Occurrence Summary Reports for:
HIGHLANDS BEHAVIORAL HEALTH SYSTEM
Tuesday, January 28, 2014 8:42 AM

Facility: HIGHLANDS BEHAVIORAL HEALTH SYSTEM
Date of Occurrence: 7/27/2013
Report Timely: Yes
Type of Occurrence: Death

DESCRIPTION OF OCCURRENCE:
On 7/27/13, a male patient in his 20s was found unresponsive in one of the facility's seclusion/quiet rooms. The patient was resuscitated, however, he expired.

FACILITY ACTION:
The facility conducted an internal investigation. The facility notified the patient's physician, family, local coroner, and police department. The facility reviewed documentation, including the patient's medical record and the coroner report. The facility interviewed the charge nurse, and all other staff working on the unit that night. The facility found that the patient was being treated for depression, anxiety, and chronic back pain at the facility. Per policy, facility staff were required to conduct welfare checks on the patient every 15 minutes, as well as assess for rise/fall of the patient's chest during the checks. An onsite federal complaint investigation was conducted by Department. Five federal deficiencies were cited related to this patient's care, including deficient practice related to failure to appropriately administer narcotic medication per physician order and failure to conduct proper welfare checks in order to ensure patient safety. The facility implemented several measures in order to achieve compliance with hospital regulations and patient safety, including additional monitoring and auditing, prohibition of specific controlled medications, implementation of patient acuity system, and consultation with a nursing manager prior to patient admissions. A full recertification survey was conducted after the complaint survey as well. The patient's autopsy revealed he expired from a medication toxicity and cerebral/pulmonary edema.

DEPARTMENT FINDINGS:
The Department reviewed the facility's report and supplemental documentation and found that the facility acted appropriately by reporting the occurrence, notifying the appropriate persons and agencies, conducting an investigation, reviewing documentation, conducting interviews, and implementing extensive interventions in order to prevent a recurrence.

Deficient practice was cited. The Department will review this occurrence prior to any survey or upon receipt of any complaint that may be filed against this facility.

Sent to Facility: 1/3/2014

FACILITY COMMENT: Following receipt of the above summary, no additional comments were submitted by the facility.

Released to Public: 1/14/2014

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