North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
2712 Mail Service Center v Raleigh, North Carolina 27699-2712

Michael F. Easley, Governor
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http://facility-services.state.nc.us

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VIA FACSIMILE

September 18, 2007

Rob Turner, PhD, CEO
Holly Hill Hospital
3019 Falstaff Road
Raleigh, NC 27610

RE: Complaint investigation NC00039502

Dear Dr. Turner:

Thank you and your staff for the assistance provided to our team during the complaint investigation conducted at Holly Hill Hospital in Raleigh, NC on September 13-14 & 17, 2007. The purpose of conducting the complaint investigation survey was to evaluate the Hospital's compliance with the Conditions of Participation. The investigation resulted in identification of an Immediate Jeopardy (IJ) on September 17, 2007 at 1400, as a result of investigative findings beginning on April 17, 2007. Specifically, pursuant to **Conditions of Participation 482.23 Nursing Services and 482.25 Pharmaceutical Services**, the hospital failed to address medication errors to include: (a) the administration of medications to the wrong patients without physician notification of the medication error, (b) medication administration without a physician's order, (c) failure to administer medications according to a physician's order; and, (d) medication omissions.

As discussed during the survey, the information gathered during the survey was forwarded to the CMS Regional Office in Atlanta (Region IV). Our state agency is recommending 23 day termination due to noncompliance with the **Conditions of Participation: 482.12 Governing Body, 482.13 Patients' Rights, 482.21 Quality Assessment and Performance Improvement, 482.23 Nursing Services and 482.25 Pharmaceutical Services**. CMS Regional Office in Atlanta will make the determination of compliance or non-compliance and abatement or non-abatement of the immediate jeopardy. The CMS Regional Office will notify you of their findings and of any action to be taken. If you have questions regarding the status of the investigation, please contact the State Representative at CMS:

Ms. Janetta Booker
Division of Survey and Certification
CMS Atlanta Regional Office
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW Suite 4T-20
Atlanta, Georgia 30303-8909
(404) 562-7343

If you have any questions, please do not hesitate to contact this office at (919) 855-4620.

Sincerely,

Doug Stanton, RN, BSN
Facility Survey Consultant
Acute and Home Care Licensure and Certification Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344014	A. BUILDING _____ B. WING _____	C 09/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY HILL MENTAL HEALTH SERVICES	3019 FALSTAFF RD RALEIGH, NC 27610

(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 000	INITIAL COMMENTS A complaint investigation was conducted at the hospital on September 13-14 & 17, 2007. As a result of investigative findings beginning on April 17, 2007, an Immediate Jeopardy (IJ) was identified on September 17, 2007 at 1400 in regards to the facility failed to address medication errors, resulting in a potential or immediate threat to the health and safety of patients served. The immediate jeopardy was not abated. Nursing staff administered the wrong medication to a patient (a seven year-old), and did not notify the physician or guardian of the medication error. The physician altered the patient's medication regimen based on current assessment, but without knowledge of the medication error (#8). Patient #11 was administered another patient's medication and the physician was not notified of the medication error. A total of 4 of 17 patients sampled had medications given which were not ordered by the physician (#8, #12, #10, #11). Nursing staff failed to monitor for identification of a side effect (low blood pressure) of a medication administered to a five year-old by failing to ensure vital signs were obtained as ordered by the physician (#16). Six of 17 patients sampled had medications not documented as given and no documentation in the nurses notes as to why the medications were not administered as ordered by the physician. The physician was not notified the patient refused or missed the dose of medication (#7, #20, #6, #4, #13, #12). A summary of the action plan submitted and implemented by the hospital on 9-17-2007 included: 1. All medication transcription and administration	A 000	**The facility has ensured that there is no potential or immediate threat of the health and safety of patients served, by taking the steps outlined in this Plan of Correction. Implementation of corrective actions began during the survey and has continued ongoing.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert J Turner Ph D — TITLE: Chief Executive Officer — (X6) DATE: 9.26.07

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 000	Continued From page 1 was halted as of 1515 on 9-17-2007 pending education of current nursing staff and supervisor staff in the building at that time. 2. Training nursing staff and supervisor staff on subsequent shifts would be provided until 100% of staff trained. 3. Unit Secretaries no longer transcribing medication orders. 4. Education provided to nursing staff through an education packet, including: a. Transcription of medication orders only by licensed nursing staff and co-signed by licensed nursing staff. 100% of medication order transcription to be monitored by management staff for 30 days for compliance. b. All medication passes for 30 days will be monitored by supervisor staff and documented. Recommendations and findings will be discussed at the Monday through Friday management meetings. c. Policy "Medication Administration: General Guidelines" to be reviewed, specifically, no medications will be given without a physician order. d. Medications Clonidine and Tenex added to the "High Risk Medications" policy. Physician education provided to 100% of physician staff by the physician Medical Director on 9-17-2007. Physician staff will order blood pressure parameters. Blood pressures and pulse rates for these medications will be documented on the medication administration record (MAR). All	A 000		

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A 000	Continued From page 2 doses of high risk medications will be called to the monitoring nurse for verification. Monitoring of MARs by the management staff for 30 days for 100% compliance. e. Education to nursing staff regarding calling all medication errors to the physician by the administering nurse or by the management staff if recognized after the administration period. f. All medication errors will be reviewed in the Monday-Friday management team meetings to ensure appropriate follow-up. g. Medication error data collected daily (number and type of errors) and aggregated weekly, monthly, and quarterly with graphical presentation. Aggregated data to be reviewed by nursing management, medical executive committee and safety committee. h. Pharmacist availability increased by 3.5 hours each day Monday through Friday, and four hours on Saturdays and Sundays. i. Education and implementation of an electronic medication administration record. j. All telephone orders will be discontinued if not signed by the physician within 24 hours. 100% of medical staff educated on 9-17-2007.	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. 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	A 043	See next page	

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A 043	Continued From page 3 that pertain to the governing body. This CONDITION is not met as evidenced by: Based on review of policy and procedures, open and closed medical records, medication error investigation reports, facility meeting minutes, quality assessment and performance improvement data, observations during tour and staff interview, the facility's leadership staff failed to provide an organized nursing and pharmaceutical service by failing to: ensure medications were administered only under the order of a physician for 4 of 17 sampled patients (#8, #12, #10, #11); administer medications as ordered by the physician for 6 of 17 patients sampled (#7, #20, #6, #4, #18, #12); reassess for the effect of medication being administered and reassess vital signs per physicians's order for 7 of 17 sampled patients (#16, #5, #2, #11, #3, #17, #9); and, notify a physician of a medication error for 2 of 17 patients sampled (#8, #11). The facility's leadership staff failed to promote the rights of its patients by failing to notify the guardian of wrong medications being given to their children for 2 of 7 unemancipated patients under the age of 18 (#8, #10). The facility's leadership staff failed to incorporate and maintain data related to medication errors, and regarding nursing and pharmaceutical services, into its quality assessment and performance improvement activities. Findings include: A) The facility's leadership staff failed to provide an organized nursing staff by failing to ensure medications were administered only under the order of a physician for 4 of 17 sampled patients	A 043	**A 043:** The hospital now ensures an effective Governing Body and leadership responsible for the conduct of the hospital as an institution. In order to effectively guide the responsibilities of nursing services and pharmaceutical services, the following actions have been taken: •The Governing Body has added 2 additional meetings to its 2007 4th quarter and 2008 1st quarter meetings to review items in this action plan. Review of the corrective actions in this action plan will be an ongoing, standing agenda, along with evaluation of outcomes with any necessary recommendations. The corporate Divisional President will participate in this review and oversight. At a minimum, the agenda will consist of an outcomes review of this corrective action plan as well as a report from the CEO on nursing services and pharmaceutical services. •A daily weekday meeting convenes to analyze medication errors and overall medication management from the previous 24 hours (The Monday meeting will include a review of all medication errors from the weekend period). This analysis also includes results from the medication monitoring on medication passes. Actions are identified from this analysis for implementation within nursing and pharmaceutical services. Continued on next page	9/18/07 ongoing

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A 043	Continued From page 4 (#8, #12, #10, #11). ~ cross refer to 482.23(c) Administration of Drugs - Tag A0404 B) The facility's leadership staff failed to provide an organized nursing staff by failing to administer medications as ordered by the physician for 6 of 17 patients sampled (#7, #20, #6, #4, #18, #12); ~ cross refer to 482.23(c) Administration of Drugs - Tag A0404 C) The facility's leadership staff failed to provide an organized nursing staff by failing to reassess for the effect of medication being administered and reassess vital signs per physicians's order for 7 of 17 sampled patients (#16, #5, #2, #11, #3, #17, #9); ~ cross refer to 482.23(b)(3) RN Supervision of Care- Tag A0395 D) The facility's leadership staff failed to provide an organized nursing service by failing to notify a physician of a medication error for 2 of 17 patients sampled (#8, #11); ~ cross refer to 482.23(b)(3) RN Supervision of Care- Tag A0395 E) The facility's leadership staff failed to provide an organized pharmaceutical service by failing to notify a physician of a medication error for 2 of 17 patients sampled (#8, #11); ~ cross refer to 482.25(b)(6) Reporting Complications - Tag A0508	A 043	Continued from page 4: **A043:** •These Governing Body members now receive updates on the following key action plan items, and take actions to ensure that: -All medications given have a physician order -Effectiveness of medications is reassessed along with the reassessment of vital signs as needed -Physician notification occurs with all medication errors -Pharmacy Services notifies physicians of all medication errors -Guardians are informed of all medication errors that involve minors -Data from medication errors related to nursing and pharmacy services are aggregated and analyzed into performance improvement. -Pharmacy services is tracking all medication errors through it own system for cross-reference to nursing services. Monitoring: Actions are identified through this review for prompt follow-up and are recorded on the Medication Variance Reports and morning management meeting notes as appropriate. Any instances of noncompliance will be reviewed and the Governing Body will ensure that any necessary related resources, education and/or corrective actions are taken. This daily weekday meeting will continue to convene for a minimum of four additional months to ensure safe administration of medications. After such period, reporting of medication errors from Pharmacy and Nursing will be a standing agenda items at the daily weekday morning management meeting. Persons Responsible: CEO, DON, Pharmacy Director, and Medical Director.	

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A 043	Continued From page 5 F) The facility's leadership staff failed to promote the rights of its patients by failing to notify the guardian of wrong medications being given to their children for 2 of 7 unemancipated patients under the age of 18 (#8, #10). ~ cross refer to 482.13(b)(2) Patients' Rights - Informed Consent - Tag A0131 G) The facility's leadership staff failed to incorporate and maintain data related to medication errors, and regarding nursing and pharmaceutical services, into its quality assessment and performance improvement activities. ~ cross refer to 482.21(e)(1) QAPI Executive Responsibilities - Tag A0311 H) The facility's leadership failed to ensure pharmacy services developed and maintained a system to analyze and track medication errors. ~ cross refer to 482.25(a)(1) Pharmacist Responsibilities - Tag A0492	A 043	**A 115** Plan of Correction: Medication Error Reporting Form ("Medication Variance Report") was revised to include the clear notification of: -Family/Guardian -Name and relationship -Date and time Implementation: Previously used forms were removed and replaced with revised form. Monitoring: All medication errors will be reviewed during the morning management meeting with members of the Governing Body present, including DON, CEO, and Medical Director, as well as Pharmacy Director. The DON, CEO, and Medical Director are responsible for this review and ensure that any medication errors without notification to family or guardian will be promptly corrected to provide proper notice. This audit will continue in order to ensure that 100% compliance is maintained. Medication errors will remain in the daily review of nursing and pharmacy supervisory staff as a standing agenda item to the weekday morning management meeting, with monthly reviews in Safety Committee, Pharmacy and Therapeutics Committee, and Medical Executive Committee. Persons Responsible: CEO, DON, and Medical Director.	9/18/07
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on review of policy and procedures, open and closed medical records, medication variance reports, and staff interview, the facility's leadership staff failed to promote the rights of its	A 115		

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A 115	Continued From page 6 patients by failing to notify the guardian of wrong medications being given to their children for 2 of 7 unemancipated patients under the age of 18 (#8, #10). Findings include: ~ cross refer to 482.13(b)(2) Patients' Rights - Informed Consent - Tag A0131	A 115		
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT 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 review of policy and procedures, open and closed medical records, medication variance reports, and staff interview, the facility failed to notify the guardian of wrong medications being given to their children for 2 of 7 unemancipated patients under the age of 18 (#8, #10).	A 131	**A 131** Plan of Correction: 1. Medication Error Reporting Form (entitled "Medication Variance Report") was revised to include the clear notification of family/guardian and physician. Previously used forms were removed and replaced with revised form. Training of new forms was initiated on 9/20/07 with a planned completion date of September 27, 2007 from all-staff competency sessions. Training content includes: •Use of revised Medication Error Reporting Form •Proper completion of the form with an emphasis on notifications •Proper documentation of medication errors and medication administration in the medical record. Any nursing staff not present at the all-staff competency session will be required to complete training prior to working. Person Responsible: Director of Nursing Continued on next page	Initiated 9/18/07 Target Completion 9/27/07

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A 131	Continued From page 7 Findings include: Review of policy "Patient Rights" revised 12-2003 revealed "...5. The patient has the right to receive information from his/her physician about his/her illness, course of treatment, outcome of care (including unanticipated outcomes)..." Further review revealed "At Time of Admission...6. (name of facility) must have all patient rights available to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient." 1. Closed record review for Patient #7 revealed a 12 year old male admitted to the facility on 8-12-2007 for bipolar disorder. Review of physician's orders on 8-13-2007 at 1350 revealed "Tegretol 200mg PO am (in the morning) and hs (at bedtime). Review revealed "noted 8/13/7 (name of unit secretary)". Further review revealed "8/13/07 noted 1405 (name of RN)". Further review revealed documented below the RN note of the order at 1405 "8/13/07 noted (name of RN #2)". Closed record review for Patient #8 revealed a seven year-old male admitted to the facility on 8-08-2007 for attention deficit hyperactivity disorder and bipolar disorder. Review of the MAR revealed "Tegregol (a medication to control seizures or to stabilize a mood disorder) 200mg po am (in the morning) & hs (at bedtime) - order 8/13/7...T (transcriber) (initials of unit secretary noting Tegretol order off Patient #7 record), NI (nurse initials) (initials of RN noting order at 1405 off Patient #7 record). Further review of the MAR revealed on 8-13-2007 at 2000 initials of the nurse who administered Tegretol 200mg po to the	A 131	**A 131** Continued from previous page Monitoring: 1. All medication errors will be reviewed during the morning management meeting by the CEO, DON, ADON, Pharmacy Director, and Medical Director for the assurance that all notifications are completed. Any errors without notification to family or guardian will be promptly corrected to provide proper notice. In addition, nursing supervisory staff will provide education, coaching and/or corrective action to nursing staff as needed related to the medication error. This audit will continue to ensure 100% compliance is maintained. 2. All medication passes are monitored by supervisory staff in order to assess medication administration and check for any medication errors. All errors will be evaluated for completeness and actions will be taken to ensure that all proper notifications are completed. Any additional staff training, coaching and/or corrective actions will also be provided as needed. This enhanced monitoring will continue until such time as there is evidence of ongoing safe and appropriate medication administration. After such period, random monitoring of medication passes will be conducted to ensure ongoing compliance. Training and/or corrective actions will also be ongoing as needed. Persons Responsible: CEO, DON, and Medical Director.	

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patient. Further review of the MAR revealed written beside the Tegretol "wrong pt's MAR". Review of the physician orders failed to reveal an order for Tegretol 200mg po by the physician. Record review of the nursing progress notes failed to reveal documentation of the medication being given or of the physician or guardian being notified of the medication being given. Review of physician progress notes on 8-14-2007 revealed "Pt sleepy during daytime - unable to assess as pt refuses to wake up...change Clonidine 0.05mg po am"

Interview with a unit secretary on 9-14-2007 at 1500 revealed the unit secretary took the order for the Tegretol 200mg po off the physician's orders for Patient #7 on 8-13-2007 at 1350, but accidentally transcribed the medication onto the MAR for Patient #8. Interview revealed a RN noted the order on Patient #7's record at 1405 and initialed the transcribed medication on the MAR for Patient #8.

Interview with the physician for Patient #8 on 9-14-2007 at 1530 revealed the physician was not aware of the Tegretol being given to her patient. Interview revealed the physician changed the Clonidine dose for Patient #8 based on the assessment that the patient was drowsy and difficult to arouse. Interview revealed with knowledge of the medication error, the physician would not have modified Patient #8's medication regimen. Interview revealed Tegretol can cause drowsiness.

Review of the investigative report of the incident dated 8-13-2007 revealed "Notifications: Doctor:" was left blank. Further review revealed "Notifications: ...Family..." was not checked "yes"

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A 131	Continued From page 9 or "no". Review of the form revealed review by a facility Assistant Director of Nursing. Interview with nurse management staff on 9-14-2007 at 1605 who completed an investigation of the medication error event revealed the staff member was unaware as to whether the guardian was notified. Interview revealed the investigation did not document whether the guardian was notified. Interview revealed either the nursing staff, after consultation with the physician, would be expected to notify the guardian of any medication error. Interview failed to reveal documentation of physician or guardian notification of the medication error. Interview confirmed staff did not follow facility policy on notifying the guardian of a medication error. Interview with nursing administrative staff on 9-14-2007 at 1635 revealed no knowledge of the medication error between Patient #7 and #8. Interview revealed the error occurred within the first week of employment at the facility. Interview revealed it has been recognized that there has been an increase in medication error reporting at the facility related to increased nursing awareness of reporting errors. Interview further revealed there is a plan for better aggregation and analysis of medication errors at the facility. Interview revealed without the aggregated information there have been no current priorities identified to address specific medication errors with nursing staff. Interview confirmed nursing staff did not follow facility policy in not notifying the physician or guardian of the medication error. 2. Closed record review for patient #13 revealed a 45 year old admitted to the facility on 7/23/2007	A 131		

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for Cocaine Dependence and Major Depressive Disorder. Review of physician's orders on 7/23/2007 at 1600 revealed "Cymbalta (anti-depressant drug) 30 mg (milligrams) po (by mouth) daily start 1st dose today." Review revealed "noted (name of unit secretary) 7/23/2007 at 1620." Further review revealed "noted (name of nurse) 7/23/2007 1700."

Closed record review of patient #11 revealed a 36 year old admitted on 7/23/2007 for Alcohol Dependence and Bipolar (psychiatric) Disorder. The patient was discharged on 8/4/2007. Review revealed "Cymbalta (anti-depressant drug) 30mg (milligrams) po (by mouth) daily (1st dose today)" transcribed (written) onto a Medication Administration Record (MAR). Further review revealed "Order 7/23/07, E/R (Expiration Date/Reorder) 8/22, T (transcriber) (initials of unit secretary noting Cymbalta order off of patient #13 record), NI (nurse initial left blank)." Further review of the MAR revealed on 7/23 at 1800, initials of the nurse who administered Cymbalta 30mg po to patient #11. Record review failed to reveal a physician's order for Cymbalta 30mg po daily, 1st dose now by the physician. Record review of nursing progress notes failed to reveal documentation of the medication being given or of the physician being notified of the medication being given.

Interview with the attending physician for patient #11 on 9/14/2007 at 1245 revealed the physician was not aware of the Cymbalta being given to the patient. Interview revealed "This patient was placed on Lexapro (antidepressant drug), so I would not have placed them on Cymbalta because that would be two drugs for depression." Further interview confirmed that the physician did

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A 131	Continued From page 11 not write an order in the physician orders for Cymbalta. Further interview revealed "I expect the nursing staff to inform me immediately when a medication error has occurred." Further interview revealed no notification of the parents or guardians of the patient regarding the medication error by the physician. Further interview confirmed the physician was not notified of the medication error and did not notified the parents or guardians. Interview with nursing management staff on 9/14/2007 at 1610 failed to reveal available documentation of a physician's order or of physician or guardian notification of the administration of Cymbalta to patient #11. Interview confirmed nursing staff did not follow facility policy in not notifying the physician or guardian of the medication error.	A 131		
A 263	482.21 QAPI 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. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 263	**A 263** Plan of Correction: The hospital ensures that an effective, ongoing, comprehensive data-driven performance improvement program is in place. Performance improvement activities and planning will include all aspects of care throughout the various hospital departments. As these activities relate to pharmacy and nursing services, the following actions have been executed: Continued on next page	9/26/07

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A 263	Continued From page 12 This CONDITION is not met as evidenced by: Based on review of policy and procedures, meeting minutes, quality assessment and performance improvement data, and staff interview, the facility's leadership staff failed to incorporate and maintain data related to medication errors, and regarding nursing and pharmaceutical services, into its quality assessment and performance improvement activities. Findings include: A) The facility's leadership staff failed to develop a system to analyze and track medication errors. ~ cross refer to 482.21(e)(1) QAPI Executive Responsibilities - Tag A0311 B) The facility's leadership staff failed to provide an organized nursing staff by failing to ensure medications were administered only under the order of a physician for 4 of 17 sampled patients (#8, #12, #10, #11). ~ cross refer to 482.23(c) Administration of Drugs - Tag A0404 C) The facility's leadership staff failed to provide an organized nursing staff by failing to administer medications as ordered by the physician for 6 of 17 patients sampled (#7, #20, #6, #4, #18, #12);	A 263	**A 263** Continued from previous page **A)** The system for data collection, aggregation, and analysis for performance improvement functions was reengaged for all hospital departments. In particular, an enhanced system to analyze and track medication errors is in place through: ▪A revised medication error reporting form. ▪Monday-Friday review of all medication errors by members of the Governing Body and Pharmacy Director for tracking, analysis and prompt intervention of medication errors for the next 4 months. After such time, medication errors will be reviewed on weekdays by the Pharmacy Director and Nursing Supervisory staff and will be reported to the daily weekday morning management meeting. On the weekends, supervisory nursing and pharmacy staff will review and report on the Monday morning management meeting. Data is aggregated for daily, monthly and quarterly analysis. **B,C)** All medication errors are reviewed daily to ensure proper follow-up. All medication errors, including medications given without a physician order and medications given that do not follow a physician's order, receive prompt follow-up and physician notification as needed. Medication errors are tracked daily and aggregated for review in Pharmacy and Therapeutics meeting, Medical Executive Committee, and Safety Committee. Continued next page	

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A 263	Continued From page 13 ~ cross refer to 482.23(c) Administration of Drugs - Tag A0404 D) The facility's leadership staff failed to provide an organized nursing staff by failing to reassess for the effect of medication being administered and reassess vital signs per physicians's order for 7 of 17 sampled patients (#16, #5, #2, #11, #3, #17, #9); ~ cross refer to 482.23(b)(3) RN Supervision of Care- Tag A0395 E) The facility's leadership staff failed to provide an organized nursing service by failing to notify a physician of a medication error for 2 of 17 patients sampled (#8, #11); ~ cross refer to 482.23(b)(3) RN Supervision of Care- Tag A0395 F) The facility's leadership staff failed to provide an organized pharmaceutical service by failing to notify a physician of a medication error for 2 of 17 patients sampled (#8, #11); ~ cross refer to 482.25(b)(6) Reporting Complications - Tag A0508 G) The facility's leadership staff failed to promote the rights of its patients by failing to notify the guardian of wrong medications being given to their children for 2 of 7 unemancipated patients under the age of 18 (#8, #10). ~ cross refer to 482.13(b)(2) Patients' Rights - Informed Consent - Tag A0131	A 263	**A 263** Continued from previous page **D)** All vital signs used for assessing and reassessing the effects of medications per physician order will be obtained and documented in the medical record and vital signs sheet. Monitoring: The obtainment, response to, and documentation of vital signs will be monitored to ensure 100% compliance is maintained. Person responsible: Director of Nursing. **E, G)** All medication errors will be promptly called to physicians and to parents/guardians by nursing staff. Medication errors will be documented on the Medication Variance Reports with notifications indicated of the date and time. Monitoring: Medication Variance Reports will be audited to ensure 100% compliance. Person responsible: Director and Assistant Directors of Nursing. **F)** All medication errors will be promptly called to physicians by pharmacy staff. Medication errors will be documented on the Medication Variance Reports with notification indicated of the date and time. Monitoring: Medication Variance Reports will be audited to ensure 100% compliance. Person responsible: Pharmacy Director.	
A 311	482.21(e)(1) EXECUTIVE RESPONSIBILITIES	A 311	See next page	

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A 311	Continued From page 14 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 that an ongoing program for patient safety, including the reduction of medical errors, is defined, implemented and maintained. This STANDARD is not met as evidenced by: Based on review of facility meeting minutes, quality assessment and performance improvement data, and staff interview, the facility's leadership staff failed to develop a system to analyze and track medication errors. Findings include: Review of facility policy "Improving Organizational Performance" revised 8-06 revealed "Philosophy - ...The facility fulfills its responsibilities...through continuous and systematic monitor, aggregation, and analysis of system and process outcomes..." Further review revealed "Scope - Organization-wide improving organizational performance/risk management activities include...medication error administration usage reports...The current status is communicated by the Quality Council to the Medical Staff Executive Committee and the Board of Trustees quarterly..." Further review of policy revealed "Pharmacy and Therapeutics function reviews...includes medication errors..."	A 311	**A 311** Plan of Correction: A) The system for data collection, aggregation, and analysis for performance improvement functions was reengaged for all hospital departments. In particular, an enhanced system to analyze and track medication errors is in place through: ▪A revised medication error reporting form. ▪Monday-Friday review for the next 4 months of all medication errors by members of the Governing Body (CEO, DON, Medical Director) and Pharmacy Director for tracking, analysis and prompt intervention of medication errors. Data is aggregated for daily, monthly and quarterly analysis. ▪After such period of 4 months, medication errors will be reviewed daily by pharmacy and nursing supervisory staff to ensure follow-up and will remain as a standing agenda item on the weekday morning management meeting. Data trending and analysis will be completed for monthly reporting to the Safety Committee, Pharmacy and Therapeutics, and Medical Executive Committee. Data trending and analysis will remain a standing agenda item at the Governing Board meeting. Persons Responsible: CEO, DON, Pharmacy Director, and Medical Director.	9/19/07

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A 311	Continued From page 15 Review of Pharmacy policy "Medication Errors" revised 10-2004 revealed "Procedure: ...C. ...The medication error data will be reviewed by the Pharmacy and Therapeutics committee...looking for trends and common causes." Review of facility policy "Medication Errors" revised 11-03 revealed "Procedure - ...4. A Medication Error Form is completed and forwarded to the Director of Nursing and pharmacist, who will review, investigate as needed, take any immediate corrective actions indicated, and incorporate into quality improvement data, observing for any trends or patterns..." Review of minutes from the Medical Staff Executive Committee (MEC) revealed the last report of medication errors to the MEC was in June 2006. Review of minutes from the Pharmacy and Therapeutics Committee From January 2007 to current failed to reveal trending of medication errors for common causes. Interview with the Pharmacy Director and Director of Nursing on 9-13-2007 at 1445 revealed there has been a recognized need for further trending and analysis of medication errors. Interview revealed re-education of medication error reporting was accomplished during the early summer of 2007, which increased medication error reporting. Interview revealed there has been no formalized aggregation and analysis of medication errors since March 2007. Interview failed to reveal any common causes or trends or patterns in medication errors to date.	A 311		

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A 311	Continued From page 16 Interview with the physician Medical Director and Interim Chief Executive Officer on 9-17-2007 at 1415 revealed the medication error reporting is accomplished at the MEC meetings through the Performance Improvement summary. Interview failed to reveal reporting of medication errors at the MEC from July 2006 to current.	A 311		
A 385	482.23 NURSING SERVICES 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: Based on review of facility policies and procedures, open and closed medical record review, observations during tour, review of medication variance reports, staff human resource (HR) files, and staff interview, the facility's leadership staff failed to provide an organized nursing service by failing to: ensure medications were administered only under the order of a physician for 4 of 17 sampled patients (#8, #12, #10, #11); administer medications as ordered by the physician for 6 of 17 patients sampled (#7, #20, #6, #4, #18, #12); reassess for the effect of medication being administered and reassess vital signs per physicians's order for 7 of 17 sampled patients (#16, #5, #2, #11, #3, #17, #9); notify a physician of a medication error for 2 of 17 patients sampled (#8, #11); report a critical	A 385	**A 385** Plan of Correction: 1. All nursing staff training was initiated on 9/18/07 and included: ▪Only medications ordered by physicians will be given. ▪Use of high risk medications (Clonidine and Tenex) with vital sign parameters. ▪Medication error notification requirements and documentation. ▪Use of pre-printed Medication Administration Records (MARs). ▪Telephone orders by physicians. (See attached training packet entitled "Holly Hill Hospital Medication Administration: Registered and Licensed Nurse Training"): Monitoring: All medication errors, notifications, use of the pre-printed MARs, telephone orders, and use of Clonidine and Tenex with vital signs are reviewed daily by the CEO, DON, Pharmacy Director, and Medical Director to ensure follow-up. This daily group review will continue for 4 additional months and will then be reviewed daily by the pharmacy and nursing supervisory staff. The review of medication errors will remain a standing agenda item at the weekday morning management meeting. In addition, nursing supervisory staff will provide education, coaching and/or corrective action to nursing staff as needed related to the medication error. Persons Responsible: CEO, DON, Medical Director and Pharmacy Director. Continued next page.	Initiated 9/18/07 Target Completion 10/10/07

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A 385	Continued From page 17 lab value to the physician per facility policy for 1 of 18 patients sampled (#5); update 2 of 1 sampled patients treatment plans (#16, #2); and, ensure current certification was maintained in CPR (Cardiopulmonary Resuscitation) for 3 of 5 files reviewed for employees requiring current CPR by the job description (#2, #3, #4). Findings include: A) The facility's nursing staff failed to ensure medications were administered only under the order of a physician for 4 of 17 sampled patients (#8, #12, #10, #11). ~ cross refer to 482.23(c) Administration of Drugs - Tag A0404 B) The facility's nursing staff failed to administer medications as ordered by the physician for 6 of 17 patients sampled (#7, #20, #6, #4, #18, #12); ~ cross refer to 482.23(c) Administration of Drugs - Tag A0404 C) The facility's nursing staff failed to reassess for the effect of medication being administered and reassess vital signs per physicians's order for 7 of 17 sampled patients (#16, #5, #2, #11, #3, #17, #9); ~ cross refer to 482.23(b)(3) RN Supervision of Care- Tag A0395 D) The facility's nursing staff failed to notify a physician of a medication error for 2 of 17 patients sampled (#8, #11); ~ cross refer to 482.23(b)(3) RN Supervision of	A 385	**A 385** Continued from previous page 2. Critical Lab Tests and Treatment Plans: All nursing staff reeducation was conducted on 9/27/07 to include: ▪Reporting of critical lab values to physicians ▪Updates to patient treatment plans Monitoring: ▪Critical Lab testing and completion of treatment plans will be audited to ensure that 100% compliance is maintained. All variances of critical lab test reporting will be followed up daily and promptly by nursing supervisory staff. Persons Responsible: Director and Assistant Directors of Nursing. 3. CPR Certifications: Staff training for those who require certification and recertification in CPR, will be conducted on: ▪9/28/07 ▪9/29/07 ▪10/1/07 ▪10/2/07 Any staff who cannot attend this mandatory training will be required to obtain certification or recertification by 10/10/07 in order to be eligible to work. Records of this certification will be made available for inspection. Persons Responsible: Director and Assistant Directors of Nursing; Director of Human Resources	

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A 385	Continued From page 18 Care- Tag A0395 E) The facility's nursing staff failed to report a critical lab value to the physician per facility policy for 1 of 17 patients sampled (#5); ~ cross refer to 482.23(b)(3) RN Supervision of Care- Tag A0395 F) The facility's nursing staff failed to update 2 of 17 sampled patients treatment plans (#16, #2); ~ cross refer to 482.23(b)(4) Nursing Care Plan - Tag A0395 G) The facility's nursing staff failed to ensure current certification was maintained in CPR (Cardiopulmonary Resuscitation) for 3 of 5 files reviewed for employees requiring current CPR by the job description (#2, #3, #4). ~ cross refer to 482.23(b)(2) Licensure of Nursing Staff - Tag A0394	A 385		
A 394	482.23(b)(2) LICENSURE OF NURSING STAFF The nursing service must have a procedure in place to ensure that hospital nursing personnel for whom current licensure is required have a valid and current licensure. This STANDARD is not met as evidenced by: Based on review of staff human resource (HR) files and staff interview, the facility failed to ensure current certification was maintained in CPR (Cardiopulmonary Resuscitation) for 3 of 5	A 394	**A 394: Plan of Correction:** **Implementation: Staff training who require certification and recertification in CPR will be conducted on:** **•9/28/07** **•9/29/07** **•10/1/07** **•10/2/07** **Any staff who cannot attend this mandatory training will be required to obtain certification or recertification by 10/10/07 in order to be eligible to work. Records of this certification will be made available for inspection. Future scheduling and auditing for upcoming needs of CPR certification and recertification will be conducted by the Director of Human Resources.** **Persons Responsible:** **Director and Assistant Directors of Nursing; Director of Human Resources**	Initated 9/28/07 Target Completion 10/10/07

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A 394	Continued From page 19 files reviewed for employees requiring current CPR by the job description (#2, #3, #4). Findings include: 1. Review of job description on 9-14-2007 for "Assistant Director of Nursing - Youth Services" (6-11-07) revealed "Maintain certification to teach CPR...". Review of HR file for staff #2 on 9-14-2007 for the Youth Services Assistant Director of Nursing (ADON) revealed a CPR card with a recommended recertification date of 7-2007 (one month and 14 days since the end of July 2007). Review of the file failed to reveal a current CPR certification. Interview with human resources staff on 9-14-2007 at 1400 revealed by job description the ADON is required to have up to date CPR certification. Interview confirmed the CPR card copy on file was expired. Interview revealed there was no documentation available of current CPR certification. Interview revealed the ADON was not currently certified in CPR. 2. Review of job description on 9-14-2007 for "Registered Nurse" (4-16-07) revealed "Licensure/Certification: ...Current CPR certification...". Review of HR file for staff #3 on 9-14-2007 for a staff Registered Nurse (RN) revealed a CPR card with a recommended recertification date of 7-2007 (one month and 14 days since the end of July 2007). Review of the file failed to reveal a current CPR card.	A 394		

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A 394	Continued From page 20 Interview with human resources staff on 9-14-2007 at 1400 revealed by job description the RN is required to have up to date CPR certification. Interview confirmed the CPR card copy on file was expired. Interview revealed there was no documentation available of current CPR certification. Interview revealed the staff RN #3 was not currently certified in CPR. 3. Review of job description on 9-14-2007 for "Mental Health Technician" (6-11-07) revealed "Licensure/Certification: ...Current CPR certification...". Review of HR file for staff #4 on 9-14-2007 for a staff Mental Health Technician (MHT) revealed a CPR card with a recommended recertification date of 7-2007 (one month and 14 days since the end of July 2007). Review of the file failed to reveal a current CPR card. Interview with human resources staff on 9-14-2007 at 1400 revealed by job description the MHT is required to have up to date CPR certification. Interview confirmed the CPR card copy on file was expired. Interview revealed there was no documentation available of current CPR certification. Interview revealed the staff MHT #4 was not currently certified in CPR.	A 394		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.	A 395	See next page	

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A 395	Continued From page 21 This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, open and closed medical record review, review of medication variance reports and staff interview, the facility's nursing staff failed to: A) reassess for the effect of medication being administered and reassess vital signs per physicians's order for 7 of 17 sampled patients (#16, #5, #2, #11, #3, #17, #9); B) notify a physician of a medication error for 2 of 17 patients sampled (#8, #11); and, C) report a critical lab value to the physician per facility policy for 1 of 17 patients sampled (#5). Findings include: A) The facility's nursing staff failed to reassess for the effect of medication being administered and reassess vital signs per physicians's's order for 7 of 17 sampled patients (#16, #5, #2, #11, #3, #9, #17). Review of facility policy "Vital Signs / Weight" revised 3-2004 revealed "1. Vital signs will be performed at least daily...5. Nursing staff shall notify physicians of significant abnormalities...6. Vital signs will be recorded in the medical record...9. Nursing staff will alert M.D. of significant variances and/or treatment related concerns." Review of facility policy "Monitoring of Medication Effects on Patients" revised 02-2004 revealed "The RN will record observations...in the daily nursing assessment. Response to PRN medications will be recorded in the medical	A 395	**A 395:** Plan of Correction: All nursing staff training on medication administration was initiated on 9/17/07 with reeducation on 9/27/07. Focus areas include: 1. The assessment and reassessment of the effectiveness of medications as it relates to vital signs. 2. The assessment and reassessment of pain with use of pain scale and physician notification of unrelieved pain. 3. Physician notification of medication errors. 4. Reporting of critical lab results within one hour of notification. Monitoring: 1. All vital signs for assessing and reassessing the effects of medications will be obtained and documented in the medical record and vital signs sheet. An audit of the obtainment, response to, and documentation of vital signs will be monitored to ensure 100% compliance is maintained. 2. The effectiveness of medications given for pain will be assessed and reassessed within one hour. An audit of will be conducted on this procedure to ensure 100% compliance is maintained. 3. All medication errors will be promptly called to physicians by nursing staff. Medication Variance Reports will be audited to ensure 100% compliance is maintained. 4. Critical Lab testing will be audited to ensure 100% compliance is maintained. All variances of critical lab test reporting will be followed up daily by nursing supervisory staff. Persons Responsible: Director and Assistant Directors of Nursing	Initiated 9/17/07 Target Completion 9/27/07

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A 395	Continued From page 22 record, including the patient's perception of effectiveness." Review of facility policy "Medication Administration: General Guidelines" revised 7-2005 revealed "10. The nurse should know the reason a medication is given to a patient and the side-effect(s) of each drug..." 1. Open record review on 9-17-2007 for Patient #16 revealed a five year-old male admitted to the facility on 9-04-2007 for psychosis and mood disorder. Record review of the admitting orders written by the physician revealed Vital Signs: (checked) Daily". Record review of a physician's examination of the patient on 9-05-2007 at 1300 revealed "r/o (rule out) arrhythmia" and "r/o Rt (right) sided weakness". Review of physician's orders on 9-05-2007 at 1730 revealed "Transfer pt (patient) to the ER (Emergency Room) - abnormal EKG (electrocardiogram - test to map electrical activity of the heart) & possible brain ischemia ? psychosis". Review of the form "Scheduled Medications" revealed "Clonidine 0.1mg po q am (every morning) and q noon (every evening) Hold if SBP (top number of blood pressure) < (less than) 90 or DBP (bottom number of blood pressure) < (less than) 50" Record review of documentation on the "Vital Signs" flowsheet for 9-06-2007 revealed a blood pressure 86 (systolic - four points below the parameter)/38 (diastolic - 12 points below parameter), on 9-07-2007 a blood pressure 85 (five points below parameter)/41 (nine points below parameter), on 9-08-2007 a blood pressure 84 (six points below parameter)/41 (nine points below parameter), on 9-10-2007 revealed "No vitals" and on 9-11-2007 revealed "No vitals". Review of documentation on "Scheduled	A 395		

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Medications" revealed the medication Clonidine was administered each day from 9-06-2007 through 9-11-2007. Review of nursing progress notes failed to reveal documentation that the physician was notified of the low blood pressures or that no vital signs were obtained prior to administration of the Clonidine. Record review failed to reveal why the nurse gave the medications outside of the parameters.

Interview with the patient's physician on 9-17-2007 at 1100 revealed the patient was ordered daily vital signs because of the Clonidine as well as the irregular EKG found during the physician's initial assessment. Interview revealed the patient was transferred to the local emergency department on 9-05-2007 for evaluation of the bradycardic rhythm and for possible brain ischemia (decreased blood flow to the brain) since the patient also had some weakness of the extremities. Interview revealed the child was returned back to the facility on the same day for negative findings. Interview revealed the physician would expect nursing staff to call prior to administering the Clonidine if no vital signs had been obtained and if the blood pressure was less than 90 systolic or less than 50 diastolic. Interview revealed the physician was not notified on 9-06-2007, 9-07-2007, 9-08-2007 or 9-09-2007 of the low blood pressures prior to administration of the Clonidine. Interview further revealed the physician was not notified vital signs were not obtained on 9-10-2007 and 9-11-2007 prior to the administration of the Clonidine.

Interview with nursing management staff on 9-17-2007 at 1200 revealed vital signs are collected regularly since medications such as Clonidine and other psychiatric medications can

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effect the blood pressure. Interview further revealed when "no vitals" is documented, the mental health technician was unable to obtain the vital signs because the child was not cooperative. Interview confirmed that on 9-06-2007, 9-07-2007, 9-08-2007 or 9-09-2007 staff did not document the physician was notified of the low blood pressures (blood pressure less than 90 systolic and less than 50 diastolic) and on 9-10-2007 and 9-11-2007 the staff failed to document the vital signs as ordered by the physician. Interview failed to reveal documentation by nursing as to why vital signs were not obtained. Interview failed to reveal documentation the physician was notified of the low blood pressures or that they were unable to obtain vital signs as ordered by the physician prior to administration of the Clonidine. Interview confirmed staff did not follow physician's orders or facility policy of obtaining vital signs at least daily.

2. Closed record review of patient #5 revealed a 36 year old admitted on 8/27/2007 for Alcohol Dependence, Malignant Hypertension (constant high blood pressure), history of hypokalemia (low potassium). The patient was discharged on 9/3/2007. Record review revealed a physician's telephone order written on 8/27/2007 at 1715 by a nurse "...2. Check BP (blood pressure) in 1 hour if DBP (diastolic blood pressure) is greater than 100 at 3 PM (evening) or 10 PM give Clonidine (for blood pressure)... 4. Check B/P TID (three times per day) (9, 3, 10)..." Further review revealed a red line drawn under the order and "noted 8/27/07 2015 (name of nurse #1)/(name of nurse #2)." Review of the nursing progress notes on 8/27/2007 at 1700 revealed "...placed on BP (check mark)s hourly." Further record review revealed no documentation of blood pressures on

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A 395	Continued From page 25 the vital signs record, nursing progress notes after the 1700 entry or on the MAR for 8/27/2007. Interview with nursing management staff on 9/14/2007 at 1500 failed to reveal any available documentation of blood pressures as ordered by the physician. Further interview confirmed that the nursing staff failed to reassess the patient's blood pressure per physician order. Further interview confirmed the nursing staff did not follow hospital policies. 3. Closed medical record review of patient #2 revealed a 19 year old admitted on 8/5/2007 with a diagnosis of Bipolar Disorder, manic, with psychotic features. While hospitalized the patient sustained an injury to the right ankle on 8/10/2007, and was diagnosed with an avulsion fracture (break) of the right lateral malleolous (ankle bone). The patient was discharged on 8/13/2007. Review of the progress notes by a nurse on 8/10/2007 at 2230 revealed "Pt. (patient) reported she must have twisted her (R) (right) ankle during gym today causing current discomfort...." Further review of a physician note on 8/13/2007 at 1140 revealed "...pt's ankle still has pain and pt. wants d/c (discharge to have orthopedist examine and possible apply a splint..." Further review of a social worker note on 8/13/2007 at 1250 revealed "Pt. said she was in pain from her ankle...she wanted to be d/c to go to the hospital." Review of a physician's order sheet revealed a telephone order written on 8/10/2007 at 1750 by a nurse for "...Apply Ice to (R) ankle PRN (as needed) swelling, Motrin (for pain) 600 mg (milligrams) po (by mouth) q6hr (every six hours) PRN pain..." Review of a medication administration record (MAR) revealed "apply ice to (R) ankle PRN swelling. Order	A 395		

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A 395	Continued From page 26 8/10/07, Exp (expiration) Date 9/9/07, Tran (transcribed) [initials of nurse #1 who wrote the order onto the MAR], RN (registered nurse) Init (Initials) [initials of nurse #2]." Further review revealed documentation by a nurse on 8/11 at 1700 ice applied "Reason: 10 (pain), Pain Scale: 8/10, F/U (follow up): De (decreased)." Further review failed to reveal a reassessment time, documentation of a F/U pain level (scale 1/10), and the implementation of additional pain control measures. Further review revealed on 8/12/07 at 2100 ice applied (28 hours after 1st application) "Reason: 10, Pain Scale: 8/10, F/U (follow up): De." Further review failed to reveal a reassessment time, documentation of a F/U pain level (scale 1/10), and the implementation of additional pain control measures. Further review failed to reveal the application of ice on 8/13/2007. Further review revealed an "Motrin 600mg po q6hr, Order 8/10/07, Exp Date 9/9/07, Tran (initials of nurse #1 who wrote the order onto the MAR), RN Init (initials of nurse #2)." Further review revealed documentation of administration by a nurse on 8/10 at 1915 "Reason: 10, Pain Scale: 8/10, F/U: De." Further review failed to reveal a reassessment time, documentation of a F/U pain level (scale 1/10), and the implementation of additional pain control measures. Further review revealed documentation of administration by a nurse on 8/11 at 1320 (18 hours after first dose), "Reason: 7, Pain Scale: 8/10, F/U: De." Further review failed to reveal a reassessment time, documentation of a F/U pain level (scale 1/10), and the implementation of additional pain control measures. Further review revealed documentation of administration by a nurse on 8/12 at 0930 (21 hours after second dose), "Reason: 10, Pain Scale: 7, F/U: De." Further	A 395		

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A 395	Continued From page 27 review failed to reveal a reassessment time, documentation of a F/U pain level (scale 1/10), and the implementation of additional pain control measures. Further review revealed documentation of administration by a nurse on 8/12 at 1730 (8 hours after third dose), "Reason: 10, Pain Scale: 7/10, F/U: Al (alleviated)." Further review failed to reveal a reassessment time, documentation of a F/U pain level (scale 1/10), and the implementation of additional pain control measures. Further review failed to reveal the administration of any Motrin on 8/13/2007. Further review failed to reveal the completion of a Comprehensive Pain Assessment tool by the RN when the patient reported the onset of acute pain on 8/10/2007. Further review failed to reveal pain reassessment documentation on the vital sign record or in the progress notes. Review of the master treatment plan failed to reveal an individualized treatment plan that specifically addressed pain. Further review failed to reveal documentation of physical reassessment of the injured ankle and responses to interventions guiding pain management, and updated and/or modified treatment plan. Further review failed to reveal documentation of the physician being notified for additional evaluation and treatment by the RN. Interview with nursing management staff on 9/14/2007 at 1500 revealed, "According to the MAR, Let's just say that the patient's pain was a 10 and it decreased to a 7 or 8, the Motrin was helping, but, it is obvious the patient was still having pain." Further interview revealed "The nurses should have notified the physician for a change in medication, for something stronger." Interview revealed that "It does not look like the nurses documented the patient's response to the	A 395		

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A 395	Continued From page 28 Motrin or Ice in the progress notes." Interview confirmed the nursing staff failed to reassess for pain and update the master treatment plan to address pain per hospital policy CLS091A. 4. Closed record review of patient #11 revealed a 36 year old admitted on 7/23/2007 for Alcohol Dependence and Bipolar (psychiatric) Disorder. The patient was discharged on 8/4/2007. Review of a physician's order sheet revealed a telephone order written by a nurse on 7/23/07 (not timed) for "Phenergan 25mg IM or PO q4hr (every four hours) PRN Nausea/Vomiting." Review of nursing documentation on 7/23/07 at 2000 revealed "...Phenergan (for nausea and vomiting) IM (intramuscular) x1 (times one) for nausea...." Further review revealed on 7/24/07 at 0700 "...c/o (complains of) nausea..." Further review of a MAR revealed the patient received 3 dosages (one per day) of Phenergan 25 mg IM on 7/23, 7/24, and 7/25 and 1 dosage of Phenergan 25mg PO on 7/24/2007. Review of the progress notes failed to reveal documentation of a nursing reassessment for the effectiveness of Phenergan for 3 out of 4 doses administered. Further review revealed a nurses note on 7/24/07 at 1730 "...c/o migraine (headache)..." Review of a physician's order sheet revealed a telephone order written by a nurse on 7/24/07 at 1100 for "Tylenol (for pain) 650mg po q4hrs prn HA (headache)." Further review revealed a red line drawn under the order and "noted (name unit secretary) 7/24/07 at 1245/ (name of RN)." Review of a MAR revealed "Tylenol 650mg po q4hr, Order (left blank), E/R (expiration date/reorder) [left blank], T (transcribed) [left blank], NI (nurses initial) [left blank]." Further review failed to reveal the administration of Tylenol to the patient as ordered for headache. Further record review failed to	A 395		

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A 395	Continued From page 29 reveal a nursing reassessment regarding the patient's headache status. Interview with nursing management staff on 9/14/2007 at 1500 revealed, "The nurse should reassess the patient after administration of a medication." Further interview revealed no available documentation of nursing reassessments. Interview confirmed the nursing staff failed to follow hospital policy for patient reassessment after the administration of a medication. 5. Closed record review of Patient #3 on 9-13-2007 revealed a 15 year old male admitted to the facility on 8-14-2007 as an involuntary commitment related to an attempted suicide. Review of physician's admission orders on 8-14-2007 at 1135 revealed "Vital Signs: ... (checked) twice daily". Review of the record failed to reveal documentation of vital signs being obtained twice per day. Review of physician orders on 8-18-2007 at 0150 revealed "T.O. (telephone order) Send pt (patient) to E.R. (emergency room) at (facility name) via EMS (emergency medical services)...Rationale... (symbol for increased) pain, abd (abdominal); (symbol for decreased) O2sat (oxygen saturation), hx (history) sickle cell dis. (disease)". Record review revealed the patient was transferred to another facility for evaluation and admission on 8-21-2007. Interview with nursing management staff on 9-14-2007 at 1530 confirmed the patient was ordered vital signs twice per day. Interview confirmed there was no documentation on the record of vital signs having been obtained twice daily. Interview confirmed staff did not follow	A 395		

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A 395	Continued From page 30 physician's orders of twice daily or facility policy of obtaining vital signs at least daily. 6. Open record review of Patient #17 on 9-17-2007 revealed a fifteen year old male admitted to the facility on 9-05-2007 for depressive disorder. Review of physician's admission orders on 9-06-2007 at 1320 revealed "Vital Signs: (checked) Daily". Review of documentation on the MAR revealed "Eskalith CR (medication for manic depression) 450mg PO bid" was ordered and being administered as ordered. Review of documentation on the "Vital Signs" flowsheet revealed on 9-15-2007 was blank with no vital signs recorded. Review of nursing progress notes on 9-15-2007 failed to reveal documentation of why the vital signs were not obtained and of notifying the physician that vital signs were not obtained. Interview with nursing management staff on 9-17-2007 at 1200 revealed vital signs are collected regularly since medications such as anti-depressants can effect the blood pressure. Interview revealed the staff failed to document the vital signs as ordered by the physician. Interview failed to reveal documentation by nursing as to why the vital signs were not obtained. Interview failed to reveal documentation the physician was notified that the staff were unable to obtain vital signs as ordered by the physician. Interview confirmed staff did not follow physician's orders or facility policy of obtaining vital signs at least daily. 7. Open record review of Patient #9 on 9-17-2007 revealed an eight year old male admitted to the facility on 9-06-2007 for Cyclothymia and oppositional defiant disorder. Review of physician's admission orders on 9-06-2007 at	A 395		

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A 395	Continued From page 31 1320 revealed "Vital Signs: (checked) Daily". Review of documentation on the MAR revealed Review of documentation on the "Vital Signs" flowsheet revealed on 9-10-2007 "No vitals". Review of nursing progress notes on 9-10-2007 failed to reveal documentation of notifying the physician that vital signs were not obtained. Interview with nursing management staff on 9-17-2007 at 1200 revealed when "no vitals" is documented, the mental health technician was unable to obtain the vital signs because the child was not cooperative. Interview confirmed that on 9-10-2007 the staff failed to document the vital signs as ordered by the physician. Interview failed to reveal documentation by nursing as to why the vital signs were not obtained. Interview failed to reveal documentation the physician was notified that the staff were unable to obtain vital signs as ordered by the physician. Interview confirmed staff did not follow physician's orders or facility policy of obtaining vital signs at least daily. B) The facility's nursing staff failed to notify a physician of a medication error for 2 of 17 patients sampled (#8, #11). Review of facility policy "Medication Errors" revised 11-2003 revealed "3. Documentation on the medical record shall include the following: a. error made, b. notification of physician..." Review of facility policy " Medication Administration: General Guidelines" revised 07-2005 revealed "Procedure - 1. Medications are not given without a physician's order...3. The nurse transcribes the order on the medication administration record...12. The five (5) rights of medication administration will be followed: the	A 395		

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right amount, the right medicine, the right patient, the right time, the right route...35. All medications are documented on the Medication Administration Record immediately after they are given..."

1. Closed record review for Patient #7 revealed a 12 year old male admitted to the facility on 8-12-2007 for bipolar disorder. Review of physician's orders on 8-13-2007 at 1350 revealed "Tegretol 200mg PO am (in the morning) and hs (at bedtime). Review revealed "noted 8/13/7 (name of unit secretary)". Further review revealed "8/13/07 noted 1405 (name of RN)". Further review revealed documented below the RN note of the order at 1405 "8/13/07 noted (name of RN #2)".

Closed record review for Patient #8 revealed a seven year-old male admitted to the facility on 8-08-2007 for attention deficit hyperactivity disorder and bipolar disorder. Review of the MAR revealed "Tegregol (a medication to control seizures or to stabilize a mood disorder) 200mg po am (in the morning) & hs (at bedtime) - order 8/13/7...T (transcriber) (initials of unit secretary noting Tegretol order off Patient #7 record), NI (nurse initials) (initials of RN noting order at 1405 off Patient #7 record). Further review of the MAR revealed on 8-13-2007 at 2000 initials of the nurse who administered Tegretol 200mg po to the patient. Further review of the MAR revealed written beside the Tegretol "wrong pt's MAR". Review of the physician orders failed to reveal an order for Tegretol 200mg po by the physician. Record review of the nursing progress notes failed to reveal documentation of the medication being given or of the physician or guardian being notified of the medication being given. Review of physician progress notes on 8-14-2007 revealed

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A 395	Continued From page 33 "Pt sleepy during daytime - unable to assess as pt refuses to wake up...change Clonidine 0.05mg po am" Interview with a unit secretary on 9-14-2007 at 1500 revealed the unit secretary had been at the facility since June 2007. Further interview revealed the unit secretary received the general three-day orientation to the facility then was assigned to shadow a nurse one day, who had a patient assignment and to shadow a MHT another, who also had a patient assignment. Interview revealed that since the staff members assigned as her preceptors were not functioning as a unit secretary, but had a primary responsibility for patient care, there was not time for many questions or for observation of the duties of the role of unit secretary. Interview revealed "you just have to learn what you can and learn the rest as you go along I guess." Interview revealed the unit secretary took the order for the Tegretol 200mg po off the physician's orders for Patient #7 on 8-13-2007 at 1350, but accidentally transcribed the medication onto the MAR for Patient #8. Interview revealed a RN noted the order on Patient #7's record at 1405 and initialed the transcribed medication on the MAR for Patient #8. Interview with the physician for Patient #8 on 9-14-2007 at 1530 revealed the physician was not aware of the Tegretol being given to her patient. Interview revealed the physician changed the Clonidine dose for Patient #8 based on the assessment that the patient was drowsy and difficult to arouse. Interview revealed with knowledge of the medication error, the physician would not have modified Patient #8's medication regimen. Interview revealed Tegretol can cause	A 395		

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	344014	A. BUILDING _____ B. WING _____	C 09/17/2007

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A 395	Continued From page 34 drowsiness. Interview with nurse management staff on 9-14-2007 at 1605 who completed an investigation of the medication error event revealed the staff member was unaware as to whether the physician was notified. Interview revealed the investigation did not document whether the physician was notified. Interview revealed nursing staff would be expected to notify the physician of any medication error. Interview failed to reveal documentation of physician notification of the medication error. Interview confirmed staff did not follow facility policy on notifying the physician of a medication error. Interview with nursing administrative staff on 9-14-2007 at 1635 revealed no knowledge of the medication error between Patient #7 and #8. Interview revealed the error occurred within the first week of employment at the facility. Interview revealed it has been recognized that there has been an increase in medication error reporting at the facility related to increased nursing awareness of reporting errors. Interview further revealed there is a plan for better aggregation and analysis of medication errors at the facility. Interview revealed without the aggregated information there have been no current priorities identified to address specific medication errors with nursing staff. Interview confirmed nursing staff did not follow facility policy in not notifying the physician of the medication error. 2. Closed record review for patient #13 revealed a 45 year old admitted to the facility on 7/23/2007 for Cocaine Dependence and Major Depressive Disorder. Review of physician's orders on 7/23/2007 at 1600 revealed "Cymbalta	A 395		

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A 395	Continued From page 35 (anti-depressant drug) 30 mg (milligrams) po (by mouth) daily start 1st dose today." Review revealed "noted (name of unit secretary) 7/23/2007 at 1620." Further review revealed "noted (name of nurse) 7/23/2007 1700." Closed record review of patient #11 revealed a 36 year old admitted on 7/23/2007 for Alcohol Dependence and Bipolar (psychiatric) Disorder. The patient was discharged on 8/4/2007. Review revealed "Cymbalta (anti-depressant drug) 30mg (milligrams) po (by mouth) daily (1st dose today)" transcribed (written) onto a Medication Administration Record (MAR). Further review revealed "Order 7/23/07, E/R (Expiration Date/Reorder) 8/22, T (transcriber) (initials of unit secretary noting Cymbalta order off of patient #13 record), NI (nurse initial left blank)." Further review of the MAR revealed on 7/23 at 1800, initials of the nurse who administered Cymbalta 30mg po to patient #11. Record review failed to reveal a physician's order for Cymbalta 30mg po daily, 1st dose now by the physician. Record review of nursing progress notes failed to reveal documentation of the medication being given or of the physician being notified of the medication being given. Interview with the attending physician for patient #11 on 9/14/2007 at 1245 revealed the physician was not aware of the Cymbalta being given to her patient. Interview revealed "This patient was placed on Lexapro (antidepressant drug), so I would not have placed them on Cymbalta because that would be two drugs for depression." Further interview confirmed that the physician did not write an order in the physician orders for Cymbalta. Further interview revealed "I expect the nursing staff to inform me immediately when a	A 395		

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A 395	Continued From page 36 medication error has occurred." Further interview confirmed the physician was not notified of the medication error. Interview with nursing management staff on 9/14/2007 at 1610 failed to reveal no available documentation of a physician's order for or of physician notification of the administration of Cymbalta to patient #11. Further interview confirmed that the nursing staff did not follow hospital policies. C) The facility's nursing staff failed to report a critical lab value to the physician per facility policy for 1 of 17 patients sampled (#5). Review of facility policy CLS141 - Critical Test Results, original date 03/04 last revised date 01/07 revealed "Policy: It is the policy of (facility name) to notify the physician immediately of any critical test results...Procedure: 1. Critical laboratory tests are defined as tests that are ordered STAT runs. All critical lab values are defined as lab results that have identified (private lab name) panic limits...All critical lab test results and those called in by (private lab name) as having panic limits must be reported to the physician within one hour of receiving the result. 2. Stat/Critical lab results that are phoned in by the lab are documented using the STAT/Critical Lab form...The attending physician is immediately paged...." Closed record review of patient #5 revealed a 36 year old admitted on 8/27/2007 for Alcohol Dependence, Malignant Hypertension (constant high blood pressure), History of hypokalemia (low potassium name). The patient was discharged on 9/3/2007. Further record review	A 395		

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A 395	Continued From page 37 revealed a lab report from (private lab #1). Further review revealed "...Potassium, Serum called to (nurse name) on 8/29/2007 at 0141 EST (Eastern Standard Time)." Review of a STAT/Critical Lab Phone Report dated 8/29/2007 at 0145 revealed "...Potassium...2.5....Nurse Notified: (nurse name) Time/Date Notified: 0145 8/29/2007, Doctor Paged: (doctor name) Time/Date Notified: 0630 8/29/2007 [4 hours 45 minutes after initial notification of nurse], Doctor returned call @ (at): 0620..." Further record review revealed a lab report from (private lab #2 name). Further review revealed "Coll: (collected) 9/01/2007 0645, : (received) 9/1/2007 1036, Printed 9/1/2007 1127...Potassium...2.5...Critical result verified..." Further record review failed to reveal additional documentation of immediate physician notification of the critical lab results on 8/29/2007. Further record review failed to reveal completion of a STAT/Critical Lab Phone Report or immediate physician notification of critical lab results on 9/1/2007 by nursing staff. Interview with nursing management staff on 9/14/2007 at 1500 revealed "Critical labs are called immediately to the doctor, no matter what time of day." Further interview confirmed the nursing staff did not notify a physician until 4 hours and 45 minutes after the initial report of a critical lab value to the nursing staff on 8/29/2007 @ 0145. Further interview revealed no available documentation of a STAT/Critical Lab Phone Report for a lab report dated 9/1/2007 @ 1124. Interview confirmed that the nursing staff did not follow hospital policies.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan	A 396		

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A 396	Continued From page 38 for each patient. This STANDARD is not met as evidenced by: Based on policy and procedure review, review of open and closed records, and staff interviews, the facility's nursing staff failed to update 2 of 17 sampled patients treatment plans (#16, #2). Findings include: Review of facility policy CLS053 - "Master Treatment Plan", revised 07/05 revealed "Policy:...The Master Treatment Plan will set goals...based on the nursing assessment and are realistic, measurable and consistent with the medical plan of care...The Master Treatment Plan includes measures that will restore, maintain and /or promote the patient's well being...The scope of the plan is determined by the anticipated needs of the patient and is reviewed and revised as the needs of the patient change..." Further review revealed "Procedure: I. Master Treatment Plan...Problems/Medical: The RN (registered nurse) numbers each medical problem that is currently being treated. The RN initiates a Treatment Problem Sheet for each problem...II. Problem Sheets:...Nursing will always initiate medical problem sheets..." 1. Open record review on 9-17-2007 for Patient #16 revealed a five year-old male admitted to the facility on 9-04-2007 for psychosis and mood disorder. Record review of a physician's examination of the patient on 9-05-2007 at 1300 revealed "r/o (rule out) arrhythmia" and "r/o Rt	A 396	**A 396** Plan of Correction: Mandatory All-Nursing Training was initiated on 9/27/07. All nursing staff not in attendance will be required to receive training prior to their next scheduled shift. Content of training to include: •Completion of a master treatment plan for all patients with a focus on the completion of medical problem sheets. •Pain assessment, pain reassessment, and appropriate follow-up in the treatment of pain. •Completion of the comprehensive pain assessment for patients who have pain. Monitoring: An audit on master treatment plans, pain assessments, and completion of the comprehensive pain assessment will be conducted to ensure 100% compliance is maintained. Persons Responsible: Director and Assistant Directors of Nursing	9/27/07