CENTRAL FLORIDA BEHAVIORAL HOSPITAL

6601 CENTRAL FLORIDA PARKWAY, ORLANDO, FL

Violations dated for Aug 27, 2014

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VIOLATION: NUTRITIONAL CARE - Quality Control **Survey Type:** State **Tag No:** H0080

Based on interview and record review, the facility failed to assure that * of ** sampled patients was not served a food item to which the patient was allergic that resulted in an emergent medical hospital transfer (#*).

Findings:

In an interview with patient #* on */**/** at *:** AM, she revealed that while at the facility she had eaten peanut butter, a food item she was highly allergic to, which sent her to a nearby hospital emergency room for treatment. The patient related her allergy was documented in her medical record, however she was given a container of peanut butter at her request, by the kitchen staff. The patient related the facility did not give her a bracelet to wear indicating her allergy and the dietary staff were unaware of her food allergy.

Review of patient #*'s record revealed a voluntary admission with a diagnosis of major depressive disorder, recurrent, severe without psychosis, suicidal ideation and anxiety. A comprehensive assessment part *-Intake dated */**/** page * at *:** AM documented, "Patient reports suicidal ideation with a plan to overdose on medication....obsessive thoughts about hurting herself." Page * documented Allergies:
yes,"peanuts, walnuts"

The comprehensive assessment-Nursing page * dated */**/** at *:** AM documented "Allergies & sensitivities -Food : Nuts." The nursing nutritional screening dated */**/** at *:** AM documented "Food allergies/intolerance's: Nuts," regular diet. The disposition of patient's medications upon admission, page * dated */**/** documented: "Allergies: Nuts."

A history and physical dated */**/** from a previous hospitalization with an addendum for */**/** documented allergies as No Known Drug Allergies (NKDA) and Nuts. Admitting physician orders dated */**/** documented Allergies: Peanuts, walnuts-anaphylaxis. Precaution level: suicidal. Physician orders dated */**/** at *:** AM documented Benadryl ** milligrams (mg) IM (intramuscularly) now, for allergic reaction, and */**/** at **:** AM Send patient to ER-call ***."

A Certificate of professional initiating involuntary examination dated */**/** at **:** AM, documented a diagnosis of suicidal ideation with supporting evidence "patient is depressed and attempted to kill herself by allergic reaction to peanut butter."

The physician discharge summary dated */**/** documented "She reported that she ate some peanuts, although she was aware that she was allergic to peanuts. She was transported to the emergency room for medical evaluation.....she reported that she had intentionally eaten the peanuts in a suicide attempt."

During an observation of a noon meal service for patients with the facility Director of Nurses (DON) at **:** PM on */**/**, revealed * patient's observed without bracelets for patient identifiers and allergies. The DON related at times patients refuse to wear the hospital bracelet and the kitchen personnel have notebooks of patient picture, dietary information, special diets and identifiers.

Interview with the facility registered dietician at **:** PM on */**/** and later with the kitchen manager at *:** PM on */**/** revealed the facility has a process in place if a patient comes to the tray line to ask for food items. They related dietary personnel pull their

books of patient names, special diets and allergies to verify what they are able to provide for patients. They related dietary personnel are not allowed to give out food items without verifying the book. They were not aware of any employee providing peanut butter to a patient with a known and documented nut allergy.

The facility distributed peanut butter to a patient with a known allergen whose medical condition was adversely affected, thereby failing to meet the special needs of the patient.

VIOLATION: INCIDENT REPORTING SYSTEM - Reports **Survey Type:** State **Tag No:** H0412

Based on interview and review of the facility incident report log for June through August **, ****, the facility failed to complete an incident report regarding a suicide attempt within the facility, for * patient of ** sampled patients (#*).

Findings:

In an interview with patient #* on */**/** at *:** AM, she revealed that while at the facility she had eaten peanut butter, a food item to which she was highly allergic, which sent her to a nearby hospital emergency room for treatment. The patient related her allergy was documented in her /his medical record, however she was given a container of peanut butter at her request, by the kitchen staff. The patient related the facility did not give her a bracelet to wear indicating her allergy and the dietary staff were unaware of her food allergy.

Review of the facility incident report log for June through August **, ****, revealed no incident reports concerning patient #*. Interview with the facility Risk Manager at **:** AM on */**/** confirmed there were no incident reports filed for patient #*. She related she was not aware of the event and staff should have completed an incident report on patient #*, as the patient experienced a change in medical condition and was transported to an acute care hospital for emergent treatment.

Review of the facility policy entitled: Healthcare Peer review (HPR) Occurrence Reporting System, revised **/** page *,documented: "Definitions:
A. Occurrence (incident type): that which is not consistent with the routine care of a patient and/or the desired operations of the facility. The results of this event require or could have required (near miss) unexpected medical intervention, unexpected intensity of care, or causes or had the potential to cause an unexpected physical or mental impairment.
B. Serious injuries/events constitute any of the following outcomes as a result of healthcare intervention but may not be limited to this list.
-*** Suicidal gestures or attempt resulting in serious injury
Injury/physical harm to patients, staff or third parties
Self-inflicted injuries, self mutilation

Page * of the policy documented: "Procedure: A. Any facility employee or staff member who discovers, is directly involved in or is responding to an event/occurrence is to complete or direct the completion of a Healthcare Peer Review (HPR) form.

VIOLATION: DIETS **Survey Type:** Federal **Tag No:** A0628

Based on interview and record review, the facility failed to assure that * of ** sampled patients was not served a food item to which the patient was allergic that resulted in an emergent medical hospital transfer (#*).

Findings:

In an interview with patient #* on */**/** at *:** AM, she revealed that while at the facility she had eaten peanut butter, a food item she was highly allergic to, which sent her to a nearby hospital emergency room for treatment. The patient related her allergy was documented in her medical record, however she was given a container of peanut butter at her request, by the kitchen staff. The patient related the facility did not give her a bracelet to wear indicating her allergy and the dietary staff were unaware of her food allergy.

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