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	344016	A. BUILDING _____ B. WING _____	R-C 03/21/2023

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{A 000}	INITIAL COMMENTS A Revisit Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare and Medicaid (CMS) Atlanta. An unannounced Revisit Survey (ASPEN #73VG13) was conducted at the above-named Hospital from 03/20/23-03/21/23 for the purpose of removing the Immediate Jeopardy received on 02/09/23 for failure to ensure a safe environment for adolescent patients by allowing an involuntarily admitted adolescent to elope from the facility. Observations, interviews, and document reviews revealed that the hospital had completely implemented its IJ Removal Plan and patients were no longer at risk of harm. The Immediate Jeopardy has been removed. The Hospital continues to be non-compliant with the conditions, 482.12 Governing Body, 482.13 Patient Rights, 482.21 Quality Assessment and Performance Improvement, and 482.83 Nursing Services.	{A 000}		
{A 043}	The Hospital is certified for 84 inpatient beds. The average daily census is 44. GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by:	{A 043}	ACTION: The Governing Body received and reviewed the CMS Conditions of Participation report and directed the CEO during the Board of Governors Meeting to develop and implement a plan of correction. The CEO submitted the plan of correction to the Governing Body for review and approval on 3/9/23. MONITORING: For a period of at least 6 months, the Governing Body is meeting on a monthly basis to ensure completion of the plans of correction and to monitor effectiveness of actions taken. See Responses: A 144; A 286; A 395	

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{A 115}	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by:	{A 115}	See Responses: A 144; A 286; A 395	
{A 144}	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by:	{A 144}	ACTION: The CNO and Risk Manager reviewed and affirmed the following policies contained correct instruction to staff: • Policy “Elopement PC-1-020” requires staff to be assigned to responding to an elopement event, attempt to locate and prevent the patient from leaving the facility property as well as notifying designated persons or authorities if a patient leaves the facility without authorization. No revisions necessary • “Patient Observation Policy PC-1-002” provides guidance to staff regarding timing and interval of rounding in order to minimize planned acting out opportunities. No revisions necessary. The CNO and Director of RM/PI reviewed and revised the following policies to improve patient safety: “Patient Precaution/Restriction Level PC-1-004" - revised Elopement Precautions to include additional interventions such as the unit restriction, slipper socks, etc. Revised 3/6/23.	

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{A 144}		{A 144}	• "Patient Precaution/Restriction Level PC-1-004" – revised to include the ability of the RN to initiate safety precautions based upon their clinical assessment until the patient is seen and reassessed by the provider. Revised 3/6/23. • "Handoff Communication" - revised to include the requirement to maintain Nurse Supervisor shift reports for a period of no less than 2 years in hard copy or electronically scanned with records maintained in the Nursing Office. Revised 3/14/23. • "Psychiatric Emergency Code PC-1-008 – revised to provide additional guidance regarding assessment and identification of imminent risk to self/others, role of leader during crisis situation, decision making and proactively responding to crisis. Revised 3/2/23. • "Incident Reporting" – revised to clarify the process for reporting events including what to report, who is responsible for reporting, who to report to, time frames for reporting incidents, as well as guidelines for contacting the police. Guidelines include contacting the CEO and/or Risk Manager to ensure situation requires police involvement prior to contacting the police. Revised 3/1/23. The CEO conducted a series of Town Hall Meetings on 3/3/23 to communicate the organizations mission and expectation to provide quality care in a safe setting without police assistance and the commitment of the leadership team to support staff by providing additional training resources as well as any other needs identified through quality reviews and staff feedback. Staff attendance was documented on an attendance log.	

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{A 144}		{A 144}	Information provided during the Town Hall Meeting was communicated to staff not in attendance in writing from the CEO via email, posting in staff lounge and unit communication books. The CNO, HRD and Clinical Training Coordinator reviewed and revised Crisis Intervention training to include an additional eight (8) hours for a total of sixteen (16) hours of training at the time of new hire orientation to allow for content learning, application opportunities, and skills practice. CPI recertification training (the crisis intervention training) is provided every 6 months for RNs, LPNs, MHTs, and Therapy staff. A four (4) hour abbreviated version of this training was provided to current direct care staff (RNs, LPNs, MHTs) by the certified trainers with all staff expected to be trained by 3/10/23. Any staff member not completing this training by 3/10/23 is not allowed to work until training is completed. The Risk Manager and CNO re-implemented the incident reporting process outlined in policy requiring the person with direct knowledge of the incident to complete the incident report prior to the end of the shift. The practice of not allowing MHTs to enter reports was discontinued and the expectation for compliance with the policy was communicated to all MHTs and nursing staff. The facility IT coordinator assigned computer login credentials for all MHTs. Receipt of credentials and understanding of process was acknowledged through written attestation.	

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{A 144}		{A 144}	TRAINING: The CNO/designee provided re-education to nursing staff (RNs, LPNs and MHTs), therapy staff and Medical Staff on the following requirements of the revised policies and procedures: • “Patient Precaution/Restrictions” and use of additional interventions such as unit restriction, and slipper socks for patients placed on Elopement Precautions. Revised 3/6/23. • “Patient Precaution/Restrictions” including the RNs ability to initiate precautions and interventions such as unit restriction and/or slipper socks based on their clinical assessment until the provider reassesses the patient. Revised 3/6/23. • “Psychiatric Emergency Code” and the assessment/identification of imminent risk, proactive intervention, leadership role during code and use of decision-making matrix during crisis. Revised 3/2/23. • “Incident Reporting” and the requirements for reporting incidents including what to report, to whom to report, time frames for reporting and guidelines for contacting the police. Revised 3/1/23. The Risk Manager/designee provided education to all MHTs on the use of login credentials and entering incident reports in Midas. Receipt of credentials was acknowledged through written attestation. Competency regarding completion of incident reports was assessed through written examination.	

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{A 144}		{A 144}	The CNO/designee and Clinical Training Coordinators provided a 4-hour training regarding Milieu Management and Non-violent Crisis Management to all RNs, LPNs and MHTs. Training which is included in the additional day of CPI training included: • Use of Crisis Development Model and proactive response to a crisis • Use of Decision-Making Tool during crisis • Understanding and identifying imminent risk • Review and practice of non-restrictive and restrictive interventions. The CNO provided education to the Nursing Supervisors regarding the requirement to maintain Nursing Supervisor shift reports for a period of 2 years and where they will be maintained. The CNO and HRD verified all training information/materials are included in the New Hire Orientation and Annual Trainings. All training as outlined above regarding policies, incident reporting and milieu management/crisis intervention was provided in small group settings and/or individually. Understanding of policies and expectations for compliance was acknowledged through written attestation. Competency for completing incident reports, milieu management and crisis management was assessed through written examination and/or return demonstration. All training was completed by 3/10/23. Any staff who did not complete training by this date were required to complete prior to the beginning of their next assigned shift.	

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{A 144}		{A 144}	MONITORING: Each shift, the House Supervisor monitors patient precautions and verifies patients identified at risk for elopement are placed on Elopement precautions and have an additional intervention such as unit restriction, use of slipper socks, etc. The audit is submitted to the CNO daily for review and monitoring. Findings are reviewed in Daily Nurse Leadership shift reports. Identified deficiencies regarding patients identified at risk of elopement not correctly placed on precautions and unit restriction are addressed immediately and continued non-compliance results in additional corrective actions up to and including termination. Goal: 100% compliance with identified patients at risk for elopement are assigned precautions and additional intervention such as unit restriction and/or slipper socks have been taken. Monitoring is ongoing. Aggregated data regarding proper identification of Elopement risk, assignment of elopement precautions and appropriate interventions for patients with elopement risk is reported monthly to the Quality Council, MEC and Governing Body. Each House Supervisor monitors completion of incident reports prior to the end of each shift. The House Supervisor documents all incidents on the Nursing Supervisor Report. The CNO and Risk Manager review and reconcile the Nursing Supervisors shift report and incident reports to verify completion of incident reports for all reported incidents. Identified deficiencies regarding completion of incident reports are addressed immediately with corrective action and continued non-compliance results in additional corrective actions up to and including termination.	

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{A 144}		{A 144}	Goal: 100% compliance entering incident reports accurately and timely for all reportable events on an ongoing basis. Aggregated data regarding accurate reporting of incidents is reported monthly to the Quality Council, MEC and Governing Body. The CNO and Director of RM/PI implemented unannounced Mock Code Drills to simulate crisis situations and to allow staff continued opportunities to practice crisis management skills developed during new hire and annual Milieu Management/Crisis Intervention training including, but not limited to identification of escalating behaviors/imminent risk, proactive responses to crisis, decision making and use of non-restrictive and restrictive interventions. The CNO created a Mock Code Drill Schedule with drills occurring a minimum of one time per shift per week for one month, then will be reduced to one time per shift, per month on an ongoing basis. The CNO and Director of RM/PI are using the Mock Code Drills to assess staff performance, coach staff, and identify additional training needs such as revisions to training materials, assigning additional training for individual staff members, or increasing the frequency of mock drills to practice skills obtained in Milieu Management/ Crisis Intervention training. Aggregated data on mock drills, including recommendations for training or other actions is submitted monthly to the Quality Council, MEC, and Governing Body. CNO/designee and CEO review and reconcile the Police Log during operations meeting each weekday verifying the CEO/RM were notified prior to police being called and that calls were made according to established policy/protocol.	

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{A 144}		{A 144}	Goal: 100% of all police calls are reviewed with the CEO prior to the call being made and documented on the Police Log as required. Aggregated data regarding compliance with contacting the CEO prior to calling the police is reported monthly to the Quality Council, MEC and Governing Body. The CNO and Director RM/PI review data related to police calls monthly to identify any trends that indicate a need for training or process/policy review. The Risk Manager reports aggregated trending data regarding patient safety incidents and request for police assistance monthly to the Quality Council, MEC and Governing Body. Aggregated data regarding compliance is reported monthly to the Quality Council, MEC and Governing Body. If goal of 100% is not met, individual retraining and/or disciplinary action will be provided to the staff member not in compliance. Responsible: CNO	
{A 263}	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.	{A 263}	See responses to A 286.	

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{A 263}	Continued from previous page: The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by:	{A 263}	See responses to A 286.	
{A 286}	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a)Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by:	{A 286}	ACTION: The CEO reviewed the role and responsibility of the Facility Risk Manager to track and analyze incidents, communicate trends and/or risks and facilitate communication with multidisciplinary team members in order to assist in providing safe quality care to patients and reduce risk . The CEO provided re-education and counseling to the Director regarding identification of risk and the expectation to facilitate/initiate immediate actions in order to protect the safety of the patients.Understanding of expectations was verified by signed attestation. The Director of RM/PI reviewed and revised Incident Reporting Policy on 3/1/23 to clarify that the person with direct knowledge of the incident is responsible for completing an incident report by their end of the shift. Additional policy revisions included clarification regarding what events to report, when to report, and to whom to report, including the need to complete an incident report whenever police are contacted. The Director of RM/PI created and posted an Incident Reporting Guide prominently on each unit to provide a visual reminder to staff regarding incident reporting.	

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{A 286}		{A 286}	A Resource Binder was also created and placed on each unit to provide immediate access to information regarding Incident Reporting. The binder includes a copy of the policy, Incident Reporting Training materials, and Incident Reporting Dictionary. The CEO made the decision to separate the responsibilities of Risk Management and Performance Improvement and created a new position, Director of Performance Improvement. The new position is responsible for the facility quality assurance and performance improvement program including the tracking of patient care incidents, analysis and facilitation of performance improvement initiatives. (See attached job description). The position was approved by the Governing Body and posted on 2/15/23 with a hire date goal of 4/15/23. TRAINING: The CEO required the Director of RM/PI to attend Facility Risk Management Training on Investigating Events provided by corporate Risk Management staff. The Director of RM/PI provided education to the RNs, LPNs, MHTs, Therapy Staff and Providers regarding the revised policy and procedure for incident reporting and the requirement for the person with direct knowledge of the incident to complete the incident report prior to the end of the shift or as soon as possible. Training for the process of completing the incident report was provided to the MHT staff and any others not previously required. Policy revisions made 3/1/23.	

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{A 286}		{A 286}	Training as outlined above regarding incident reporting was provided in small group settings and/or individually to RN' s, LPN's, MHT's, Therapy Staff and Providers. Understanding of policies and expectations for compliance was acknowledged through written attestation. Competency for completing incident reports was assessed by written examination. The HRD verified training information/materials were added to the new hire orientation and annual trainings. MONITORING: Each House Supervisor monitors completion of incident reports prior to the end of each shift. The House Supervisor documents all incidents on the Nursing Supervisor Report. The CNO and Risk Manager review and reconcile the Nursing Supervisors shift report and incident reports to verify completion of incident reports for all reported incidents. Identified deficiencies with failure to follow Incident Reporting policy are addressed immediately and continued non-compliance results in additional corrective actions up to and including termination. Aggregated data regarding accurate reporting of incidents is reported monthly to the Quality Council, MEC and Governing Body. Goal: 100% compliance with accurate reporting of incidents. Ongoing monitoring. All incidents are reviewed with the leadership team during the daily morning meeting to discuss investigation/review activities needed. On a weekly basis, the CEO and Director of PI/ RM review all incident reports for the week as well as investigations to ensure that an adequate investigation has been completed for each.	

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{A 286}		{A 286}	On a monthly basis, the Director of RM/PI submits an analysis of all incident reports that includes aggregated data by type of incident, units, shifts, staff involved, and trends; as well as corrective actions taken and/or recommended. The analysis is submitted to the Quality Council, MEC, and Governing Body. Any failure to adequately investigate an individual incident or perform a trending analysis will be addressed by the CEO with additional training or disciplinary action as appropriate. The CEO provides a progress report on the status of recruitment for the Director of Performance Improvement position monthly to the Governing Body until the position is filled. Target hire date is 4/15/23. Responsible: Director RM/PI	
{A 385}	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by:	{A 385}	See Responses to A 395	
{A 395}	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by:	{A 395}	ACTION: The CNO and Risk Manager reviewed and affirmed the following policies contained correct instruction to staff:	

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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 395}		{A 395}	• Policy "Elopement PC-1-020"- requires staff to be assigned to responding to an elopement event, attempt to locate and prevent the patient from leaving the facility property as well as notifying designated persons or authorities if a patient leaves the facility without authorization. No revisions necessary. • "Patient Observation Policy PC-1-002" provides guidance to staff regarding timing and interval of rounding in order to minimize planned acting out opportunities. No revisions necessary. The CNO and Director of RM/PI reviewed and revised the following policies to improve patient safety: • "Patient Precaution/Restriction Level PC-1-004" – revised Elopement Precautions to include additional interventions such as the unit restriction, slipper socks, etc. Revised 3/6/23. • "Patient Precaution/Restriction Level PC-1-004" – revised to include the ability of the RN to initiate safety precautions based upon their clinical assessment until the patient is seen and reassessed by the provider. Revised 3/6/23. • "Psychiatric Emergency Code PC-1-008 – revised to provide additional guidance regarding assessment and identification of imminent risk to self/others, role of leader during crisis situation, decision making and proactively responding to crisis. Revised 3/2/23. The CEO conducted a series of Town Hall Meetings on 3/3/23 to communicate the organizations mission and expectation to provide quality care in a safe setting without police assistance and the commitment of the leadership team to support staff by providing additional training resources as well as any other needs identified through quality reviews and staff feedback.	

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	344016	A. BUILDING _____ B. WING _____	R-C 03/21/2023

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{A 395}		{A 395}	Staff attendance was documented on an attendance log. Information provided during the Town Hall Meeting was communicated to staff not in attendance in writing from the CEO via email, posting in staff lounge and unit communication books The CNO, HRD and Clinical Training Coordinator reviewed and revised Crisis Intervention training to include an additional eight (8) hours for a total of sixteen (16) hours of training at the time of new hire orientation to allow for content learning, application opportunities, and skills practice. A four (4) hour abbreviated version of this training was provided to current staff (RNs, LPNs, MHTs) by 3/10/23. CPI recertification training is provided every 6 months for RNs, LPNs, MHTs, and Therapy staff. The Risk Manager and CNO re-implemented the incident reporting process outlined in policy requiring the person with direct knowledge of the incident to complete the incident report prior to the end of the shift. The practice of not allowing MHTs to enter reports was discontinued and the expectation for compliance with the policy was communicated to all MHTs and nursing staff. The facility IT coordinator assigned login credentials for all MHTs and credentials were provided to MHTs by the Risk Manager/ designee. Receipt of credentials and understanding of process was acknowledged through written attestation. All direct care staff including RNs, LPNs, MHTs, Therapy staff received training on policy requiring the person with direct knowledge of the incident to complete the incident report prior to the end of the shift. Understanding of the new process was acknowledged through written attestation.	

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{A 395}		{A 395}	The CNO reviewed and revised job descriptions and clarified the role and responsibilities of the Unit RN, Therapeutic Intervention Coordinator (TIC) and MHT. Clarification included: •The unit RN is ultimate responsibility for the supervision and safe care of patients, including making assignments for all MHT staff and directing care provided by the nursing/MHT team during that shift. •Under the direction of the RN, the TIC assists nursing/MHT staff with milieu management support and proactive responses to patient behaviors in order to reduce need for crisis management. •MHT responsibilities include monitoring of patient behaviors, identification of y safety risk, communication of changes in patient condition, and proactive intervention in order to reduce the risk of patient aggression resulting in harm to self or others. TRAINING: The CNO/designee provided re-education to nursing staff (RNs. LPNs and MHTs), therapy staff and Medical Staff on the following requirements of the revised policies and procedures: • “Patient Precaution/Restrictions” and use of additional interventions such as unit restriction, and slipper socks for patients placed on Elopement Precautions. Revised 3/6/23. • “Patient Precaution/Restrictions” including the RN’s ability to initiate precautions and interventions such as unit restriction, increased level of observations based on their clinical assessment until the provider reassesses the patient. Revised 3/6/23	

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{A 395}		{A 395}	• "Psychiatric Emergency Code" and the assessment/identification of imminent risk, proactive intervention, leadership role during code and use of decision-making matrix during crisis. Revised 3/2/23 • "Incident Reporting" and the requirements for reporting incidents including what to report, to whom to report, time frames for reporting and guidelines for contacting the police. Revised 3/1/23. The Risk Manager/designee provided education to all MHTs on the use of login credentials and entering incident reports in Midas. Receipt of credentials was acknowledged through written attestation. Competency regarding completion of incident report was assessed through written examination. The CNO/designee and Clinical Training Coordinators provided a 4- hour abbreviated Milieu Management and Non-violent Crisis Management training as referenced above to all RNs, LPNs and MHTs. Training which is included in the additional day of CPI training included: • Use of Crisis Development Model and proactive response to a crisis • Use of Decision Making Tool during crisis • Understanding and identifying imminent risk • Review and practice of non-restrictive and restrictive interventions The CNO and HRD verified all training information/materials are included in the New Hire Orientation and Annual Trainings. All training as described above was provided in small group settings and/or individually. Understanding of policies and expectations for compliance was acknowledged through written attestation.	

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{A 395}		{A 395}	Competency for completing incident reports, milieu management and crisis management was assessed through written examination and/or return demonstration. All training was completed by 3/10/23. Any staff (RN, LPN, MHT, Therapy Staff and Medical Staff) who did not complete the training as outlined above by this date were required to complete prior to the beginning of their next assigned shift. The Divisional Director of Nursing provided training to the Nurse Managers, House Supervisors and unit RNs regarding the role and responsibilities of a nurse leader to include, but not limited to, responsibilities, standards of care, quality and safety and critical thinking skills. The CNO/designee provided re-education to the RNs, LPNs, and MHTs on the distinctions between the roles and responsibilities of the RN, TIC, and MHT with an emphasis on the RN's responsibility for the direction and supervision of the care of the patients. All training as outlined above was provided in small group settings and/or individually to RNs, LPNs and MHTs. Understanding of policies and expectations for compliance was acknowledged through written attestation. HRD verified that training information/materials are included in new hire orientation and annual training. MONITORING: Each shift, the House Supervisor monitors patient precautions and verifies patients identified at risk for elopement are placed on Elopement precautions and have an additional intervention such as unit restriction, use of slipper socks, etc. The audit is submitted to the CNO daily for review and monitoring. Findings are reviewed in Daily Nurse Leadership shift reports.	

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{A 395}		{A 395}	Identified deficiencies regarding patients identified at risk of elopement not correctly placed on precautions and unit restriction are addressed immediately and continued non-compliance results in additional corrective actions up to and including termination. Goal: 100% compliance with identified patients at risk for elopement are assigned precautions and additional interventions such as unit restriction and/or slipper socks. Monitoring is ongoing. Aggregated data regarding assignment of interventions for patients on Elopement Precautions is reported monthly to the Quality Council, MEC and Governing Body. Each House Supervisor monitors completion of incident reports prior to the end of each shift. The House Supervisor documents all incidents on the Nursing Supervisor Report. The CNO and Risk Manager review and reconcile the Nursing Supervisors shift report and incident reports to verify completion of incident reports for all reported incidents. Identified deficiencies regarding completion of incident reports are addressed immediately with corrective action and continued non-compliance results in additional corrective actions up to and including termination. Goal: 100% compliance entering incident reports accurately and timely for all reportable events on an ongoing basis. Monitoring is ongoing. Aggregated data regarding accurate reporting of incidents is reported monthly to the Quality Council, MEC and Governing Body.	

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{A 395}		{A 395}	The CNO and Risk Manager review and reconcile the Nursing Supervisors shift report and incident reports to verify completion of incident reports for all reported incidents. Identified deficiencies regarding completion of incident reports are addressed immediately with corrective action and continued non-compliance results in additional corrective actions up to and including termination. Goal: 100% compliance entering incident reports accurately and timely for all reportable events on an ongoing basis. Monitoring is ongoing. Aggregated data regarding accurate reporting of incidents is reported monthly to the Quality Council, MEC and Governing Body. The CNO and Director of RM/PI implemented unannounced Mock Code Drills to simulate crisis situations and to allow staff continued opportunities to practice crisis management skills developed during new hire and annual Milieu Management/Crisis Intervention training including, but not limited to identification of escalating behaviors/imminent risk, proactive responses to crisis, decision making and use of non-restrictive and restrictive interventions. The CNO created a Mock Code Drill Schedule occurring a minimum of one time per shift per week for one month, then will be reduced to one time per shift, per month on an ongoing basis. The CNO and Director of RM/PI are using the Mock Code Drills to assess staff performance, coach staff, and identify additional training needs. Aggregated data on mock drills, including recommendations for training or other actions is submitted monthly to the Quality Council, MEC, and Governing Body.	

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{A 395}		{A 395}	CNO/designee and CEO review and reconcile the Police Log during operations meeting each weekday verifying the CEO/RM were notified prior to police being called and that calls were made according to established policy/protocol. Goal: 100% compliance police calls reviewed with the CEO prior to the call being made and documented on the Police Log as required. Aggregated data regarding compliance with contacting the CEO prior to calling the police is reported monthly to the Quality Council, MEC and Governing Body. Monitoring is ongoing. The CNO and Director RM/PI reviews data related to police calls monthly to identify any trends that indicate a need for training or process/policy review. The Risk Manager reports aggregated trending data regarding patient safety incidents and requests for police assistance monthly to the Quality Council, MEC and Governing Body. Responsible: CNO	
{A 450}	MEDICAL RECORD SERVICES CFR(s): 482.24(c)(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by:	{A 450}	ACTION: The CEO and CNO reviewed and confirmed “Active Treatment and Individualized Treatment-Acute” policy requires the group leader to maintain an attendance list of patient in-group and document participation in the medical record. No revisions necessary. The DCS provided a sample attendance roster to the therapy staff, RNs and MHTs for use during their groups. The Medical Records Director, CEO and Medical Director reviewed and affirmed the Medical Staff Rules and Regulations to state the requirement to authenticate progress notes via signature, time and date. Revised 3/9/23.	

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{A 450}		{A 450}	TRAINING: The CEO and CNO provided re-education to the Therapy Staff, RNs, MHTs and Medical Staff regarding the policy “Active and Individualized Treatment- Acute” and the requirement to maintain an attendance list of patients who are in-group and document the patient’s participation in the medical record. The Medical Director/designee provided re-education to the Medical Staff regarding the Medical Staff Rules and Regulations and the requirement to authenticate progress notes via signature, time and date. Provider Assistants were provided education by the CEO and/or the Director of PI/RM on documentation requirements including 1) correct signatures with date/time, 2) the correct process, including correct identification of scribe for progress notes from the provider, and 3) the correct process for documentation of independent contact progress notes. All training as outlined above was provided in small group settings and/or individually to RNs, MHTs, Therapy Staff and Medical Staff. Provider Assistants were provided training in person or via Zoom. Understanding of policies and expectations for compliance was acknowledged through written attestation. MONITORING: For a period of at least four months, the Director of Medical Records/designee and Director of Clinical Services are conducting an audit of all discharge patient records to verify patient record documentation accurately reflects patient participation in group activities. Upon achieving 90% compliance with medical record documentation for four months, sampling will be reduced to 20% of records.	

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{A 450}		{A 450}	The Medical Records Director/ designee analyzes 100% of discharge records to identify any missing signatures, dates or times on Medical Staff documentation. Missing signatures, dates or times are reported to the supervisor, addressed immediately through corrective action/counseling, and reflected in provider OPPE. Corrections to the medical record are made in compliance with facility policy and procedure. Continued non-compliance results in additional corrective actions up to and including termination. Upon achieving 90% compliance with medical record documentation for four months, sampling will be reduced to 20% of records. Responsible: Medical Records Director	
{A 454}	CONTENT OF RECORD: ORDERS DATED & SIGNED CFR(s): 482.24(c)(2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by:	{A 454}	ACTION: The Medical Director reviewed and revised the Medical Staff Rules and Regulations to require authentication of telephone orders with signature, date and time within 24 hours. Revised 3/9/23. The Medical Records Director developed and implemented an auditing process to verify authentication of electronic and paper telephone orders per policy/procedure and Medical Staff Rules and Regulations on 3/10/23. The new process includes a daily review of HCS reports to verify authentication of electronic orders, notification of providers regarding orders that have not been authenticated, provision of colored flag designated for physicians to each unit as a visual aid for Providers for paper orders, and review of paper medical records daily to verify paper orders are authenticated.	

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{A 454}		{A 454}	TRAINING: The Director of Medical Records and Medical Director provided training to medical records staff and Providers regarding the revised policy and procedure and revised Medical Staff Rules and Regulations regarding: • Requirement for authentication of telephone orders within 24 hours with a signature, time and date. • Use of color flags as a visual aid to providers that orders require a signature, date and time • Process of notification regarding any deficiencies and expectation to complete as soon as possible. Data regarding compliance with authentication of orders is included in the provider OPPE. The Medical Records director provided education to the RNs and LPNs regarding the flagging system and the process for flagging telephone orders with color flags to alert physicians to authenticate orders. Trainings as outlined above were provided in small group settings and/or individually to RNs, LPNs, Medical Records Staff and Medical Staff by 3/10/23. Anyone not trained by this date received individual training prior to working the next shift. Understanding and agreement to comply with the policy and procedure/Medical Staff Rules and Regulations regarding authentication of telephone orders with a signature, date and time was acknowledged by written attestation. The HRD revised new hire orientation and annual trainings in include updated medical record documentation training information for medical records staff, RNs, LPNs and Medical Staff.	

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{A 454}		{A 454}	MONITORING: The Director of Medical Records/designee audits 100% of all paper orders and HCS electronic orders for unsigned orders on all active and discharged medical records. Goal: 100% compliance with authentication of telephone orders within 24 hours. Monitoring is ongoing. Unsigned orders are communicated to the Provider for correction and data is included in the Provider OPPE. Continued non-compliance with authentication of telephone orders within 24 hours is reported to the Medical Director and is addressed through corrective counseling and/ or initiation of an FPPE. The Medical Director/designee reports aggregated data regarding compliance with authentication of telephone orders monthly in Quality Council, MEC and Governing Body. Responsible: Medical Director	

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