 3 & 4. NM 3 and NM 4 stated the

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following: Patient 16 was placed in ankle restraints on 1/21/2025 from 9:30 a.m. to 2:45 p.m. during transportation to a clinic appointment because Patient 16 was an AWOL (absent without leave, a mental health patient leaves a facility without permission) risk. While a patient was placed on restraints, the patient's behavior, circulation (flow of fluid, blood in the body), sensation (seeing, hearing, or smelling), and movement should be assessed every 15 minutes. In addition, patients should be offered range of motion (movement of a joint), toileting, fluids, food, and hygiene every 2 hours. The assessment should be documented in the "Seclusion & Restraint Flow Sheet."

During the same interview with Nurse Managers 3 and 4 (NM 3 and NM 4) on 1/22/2025 at 4:18 p.m., NM 3 and NM 4 verified that these assessments or interventions (such as toileting and offering fluids) were not done for Patient 16 while Patient 16 was placed on restraints. NM 3 and NM 4 stated these assessments and interventions should be done to avoid patient injury due to restraint use or prevent patient from being hungry or thirsty.

During a review of Patient 16's "Psychiatric and Mental Status Examination," dated 11/29/2023, the Examination indicated the following: Patient 16 was admitted on involuntary status (against one's will) for danger to self, danger to others, and gravely disabled (a person is unable to meet their basic needs) on 11/27/2023.

During a review of Patient 16's physician's order dated 1/21/2025 at 9:13 a.m., the physician's order indicated the following: Type of Seclusion/Restraint: Walking

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Restraints/Transport. Associated problems: Blank

During a review of Patient 16's physician's order dated 1/21/2025 at 11:23 a.m., the physician's order indicated the following: Type of Seclusion/Restraint: Walking Restraints/Transport. Associated problems: Blank.

During a review of Patient 16's physician's order dated 1/21/2025 at 1:53 p.m., the physician's order indicated the following: Type of Seclusion/Restraint: Walking Restraints/Transport. High AWOL risk.

During a review of Patient 16's "Seclusion & Restraints Flow Sheet," dated 1/21/2025, the Flow Sheet indicated Patient 16 was placed on ankle (walking) restraints from 9:12 a.m. to 2:42 p.m., during transport.

During a review of Patient 16's "Seclusion & Restraint Flow Sheet," dated 1/21/2025, the flow sheet indicated the following:

-Section: Behavior/Observation Key, Document Q (every) 15 minutes. The section was blank. Patient 16's behaviors, such as hostile, agitated, quiet were not documented.

- Section: Circulation/Sensation/Movement: Document Q 15 minutes when in restraints. The section was blank. Patient 16's circulation whether normal, pale (loss of color from normal skin tone, indicating circulation problems), cyanotic (bluish skin color due to lack of blood flow) ..., sensation, good or diminishing ..., or the ability to move affected limbs were not documented.

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- Section: General Key: Document at least every two (2) hours. The section was blank. There was no documentation indicating the following was either, done, offered, refused, or not applicable: ROM (range of motion), BRP (restroom privileges), fluids, food, hygiene.

During a concurrent interview and review of Patient 16's "Seclusion & Restraint Flow Sheet," on 1/23/2025 at 9:38 am, with Nurse Managers (NM) 3 & 4. NM 3 and NM 4 verified that the Flow sheet was incomplete and missing the following documentation. Patient 16's behaviors, such as hostile, agitated, quiet were not documented. Patient 16's circulation whether normal, pale (loss of color from normal skin tone, indicating circulation problems), cyanotic (bluish skin color due to lack of blood flow) ..., sensation, good or diminishing ..., or the ability to move affected limbs was not documented. There was no documentation indicating the following was either, done, offered, refused, or not applicable: ROM (range of motion), BRP (restroom privileges), fluids, food, hygiene.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated the following: Patient placed in transport restraints outside the facility will be sent with a Registered Nurse to ensure the patient is continuously monitored and assessed. Assigned staff conducts 15-minute patient observation on the "Seclusion & Restraint Flow Sheet," that includes the following:

A. Review for signs of injury related to restraint application

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A 175	Continued From page 52 B. Evaluates patient behavior, staff interventions, and patient responses C. Evaluates for breathing D. Monitors for circulation and skin integrity E. Performs range of motion exercises... F. Offers food during mealtimes using paper products G. Offers fluids or upon request H. Assist with toileting I. Assist with personal hygiene J. Obtain vital signs ...	A 175		
A 179	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(12) [the patient must be seen face-to-face within 1 hour after the initiation of the intervention --] §482.13(e)(12)(ii)To evaluate - 1. The patient's immediate situation; 2. The patient's reaction to the intervention; 3. The patient's medical and behavioral condition; and 4. The need to continue or terminate the restraint or seclusion. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of two sampled Qualified Registered Nurse (QRN, trained Registered Nurse) completed the face-to-face assessment (an in person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical	A 179		

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device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body], within one hour of initiation to evaluate patient's medical condition and response to intervention) within an hour after the initiation of seclusion/restraint for two of 30 sampled patients (Patients 1 and 13), in accordance with the facility's policy and procedure regarding seclusion and restraint when:

1. The QRN (QRN 3) did not take vital signs (measurements of the body's most basic function including body temperature, heart rate, blood pressure, respirations and pain level) during the face-to-face assessment of Patient 1 on 5/13/2023.

This deficient practice had the potential for QRN not accurately identifying Patient 1's response to the treatment (chemical restraint, a medication that is not being used as a standard treatment for the patient's medical or psychiatric condition and that results in restriction of the patient's freedom of moment) and put Patient 1 at risk for respiratory distress (difficulty breathing) and/or other complications.

2. The QRN did not perform face-to-face assessment for Patient 13 when Patient 13 was placed in walking restraint (restraint applied to patient's ankles to prevent patient from AWOL [absent without official leave, leaving the hospital without discharge order from physician]) on 2/28/2024.

This deficient practice had the potential for Patient 13 not being properly assessed if the restraint (walking restraint/ankle restraint) was

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applied appropriately or if there is a need for the restraint use, which may put Patient 13 at risk for injury such as skin breakdown, compromised circulation (the flow of blood in the body), etc.

Findings:

1. During a review of Patient 1's "Medical Doctor Progress Notes," dated 5/12/2023, the MD Progress Notes indicated, Patient 1 was admitted to the facility with diagnoses including but not limited to bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration), manic (a state of abnormally elevated mood), autism spectrum disorders (ASD, a developmental disability caused by differences in the brain), medication non-compliance, random violence and gravely disabled (unable to care for self).

During an interview on 1/22/2025 at 10:14 a.m. with the Registered Nurse (RN 2), RN 2 stated, a face-to-face assessment (an in person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body] within one hour of initiation to evaluate a patient's medical condition and response to intervention) was required to check the patient's response to medication and vital signs (measurements of the body's most basic function including body temperature, heart rate, blood pressure, respirations and pain level)

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to make sure patient was stable and not in distress within an hour after an emergency medication (medications used to treat acute [new onset] agitation [a state of restlessness, unease, and excessive activity]) was administered.

During an interview on 1/22/2025 at 10:49 a.m. with the Shift Supervisor (QRN 2), QRN 2 stated the following: only the Qualified Registered Nurse (QRN) could perform the face-to-face assessment. All shift supervisors and nurse managers were trained to be the QRN. Face-to-face assessment was required within an hour after seclusion/restraint initiation. The face-to-face assessment included a head-to-toe assessment, mental assessment, vital signs, and assess patient's behavior and response to seclusion/restraint. It was done to determine the need to continue or terminate seclusion/restraint. The QRN had to communicate with the physician after face-to-face assessment to report patient's response to intervention and for further order as needed.

During a concurrent interview and record review on 1/23/2025 at 3:37 p.m. with the Nurse Manager (NM) 3, Patient 1's "Seclusion and Restraints Assessment Packet (S&R Assessment)," dated 5/13/2023, was reviewed. The S&R Assessment indicated the following: Patient 1 was placed in seclusion and restraint on 5/13/2023 at 10 a.m. and released from seclusion and restraint on 5/13/2023 at 1:50 p.m. Patient 1 received an emergency medication of Zyprexa (medication to treat severe mental health condition)10 milligrams (mg, a unit of measure) intramuscularly (IM, injection given directly into a muscle) at 10:05 a.m. The face-to-face assessment was performed on 5/13/2023 at

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10:40 a.m. There were no vital signs recorded in the face-to-face assessment.

During the same interview on 1/23/2025 at 3:37 p.m. with the Nurse Manager (NM) 3, NM 3 stated vital signs should be part of the face-to-face assessment to make sure Patient 1 was responding well and not having adverse effect such as respiratory distress (difficulty breathing) or overly sedated (excessive drowsiness, loss of response, and inappropriate movement) from the intervention (administration of Zyprexa medication) especially when the emergency medication was given. NM 3 confirmed that the face-to-face assessment was incomplete.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "A Physician, Qualified Registered Nurse (QRN), or other Licensed Independent Practitioner (LIP) as allowed by law and scope of practice conducts an in-person, face-to-face assessment of the patient in seclusion/restraint (S/R) within one (1) hour of initiation and documents findings ... The purpose of this evaluation is to determine if the use of these measures is justified to prevent the patient from causing harm to self or others. It is also completed to ensure that the use of S/R poses no undue risk to the patient's medical or psychological well-being ... The evaluation incorporates the following: B. Reviews, with the staff, the physical and psychological status of the patient; C. Evaluates the patient's immediate situation, the patient's reaction to the intervention, the patient's behavioral condition, and the need to continue or terminate the S/R ... E. Evaluate the

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patient's medical condition including a complete review of systems assessment, behavioral assessment ... F. Ensures that the use of S/R poses no undue risk to the patient's medical or psychosocial well-being ... H. Assesses the safety of patients in S/R, including the appropriate implementation/application of S/R interventions and their physical and emotional status."

During a review of the facility's policy and procedure (P&P) titled, "Emergency Medications," dated 10/2023, the P&P indicated, "Patient receiving emergency medications are to be monitored and assessed for medication efficacy and possible side effects ... the Qualified Registered Nurse (QRN)/ Licensed Independent Physician (LIP) will conduct a face-to-face assessment or the patient within one hour of administration of emergency medication to assess physical and psychological status, including the effectiveness of the medication ... vital signs will be taken immediately following administration of the emergency mediation and monitored every thirty (30) minutes until evaluation of QRN/LIP."

2. During a review of Patient 13's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician specializes in mental health])," dated 8/23/2024, the Psych Eval indicated, Patient 13 was admitted to the facility with diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought), and autism (a developmental disorder that affects a person's communication, behavior, and social interaction). The Psych Eval also indicated, Patient 13 had episodes of attempting to AWOL (absent without

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official leave, leaving the hospital without discharge order from physician).

During a review of Patient 13's physician orders, dated 2/27/2024, the physician order indicated, "transport/transfer with ambulance to [an acute care facility] emergency room with walking restraint (restraint applied to patient's ankles to prevent patient from AWOL [absent without official leave, leaving the hospital without discharge order from physician]) with Registered Nurse staff and 1:1 (a type of care where a patient is under constant observation by a single staff member) Mental Health Worker."

During an interview on 1/22/2025 at 10:49 a.m. with the Shift Supervisor (QRN 2), QRN 2 stated the following: only the Qualified Registered Nurse (QRN) could perform the face-to-face assessment (an in person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body] within one hour of initiation to evaluate patient's medical condition and response to intervention).

During the same interview on 1/22/2025 at 10:49 a.m. with the Shift Supervisor (QRN 2), QRN 2 stated that all shift supervisors and nurse managers were trained to be the QRN. Face-to-face assessment was required within an hour after seclusion/restraint initiation. The face-to-face assessment included a head-to-toe

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assessment, mental assessment, vital signs, and assess patient's behavior and response to seclusion/restraint. It was done to determine the need to continue or terminate seclusion/restraint. The QRN had to communicate with the physician after face-to-face assessment to report patient's response to intervention and for further order as needed.

During a concurrent interview and record review on 1/24/2025 at 3:50 p.m. with the Chief Nursing Officer (CNO), Patient 13's "Seclusion and Restraints Assessment Packet (S&R Assessment)," dated 2/28/2024, was reviewed. The S&R Assessment indicated, Patient 13 was placed in walking restraint on 2/28/2024 at 12:15 a.m. and released from restraint on 2/28/2024 at 8:49 a.m. (8 hours and 34 mins). The S&R Assessment Packet also indicated the face-to-face assessment section was blank. CNO stated the face-to-face assessment was not done on 2/28/2024 when Patient 13 was placed in walking restraint. CNO stated face-to-face assessment was required when Patient 13 was placed in walking restraint. CNO stated the QRN needed to check Patient 13's restraint to make sure it was applied appropriately, not too loose or not too tight.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "A Physician, Qualified Registered Nurse (QRN), or other Licensed Independent Practitioner (LIP) as allowed by law and scope of practice conducts an in-person, face-to-face assessment of the patient in seclusion/restraint (S/R) within one (1) hour of initiation and documents findings ... The purpose of this

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A 179	Continued From page 60 evaluation is to determine if the use of these measures is justified to prevent the patient from causing harm to self or others. It is also completed to ensure that the use of S/R poses no undue risk to the patient's medical or psychological well-being ... The evaluation incorporates the following: B. Reviews, with the staff, the physical and psychological status of the patient; C. Evaluates the patient's immediate situation, the patient's reaction to the intervention, the patient's behavioral condition, and the need to continue or terminate the S/R ... E. Evaluate the patient's medical condition including a complete review of systems assessment, behavioral assessment ... F. Ensures that the use of S/R poses no undue risk to the patient's medical or psychosocial well-being ... H. Assesses the safety of patients in S/R, including the appropriate implementation/application of S/R interventions and their physical and emotional status."	A 179		
A 182	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse, the trained registered nurse must consult the attending physician or other licensed practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face evaluation. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of two qualified Registered Nurses (QRN, trained Registered Nurse- QRN 2 and QRN 5)) communicated with/notified the physician after face-to-face assessment (an in	A 182		

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person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body] within one hour of initiation to evaluation patient's medical condition and response to intervention) was completed for two of 30 sampled patients (Patients 14 and 15), in accordance with the facility's policy and procedure regarding seclusion and restraint.

This deficient practice had the potential to put Patients 14 and 15 at risk for unnecessary seclusion and restraint as well as delay of care when the physicians are not informed by the QRN regarding the outcome of the face-to-face evaluation of Patients 14 and Patient 15's appropriateness for seclusion/restraint and need for other treatment or intervention.

Findings:

1. During a review of Patient 14's "Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician who specializes in mental health])," dated 3/3/2024, the Psych Eval indicated, Patient 14 was admitted to the facility with diagnosis of psychosis (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality).

During an interview on 1/22/2025 at 10:49 a.m. with the Qualified Registered Nurse/Shift

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Supervisor (QRN 2), QRN 2 stated the following: only the Qualified Registered Nurse (QRN) could perform the face-to-face assessment (an in person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of a patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body] within one hour of initiation to evaluate a patient's medical condition and response to intervention).

During the same interview on 1/22/2025 at 10:49 a.m. with the Qualified Registered Nurse/Shift Supervisor (QRN 2), QRN 2 said all shift supervisors and nurse managers were trained to be the QRN. Face-to-face assessment was required within an hour after a seclusion/restraint initiation. The face-to-face assessment included a head-to-toe assessment, mental assessment, vital signs, and assess patient's behavior and response to seclusion/restraint. It was done to determine the need to continue or terminate seclusion/restraint. The QRN had to communicate with the physician after a face-to-face assessment to report patient's response to intervention and for further order as needed.

During a concurrent interview and record review on 1/23/2025 at 11 a.m. with the Nurse Manager (NM 2), Patient 14's "Seclusion and Restraints Assessment Packet (S&R Assessment)," dated 3/5/2024, was reviewed. The S&R Assessment indicated, Patient 14 was placed in seclusion and

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restraint on 3/5/2024 at 9 a.m. and released from seclusion and restraint on 3/5/2024 at 12:20 p.m. The S/R Assessment also indicated a face-to-face assessment was completed by QRN 2 on 3/5/2024 at 9:45 a.m. with the comment of "No further orders" under "MD (medical doctor) Notified/ Comments" section.

During the same interview on 1/23/2025 at 11 a.m. with the Nurse Manager (NM) 2, NM 2 stated QRN 2 did not specify which physician was notified. NM2 stated QRN 2 should have documented the name of the physician QRN 2 contacted after the face-to-face assessment was done on Patient 14. NM 2 stated, usually, the QRN should contact the ordering physician to give report.

During an interview on 1/23/2025 at 3:22 p.m. with the Nurse Manager (NM 3), NM 3 stated the purpose of MD notification after face-to-face assessment was to give update to the physician regarding patient's condition and response to intervention, and to ask for further order as needed.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "A Physician, Qualified Registered Nurse (QRN), or other Licensed Independent Practitioner (LIP) as allowed by law and scope of practice conducts an in-person, face-to-face assessment of the patient in seclusion/restraint (S/R) within one (1) hour of initiation and documents findings ... The purpose of this evaluation is to determine if the use of these measures is justified to prevent the patient from causing harm to self or others. It is also

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completed to ensure that the use of S/R poses no undue risk to the patient's medical or psychological well-being ... The LIP/QRN contacts the attending physician or designee to discuss the evaluation of the patient, the need for other interventions or treatments, and the need to continue or discontinue the S/R. This needs to be done as soon as possible after completing the S&R Assessment Packet 1 Hour Face-to-Face Evaluation but no longer than thirty (30) minutes after the evaluation is completed."

2. During a review of Patient 15's Psychiatric and Mental Status Examination (Psych Eval, a formal and complete assessment of the patient and the problem done by Psychiatrist [physician who specializes in mental health])," dated 4/17/2024, the Psych Eval indicated, Patient 15 was admitted to the facility with diagnosis of bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration), mixed, with psychotic (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality) features.

During an interview on 1/22/2025 at 10:14 a.m. with the Registered Nurse (RN 2), RN 2 stated, a face-to-face assessment (an in person assessment completed by a physician, qualified Registered Nurse or other Licensed Independent Practitioner [LIP] of patient in seclusion [any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving]/restraint [any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body] within one hour of initiation to evaluation patient's medical condition

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 182	Continued From page 65	A 182		

and response to intervention) was required to check the patient's response to medication and vital signs (measurements of the body's most basic function including body temperature, heart rate, blood pressure, respirations and pain level) to make sure patient was stable and not in distress within an hour after an emergency medication (medications used to treat acute [new onset] agitation [a state of restlessness, unease, and excessive activity]) was administered.

During an interview on 1/22/2025 at 10:49 a.m. with the Shift Supervisor (QRN 2), QRN 2 stated the following: only the Qualified Registered Nurse (QRN) could perform the face-to-face assessment. QRN 2 also said all shift supervisors and nurse managers were trained to be the QRN. Face-to-face assessment was required within an hour after seclusion/ restraint initiation. The face-to-face assessment included a head-to-toe assessment, mental assessment, vital signs, and assess patient's behavior and response to seclusion/restraint. It was done to determine the need to continue or terminate seclusion/restraint. The QRN had to communicate with the physician after face-to-face assessment to report patient's response to intervention and for further order as needed.

During a concurrent interview and record review on 1/23/2025 at 3:22 p.m. with the Nurse Manager (NM) 3, Patient 15's "Seclusion and Restraints Assessment Packet (S&R Assessment)," dated 4/19/2024, was reviewed. The S&R Assessment indicated the following: Patient 15 was placed in seclusion on 4/19/2024 at 9:10 a.m. and released from seclusion on 4/19/2024 at 11:07 a.m. with emergency medication of Haldol (medication used to treat

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	054055	A. BUILDING _____ B. WING _____	01/24/2025

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nervous, emotional, and mental condition) 10 milligram (mg, a unit of measure) and Ativan (medication helps to reduce anxiety symptoms, produces a calming effect on the brain and nerves) 2 mg given intramuscularly (IM, injection given directly into a muscle) at 9:10 a.m. The face-to-face assessment was completed by Qualified Registered Nurse/ Shift Supervisor (QRN 5) on 4/19/2024 at 9:34 a.m. with "MD (medical doctor) Notified/ Comments" section that was blank.

During the same interview on 1/23/2025 at 3:22 p.m. with the Nurse Manager (NM) 3, NM 3 stated there was no documentation of MD notification that was done after the face-to-face assessment on 4/19/2024 at 9:34 a.m. NM 3 also stated the purpose of MD notification after face-to-face assessment was to give update to the physician regarding patient's condition and response to intervention, and to ask for further order as needed.

During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated, "A Physician, Qualified Registered Nurse (QRN), or other Licensed Independent Practitioner (LIP) as allowed by law and scope of practice conducts an in-person, face-to-face assessment of the patient in seclusion/restraint (S/R) within one (1) hour of initiation and documents findings ... The purpose of this evaluation is to determine if the use of these measures is justified to prevent the patient from causing harm to self or others. It is also completed to ensure that the use of S/R poses no undue risk to the patient's medical or psychological well-being ... The LIP/QRN

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A 182	Continued From page 67 contacts the attending physician or designee to discuss the evaluation of the patient, the need for other interventions or treatments, and the need to continue or discontinue the S/R. This needs to be done as soon as possible after completing the S&R Assessment Packet 1 Hour Face-to-Face Evaluation but no longer than thirty (30) minutes after the evaluation is completed." During a review of the facility's policy and procedure (P&P) titled, "Emergency Medications," dated 10/2023, the P&P indicated, "Patient receiving emergency medications are to be monitored and assessed for medication efficacy and possible side effects ... the Qualified Registered Nurse (QRN)/ Licensed Independent Physician (LIP) will conduct a face-to-face assessment for the patient within one hour of administration of emergency medication to assess physical and psychological status, including the effectiveness of the medication ... vital signs will be taken immediately following administration of the emergency medication and monitored every thirty (30) minutes until evaluation of QRN/LIP."	A 182		
A 208	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three sampled Qualified Registered Nurses (QRN 3) was currently	A 208		

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certified to perform face-to face-evaluations (determines if use of restraints is justified to prevent the patient from causing harm to self or others) for patients who were placed on restraints (a device attached to the patient's body that restricts freedom of movement), in accordance with the facility's "Seclusion (any involuntary confinement of a patient alone in a room or area where he or she is physically prevented from leaving) and Restraint Physical Hold Policy," and the policy and procedure regarding "Qualified Registered Nurse Training for Seclusion & Restraint."

This deficient practice had the potential for inaccurate face-to-face evaluations performed, which may result in harm committed by patients to themselves or to others.

Findings:

During a concurrent interview and personnel file review on 1/24/2025 at 1:34 p.m. with the Human Resources Director (HRD), the HRD stated the following: Qualified Registered Nurse (QRN) 3, who was also a Shift Supervisor, was hired on 9/22/2014. Registered nurses, including all shift supervisors who have completed the training regarding performing face-to-face evaluations (determines if use of restraints is justified to prevent the patient from causing harm to self or others), when patients were placed on restraints, were called QRN.

During the same interview on 1/24/2025 at 1:34 p.m. with the Human Resources Director (HRD), the HRD said all shift supervisors were required to be certified and competent in performing face-to- face evaluations for patients after being

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placed on restraints, and therefore, were required to complete an annual re-certification training and competency to ensure they were competent in performing the assessment. The training should be completed annually.

During a concurrent interview and personnel file review on 1/24/2025 at 2:09 p.m. with the Education Coordinator (EDC), the EDC stated Shift Supervisors were required to complete annual training to ensure they are certified in conducting face-to-face evaluations. The EDC verified that QRN 3's last training/competency was completed on 7/8/2023 and was valid until 7/2024. The EDC verified that QRN 3 should have completed the re-certification training in 7/2024, however, training had not been completed.

During a review of QRN 3's personnel file, the personnel file indicated QRN 3's last training titled, "QRN One Hour Face-To-Face Certification Package," was completed on 7/8/2023.

During a review of the facility's policy and procedure (P&P) titled, "Qualified Registered Nurse Training for Seclusion & Restraint," dated 10/2023, the P&P indicated the following: The Qualified Registered Nurse (QRN) provides timely and quality review of patients in seclusion/restraint (S/R) and effective guidance to staff. There is special training provided to the staff designated to be a Qualified Registered Nurse...The designated QRN can provide One-Hour Face-To-Face Medical and Behavioral evaluation. All training for the QRN role is documented including the dates of training and demonstration of competency. The QRN is required to have annual refresher training for the

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A 208	Continued From page 70 One-Hour Face-To-Face Evaluation. During a review of the facility's policy and procedure (P&P) titled, "Seclusion and Restraint Physical Hold Policy," dated 10/2023, the P&P indicated the following: A Physician, Qualified RN (QRN), or other Licensed Independent Practitioner (LIP) as allowed by law and scope of practice conducts an in-person face-to-face assessment of the patient in Seclusion/Restraint (S/R) within one (1) hour of initiation and documents the findings ...The purpose of this evaluation is to determine if the use of these measures is justified to prevent the patient from causing harm to self or others ....Special training ...is required for Registered Nurses prior to conducting the one-hour face-to-face evaluation ... A. Certification of competency is required to successfully complete training. B. Competency reassessment is to be renewed annually ...	A 208		

College Hospital Cerritos
10802 College Place
Cerritos, CA 90703
Medicare Provider Number: 054055

College Hospital Cerritos (CHC) respectfully submits its Plan of Correction (POC) in response to the Statement of Deficiencies (2567) received on February 13, 2025. This POC constitutes the facility's response to the findings of the California Department of Public Health during a Medicare Complaint Validation Survey for intake number CA00931732 and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies. This POC is submitted to meet requirements established by state and federal law.

Tag #A-115

The POC is based on the surveyor's evaluation and assessment of noncompliance with CFR 482.13 Patients' Rights. Based upon the surveyor's findings, the facility failed to:

1. Provide information about conditions of admission to the legal guardian of five sampled patients who were identified as minors upon admission in accordance with the facility's policy and procedure regarding admitting procedures (Refer to A-117).
2. Inform family members of the use of restraints (chemical restraint) for one sampled patient in accordance with the facility's policy and procedure regarding restraints use (Refer to A-131).
3. Ensure the medication informed consent was completed prior to medication administration for one sampled patient in accordance with the facility's policy and procedure regarding medication consent (Refer to A-131).
4. Ensure its nursing staff obtained a complete seclusion/restraint order for three sampled patients in accordance with the facility's policy and procedure regarding seclusion and restraints (Refer to A-168).
5. Ensure physician orders included the indication for restraint use for one sampled patient in accordance with the facility's policy and procedure regarding restraint use (Refer to A-168).
6. Ensure its nursing staff assessed and monitored for three sampled patients while placed in restraints in accordance with the facility's policy and procedures regarding seclusion and restraints (Refer to A-175).
7. Ensure two Qualified Registered Nurses completed the face to face assessment within an hour after the initiation of seclusion/restraint for two sampled patients in accordance with the facility's policy and procedure regarding seclusion and restraint (Refer to A-179).
8. Ensure two Qualified Registered Nurses communicated with/notified the physician after the face to face assessment was completed for two sampled in accordance with the facility's policy and procedure regarding seclusion and restraint (Refer to A-182).
9. Ensure one Qualified Registered Nurses was currently certified to perform face to face evaluations in accordance with the facility's seclusion and restraint physical hold policy and the policy and procedure regarding Qualified Registered Nurse Training for

Seclusion and Restraint (Refer to A-208).

Responsible Party:
The President/Chief Executive Officer on behalf of the Board of Directors is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standards.

Corrective Actions:
1. College Hospital, Inc., (“Corporation”) dba College Hospital Cerritos ("Hospital") is an acute psychiatric care proprietary hospital providing inpatient and outpatient care. The role and purpose of the Hospital is to provide an organization and facility which supports qualified medical professionals in providing quality psychiatric health care services to patients treated in the Hospital and Outpatient Partial Hospitalization Programs. The primary responsibility and goal of the Board of Directors (the "Board") is to further the role and purpose of the Hospital by providing oversight of the Hospital and advice to the Corporation, thereby facilitating institutional management and planning, the establishment of policies and the maintenance of quality patient care services, all in a manner that is responsive to and meets the needs of the community area, consistent with our mission and the advancement of our vision for the organization. The Board serves as the governing body of the Hospital and retains ultimate responsibility for the Hospital’s compliance with all applicable federal, state, and local laws and regulations. The Board receives and evaluates periodic reports from the Medical Staff and its officers, makes decisions regarding Medical Staff appointments, re-appointments, and the granting of clinical privileges, oversees performance improvement, utilization review, and similar matters regarding the provision of quality patient care at the Hospital, and establishes policies regarding such matters.

The Board is ultimately responsible for the quality of patient care and services provided by the hospital. The Board oversees and recommends resources and support systems for an effective, hospital-wide performance improvement program. The program includes activities and mechanisms implemented through the Medical Staff and staffs of the departments/services of the Hospital, with the support of the President/Chief Executive Officer. The program also includes education of the Hospital's leaders concerning the approach and methods of continuous quality improvement.

The hospital-wide performance improvement program is ongoing and includes a written plan of implementation. The performance improvement plan requires participants to implement and report on the activities and mechanism for planning, designing, measuring, assessing, and improving the processes related to important patient care and organizational functions. All organized services, including services furnished by a contractor, are evaluated. The scope of performance improvement activities being done at any given time include all specific required activities. Additionally, the program focuses on important functions or services selected by the Hospital’s leaders based on the Hospital’s mission, scope of care and services provided, populations served, performance improvement priorities and available resources. Over time, the performance of all important functions and services is to be measured, assessed, and improved as part of the performance improvement program.

The performance improvement plan establishes a process or processes designed to ensure that all individuals who provide patient care services, including those who are not subject to the medical staff privilege delineation process, are competent to provide such services. Without limiting the generality of the foregoing, such process or processes are to be designed to ensure that all individuals responsible for the assessment and treatment or care of patients are competent in the following, as appropriate to the age and condition of the patients served:

- the ability to obtain and interpret information in terms of the patient's needs;
- a knowledge of growth and development;
- an understanding of the range of and treatment needed by the patients served and ability to deliver the needed treatment.

The Board ensures that a patient safety program is implemented throughout the organization. At least annually, a report to the Board is to be presented regarding the occurrence of medical/healthcare errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

The Board oversees the performance improvement activities of the Hospital to ensure that actions are taken appropriate to the findings; and that the outcome of such actions is documented.

The Board provides for resources and support systems for the risk management functions related to patient care and safety. To the extent permitted by restrictions designed to protect patient confidentiality and the peer review privilege, there is an operational linkage between the risk management functions related to the clinical aspects of patient care and safety and the quality assessment and improvement function. The Board ensures that existing information from risk management activities that may be useful in identifying opportunities to improve patient safety, decrease the occurrence of sentinel events, improve the quality of patient care and/or resolve clinical problems which are accessible to the quality assessment and improvement function. The Medical Staff actively participates, as appropriate, in the risk management activities related to the clinical aspects of patient care and safety.

2. Reference A-117, A-131, A-168, A-175, A-179, A-182 and A-208 for specific corrective actions related to those tag numbers.

Completion Date:
The corrective actions related to this deficiency were completed on February 24, 2025.

Monitoring Activities:
1. To ensure continued compliance with the corrective actions set forth in this Plan of Correction, monthly reports will be sent to the President/CEO regarding the status of monitoring and compliance of the following:

a. Information about Conditions of Admission provided to parents/legal guardian of minor patients;
b. Family members are informed of the use of restraints;

c. Completion of medication consents;
d. Complete orders for seclusion/restraint are obtained;
e. Physicians orders include the indication for restraint use;
f. Monitoring and assessments of patients placed in restraints;
g. Face to Face assessments are completed timely;
h. Outcome of face to face assessment is communicated with the physician;
i. Qualified Registered Nurses are currently certified to perform face to face evaluations.

2. The Director of Quality Improvement/Risk Management will be responsible for sending the monthly reports to the President/CEO.

3. Please see specific action items listed under the specific a-tags listed on the following pages.

Tag #A-117
The POC is based on the surveyor's evaluation and assessment of noncompliance with Patient's Rights: Notice of Rights CFR(s): 482.13(a)(1). Based upon the surveyor's findings, the facility failed to provide information about conditions of admission to the legal guardian of five sampled patients who were identified as minors upon admission in accordance with the facility's policy and procedure regarding admitting procedures

Responsible Party:
The Admitting Supervisor is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standard.

Corrective Actions:
1. A process was developed to provide information about Conditions of Admission to the parent/legal guardian of minor patients in the event the parent/legal guardian is not present upon the patient's admission. The process includes the Admitting staff contacting the parent/legal guardian via telephone and/or email to provide the information about Conditions of Admission. The contact and any unsuccessful attempts to reach the parent/legal guardian are to be documented.

2. Education was provided to the Admitting Staff regarding the new process.

Completion Date:
The corrective actions related to this deficiency were completed on February 21, 2025.

Monitoring Activities:
1. Monitoring will be conducted by the Admitting Supervisor and will include weekly audits to ensure the parents/legal guardian of all minor patients are provided information about the Condition of Admission. Further education will immediately be provided as needed.

2. The outcome of the monitoring will be reported to the Medical Executive Committee and to the Board of Directors.

Tag #A-131

The POC is based on the surveyor's evaluation and assessment of noncompliance with Patient's Rights: Informed Consent CFR(s): 482.13(b)(2). Based upon the surveyor's findings, the facility failed to:

1. Inform family members of the use of restraints (chemical restraint) for one sampled patient in accordance with the facility's policy and procedure regarding restraints use; *and*
2. Ensure the medication informed consent was completed prior to medication administration for one sampled patient in accordance with the facility's policy and procedure regarding medication consent.

Responsible Party:

The Chief Nursing Officer in coordination with the Medical Director is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standard.

Corrective Actions:

1. The "Emergency Use of Medications Assessment Flowsheet" was revised to include a section for notifying family members of the use of emergency medications.

2. Education was provided to Registered Nurses in an educational In-service conducted by the Chief Nursing Officer. The education included, but was not limited to, education regarding: notifying family members of the use of restraints (chemical restraint) and ensuring Informed Consent was obtained by the physician prior to verifying/administering medications (specifically for minor patients). 1 on 1 education provided to any staff that was unable to attend the education in-service.

3. Education was provided to all Medical Staff during the Medical Executive Committee regarding the need to obtain consent for medications, including over the counter medications, for minor patients.

Completion Date:

The corrective actions related to this deficiency were completed on February 22, 2025.

Monitoring Activities:

1. An audit will be conducted of all episodes of emergency medications (chemical restraints) to ensure family members were notified. The audits will be documented on an audit tool and the results will be analyzed and reported monthly to the Patient Safety Committee.

2. The Licensed Nursing Staff assigned to administer medications will review the medical record to verify the Medication Consent was completed in full (including Physician's signature) prior to administering any medication requiring such. For incomplete consents, the staff will notify the physician to complete the Informed Consent Process.

3. The Medical Director will be informed of any continued incomplete consents and will follow up with involved physician(s) as needed. Continued non-compliance will be forwarded to the Medical Executive Committee and/or Quality Review Committee for appropriate action.

4. The outcome of the monitoring will be reported to the Medical Executive Committee and to the Board of Directors.

Tag #A-168
The POC is based on the surveyor's evaluation and assessment of noncompliance with Patient's Rights: Restraint or Seclusion CFR(s): 482.13(e)(5). Based upon the surveyor's findings, the facility failed to:

1. Ensure its nursing staff obtained a complete seclusion/restraint order for three sampled patients in accordance with the facility's policy and procedure regarding seclusion and restraints; *and*
2. Ensure physician orders included the indication for restraint use for one sampled patient in accordance with the facility's policy and procedure regarding restraint use.

Responsible Party:
The Chief Nursing Officer in coordination with the Medical Director is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standard.

Corrective Actions:
1. The "Behavioral Restraint/Seclusion Physician Orders" was revised to include the justification (i.e. indication) for the need for restraint/seclusion.

2. Education was provided to Registered Nurses in an educational In-service conducted by the Chief Nursing Officer. The education included, but was not limited to, obtaining physician orders for restraint/seclusion including renewal orders. 1 on 1 education provided to any staff that was unable to attend the education in-service.

3. Education was provided to all Medical Staff during the Medical Executive Committee regarding the need for indication for restraint use on all physician orders.

Completion Date:
The corrective actions related to this deficiency were completed on February 22, 2025.

Monitoring Activities:
1. An audit will be conducted of all episodes of restraint/seclusion will be reviewed to ensure there is a physician order for all episodes (including renewals) and orders include the indication for use. The audits will be documented on an audit tool and the results will be analyzed and reported monthly to the Patient Safety Committee.

2. The outcome of the monitoring will be reported to the Medical Executive Committee and to the Board of Directors.

Tag #A-175
The POC is based on the surveyor's evaluation and assessment of noncompliance with Patient's Rights: Restraint or Seclusion CFR(s): 482.13(e)(10). Based upon the surveyor's findings, the facility failed to ensure its nursing staff assessed and monitored for three sampled patients while placed in restraints in accordance with the facility's policy and procedures regarding seclusion and restraints.

Responsible Party:
The Chief Nursing Officer is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standard.

Corrective Actions:
1. Education was provided to Registered Nurses in an educational In-service conducted by the Chief Nursing Officer. The education included, but was not limited to, assessing and monitoring patients placed in restraints/seclusion. 1 on 1 education provided to any staff that was unable to attend the education in-service.

Completion Date:
The corrective actions related to this deficiency were completed on February 22, 2025.

Monitoring Activities:
1. An audit will be conducted of all episodes of restraint/seclusion will be reviewed to ensure all assessments and monitoring were completed. The audits will be documented on an audit tool and the results will be analyzed and reported monthly to the Patient Safety Committee.

2. The outcome of the monitoring will be reported to the Medical Executive Committee and to the Board of Directors.

Tag #A-179
The POC is based on the surveyor's evaluation and assessment of noncompliance with Patient's Rights: Restraint or Seclusion CFR(s): 482.13(e)(12). Based upon the surveyor's findings, the facility failed to ensure two Qualified Registered Nurses completed the face to face assessment within an hour after the initiation of seclusion/restraint for two sampled patients in accordance with the facility's policy and procedure regarding seclusion and restraint.

Responsible Party:
The Chief Nursing Officer is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standard.

Corrective Actions:
1. Education was provided to Qualified Registered Nurses in an educational In-service conducted by the Chief Nursing Officer. The education included, but was not limited to, completing the face to face assessment within an hour after the initiation of seclusion/restraint and ensuring the assessment is completed thoroughly. 1 on 1 education provided to any staff that was unable to attend the education in-service.

Completion Date:
The corrective actions related to this deficiency were completed on February 22, 2025.

Monitoring Activities:
1. An audit will be conducted of all episodes of restraint/seclusion will be reviewed to ensure the face to face assessment was completed thoroughly and timely. The audits will be documented on an audit tool and the results will be analyzed and reported monthly to the Patient Safety Committee.

2. The outcome of the monitoring will be reported to the Medical Executive Committee and to the Board of Directors.

Tag #A-182
The POC is based on the surveyor's evaluation and assessment of noncompliance with Patient's Rights: Restraint or Seclusion CFR(s): 482.13(e)(14). Based upon the surveyor's findings, the facility failed to ensure two Qualified Registered Nurses communicated with/notified the physician after the face to face assessment was completed for two sampled in accordance with the facility's policy and procedure regarding seclusion and restraint.

Responsible Party:
The Chief Nursing Officer is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standard.

Corrective Actions:
1. Education was provided to Qualified Registered Nurses in an educational In-service conducted by the Chief Nursing Officer. The education included, but was not limited to, communicating with/notifying the physician after the face to face assessment was completed. 1 on 1 education provided to any staff that was unable to attend the education in-service.

Completion Date:
The corrective actions related to this deficiency were completed on February 22, 2025.

Monitoring Activities:
1. An audit will be conducted of all episodes of restraint/seclusion will be reviewed to ensure the physician was notified after the face to face assessment. The audits will be documented on an audit tool and the results will be analyzed and reported monthly to the Patient Safety Committee.

2. The outcome of the monitoring will be reported to the Medical Executive Committee and to the Board of Directors.

Tag #A-208
The POC is based on the surveyor's evaluation and assessment of noncompliance with Patient's Rights: Restraint or Seclusion CFR(s): 482.13(f)(4). Based upon the surveyor's findings, the facility failed to ensure one Qualified Registered Nurses was currently certified to perform face to face evaluations in accordance with the facility's seclusion and restraint physical hold policy and the policy and procedure regarding Qualified Registered Nurse Training for Seclusion and Restraint.

Responsible Party:
The Chief Nursing Officer is responsible for the corrective actions listed below as well as the on-going monitoring of compliance with the standard.

Corrective Actions:
1. The Qualified Registered Nurse (QRN) identified during the survey immediately completed the QRN certification.
2. The process of tracking the certifications of the Qualified Registered Nurses was revised. Human Resources will now track the expiration dates of all QRNs and will inform Nursing Administration of such dates. Human Resources will also track if certifications are not completed and those QRNs not completing the certifications will not be allowed to complete face to face assessments until the certification is complete.

Completion Date:
The corrective actions related to this deficiency were completed on February 22, 2025.

Monitoring Activities:
1. Human Resources will report any incomplete certifications to Nursing Administration.