STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454081	A. BUILDING _____ B. WING _____	C 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLAWN MENTAL HEALTH SYSTEM	**4600 SAMUELL BLVD PO BOX 151489 DALLAS, TX 75315**

(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 Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey was conducted on site. An entrance conference was held on the morning of 02/17/15 with hospital administrative staff and other hospital representatives. The purpose and process of the survey were explained and an opportunity given for questions. The hospital representatives were informed that this complaint survey would be conducted according to the survey protocol in the State Operations Manual, Chapter 5, section 5100 and Appendix A, and according to 42 CFR 482 the Conditions of Participation for Hospitals. An exit conference was held on the afternoon of 02/25/15 by telephone with hospital administrative staff. Preliminary findings of the survey were presented and an opportunity given for discussion. An opportunity was provided for the facility to provide evidence of compliance with those requirements for which non-compliance	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 found. None was provided to the surveyor. Based on records review and interviews, it was determined that the deficient practices found posed an immediate jeopardy to the health and safety of patients, and resulted in actual harm to Patient #1. The hospital failed to ensure that patients receive care in a safe setting in that suicidal patients were not provided appropriate level of observation and ligature risks that could be utilized by suicidal patients were removed. TX00207941 was substantiated with deficiencies cited. The following conditions of Participation were not met: 42 CFR 482.13 Patient Rights 42 CFR 482.21 QAPI	A 000		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observations, interviews, and records review, the hospital failed to ensure that a safe environment was provided for 2 of 12 patients (Patient #1 and Patient #12). A) (Patient #1) passed away from hanging self on a closet door knob on 12/03/14, on the Trauma Unit. Observations conducted in the Hospital Lobby, Trauma and Geriatric Unit on 02/18/15, revealed the continued presence of unsafe items accessible to psychiatric patients for potential harm which included, plastic liners in trash cans,	A 115		

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A 115	Continued From page 2 electrical cords and phone cords. (refer to A144) B) (Patient #12) was brought to the hospital on Emergency Detention 02/17/15 for suicidal thoughts. (Patient #12's) every fifteen minute observation round record was left incomplete on 02/18/15 at 1145. (Patient #12's) location and behavior was not monitored. (refer to A144) Based on records review and interviews, it was determined that the deficient practices found posed an immediate jeopardy to the health and safety of patients, and resulted in actual harm to Patient #1. The hospital failed to ensure that patients receive care in a safe setting in that suicidal patients were not provided appropriate level of observation and ligature risks that could be utilized by suicidal patients were removed.	A 115		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observations, interviews, and records review, the hospital failed to ensure a safe environment was provided for 2 of 12 patients (Patient #1 and Patient #12). 1) (Patient #1) passed away from hanging self on	A 144		

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A 144	Continued From page 3	A 144		

a closet door knob on 12/03/14 on the Trauma Unit. Observations conducted in the Hospital Lobby, Trauma and Geriatric Unit on 02/18/15 revealed the continued presence of unsafe items accessible to psychiatric patients for potential harm which included, plastic liners in trash cans, electrical cords and phone cords.

2) (Patient #12) was brought to the hospital on Emergency Detention 02/17/15 for suicidal thoughts. (Patient #12's) every fifteen minute observation round record was left incomplete on 02/18/15 at 1145. (Patient #12's) location and behavior was not monitored.

Findings Included:

1) (Patient #1's) Integrated Assessment dated 12/01/14, timed 2330, revealed, "37 year old female positive suicidal ideations with plan to hang self, OD (over dose) on medications, other plans ...history of attempts, "a lot of times" by OD and attempted hanging...positive for homicidal ideations (to unnamed person does not want to say who)...hold them hostage and possibly kill them...says she hears people talking, mumbling but says destructive things, positive depression, positive anxiety...nightmares...history PTSD (post-traumatic stress disorder)...stressful work environment plus family stressors...does not want to discuss...plan to hang self, delusional in content...means ropes and medications...rapid mood shifts, anxiety, blunted affect, paranoid ideation...mental status...guarded, depressed, poor judgment and insight, justification for admission...diagnostic evaluation, drug therapy or

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A 144	Continued From page 4 treatment requiring continuous observation, impaired social...high risk for self-harm or suicide risk." The multidisciplinary progress note dated "12/02/14 timed at 0255" revealed, "Patient with suicidal ideation with a plan to hang herself...on assault precautions and suicide precautions...patient on constant observation and will be monitored every fifteen minutes." The Psychiatric Evaluation dated 12/02/14, timed at 1000, revealed, "Suicidal ideation, thoughts of hanging herself...here for depression, dissociative disorder, suicidal ideation...decided to come to hospital from Montana in order to get , anxious, some fear of others, suicidal ideations...hanging, homicidal ideations." The multidisciplinary progress note (social worker) dated 12/02/14, timed at 1000, revealed, "Patient reports she is having extreme anxiety that turns into a dissociative mess ...hearing voices at night...I don't cut or burn much but did last week...went to lethal intentions real fast...brain shuts down...encouraged patient to express thoughts and feelings." The multidisciplinary progress note dated 12/02/14. timed at 2300. revealed, "Depression and anxiety...feels disconnected...patient positive for auditory hallucinations but cannot make out what voices are saying...poor eye contact...will continue to monitor."	A 144		

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A 144	Continued From page 5 The Precaution Checklist dated 12/03/14, revealed, "Close observation, suicide precautions...at 0630 P4 which means, (Sleeping, patient room)...(marked over with an X written in, CPR (cardiopulmonary resuscitation) started at 0636) initialed by nurse." The multidisciplinary progress notes dated 12/03/14, timed at 0636, revealed, "Completing shift change rounds with oncoming nurse ...patient was on floor, sitting against closet door...turned light on...patient had a strip of her torn bed sheet around her neck and attached to door knob...unresponsive...face was pale and lips were slightly dusky...RN (registered nurse) pulled patient up off door knob and placed on floor in CPR position...loosened cloth around neck and assessed for pulse...no pulse and no respirations assessed...CPR chest compressions immediately started...code blue called and 911 notified...EMS (emergency medical services) arrived at 0649 and took over chest compressions, oxygen with bag and mask...at 0651 suctioned...contents contained thick saliva..." The Hospital Plant Anomalies dated 05/16/14, revealed, "Trauma unit...patient door handles and closet door handles could be a ligature risk...Lewis I...patient door handles and closet door handles could be a ligature risk...is a list of plant anomalies...please familiarize yourself with the plant anomalies for each unit and throughout the facility." On 02/17/15, at 1415, Personnel #1 was	A 144		

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A 144	Continued From page 6 interviewed. Personnel #1 stated in 05/2014, the hospital came up with a list of plant anomalies and the closet door knobs/handles and patient room door knobs were identified as a ligature risk. Personnel #1 was asked if the hospital took action on the identified door knobs and closet knobs/handles. Personnel #1 stated no not until after the event occurred with Patient #1. Personnel #1 was asked if patients were still being admitted to rooms with existing door knobs after this event had occurred. Personnel #1 said yes but plant operations started working on the removal of the closet doors and door knobs. Personnel #1 stated the hospital list of plant anomalies was located in a book on each unit and the staff had knowledge of the safety risk. On 02/17/15, at approximately 1520, Personnel #7 was interviewed. Personnel #7 was shown Patient #1's medical record for review. Personnel #7 stated she, along with a second nurse, were completing walking rounds on all the patients on the morning of 12/03/14. Personnel #7 stated Patient #1's room was entered at 0636 for the 0630 rounds. Personnel #7 stated that the patient appeared to be sleeping. Personnel #7 stated the patient was observed sitting on the floor so the light was turned on. Personnel #7 stated the patient was observed with piece of torn bed sheet tied around her neck attached to the closet door knob/handle. Personnel #7 stated a torn piece of the bed sheet was removed from the knob and loosened. Personnel #7 stated the patient had no pulse and/or respirations. Personnel #7 stated CPR was initiated and a code blue and 911 was called.	A 144		

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A 144	Continued From page 7 On 02/17/15, at 1545, Personnel #6 was interviewed. Personnel #6 stated after this event he started removing closet doors with the knobs. The surveyor referred Personnel #6 to the May 2014 anomalies list where the patient room door knobs and closet knobs/handles were identified as a ligature risk. Personnel #6 did not provide the surveyor evidence that anti-ligature knobs/handles and door knob replacements was initiated prior to the 12/03/14 event when Patient #1 hung herself. On 02/18/15, at 1120, Personnel #5 was interviewed. Personnel #5 was provided Patient #1's medical record for review. Personnel #5 stated the patient came from Montana for inpatient treatment. Personnel #5 stated he was aware the patient had a suicide plan to overdose and/or hang herself. Personnel #5 stated he never thought the patient would hang herself. The surveyor asked Personnel #5 if he had reviewed the clinical notes, high risk notification and clinical notes regarding Patient #1's suicidal ideations and plans. Personnel #5 stated he did. Personnel #5 was asked by the surveyor why a higher level of monitoring was not ordered for Patient #1 such as 1:1 and/or every five minute observation. Personnel #5 stated looking back at it, he wished he had ordered a higher level of monitoring. Personnel #5 stated Patient #1 may have been having a dissociative event which caused her to hang herself. On 02/18/15, at 0900, the lobby of the main entrance to the hospital was observed. Multiple people greater than 6 were observed sitting in the lobby either to visit and/or to have an assessment	A 144		

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A 144	Continued From page 8	A 144		

completed. A plastic trash can was observed in the lobby with a plastic liner inside it. Two wall mounted lamps were observed one on each side of the fireplace. The cord attached to the lamps was approximately two feet in length. A second plastic trash can was observed against the wall behind the desk with a plastic liner inside it. At 0910 Personnel #1 was notified regarding the above safety concerns. Personnel #1 left and returned to the conference room at 0930. Personnel #1 verified the above safety concerns.

On 02/18/15, at 1331, observation rounds were conducted with Personnel #1 on the Trauma Unit. A telephone was observed sitting on the ledge of the nursing station counter. The window to the nursing station was three quarters of the way closed leaving approximately a two inch open gap. The phone cord was easily removed from the nursing station counter. The phone cord was greater than two feet in length. Personnel #1 verified the above safety concern.

On 02/18/15, at 1345, observation rounds were conducted with Personnel #1 on the Geriatric unit. A telephone was observed sitting on the desk. The telephone cord was greater than one foot. The cord was within the reach of any patient standing at the desk.

2) On 02/18/15. at 1400. observation rounds were conducted with Personnel #1 on the Bloss Unit. Personnel #10 was asked by the surveyor to review the patient close observation rounds records. The surveyor found one patient rounds

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A 144	Continued From page 9	A 144		

record (Patient #12's) with a blank section timed at 1145 (15 minutes) which did not account for Patient #12's whereabouts. Personnel #10 stated he was new. Personnel #11 was standing next to Personnel #10 when the surveyor questioned why the 15 minute close observation was not completed. Personnel #11 said "it is only 15 minutes." Personnel #1 said rounds were supposed to be done every fifteen minutes.

(Patient #12's) notification of emergency detention dated 02/17/15, timed at 1400, reflected, "Patient stated he has been off his medication for several days and stated he wants to kill himself..."

The Precaution checklist dated 02/18/15 revealed, "Close observation 15 minute checks...the 1145 round was left blank." The every 15 minute check was not completed and did not document (Patient #12's) behavior or location.

The policy and procedure entitled, "Patient Observation/Level of Observation" with an edit date of 02/2015, revealed, "Observe each patient, a minimum of every 15 minutes and/or according to precaution level and document observation on the patient observation form concurrently while doing rounds...document patient location and behavior when observation occurs on the patient observation form...levels of observation...close observation...all inpatient admissions will be on close observation with minimum of observation to be completed every 15 minutes...heightened level of observation...5 minute observation...where the

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A 144	Continued From page 10 patient is visualized and monitored for safety at least every 5 minutes ...nurse must receive a physician's order for the 5 minute close observation...the 5 minute level of observation is ordered but not limited to...suicidal ideation, serious threats or actual attempts...extreme withdrawn or isolating behavior...1:1 Observation...is used when a situation involves a potential clinical crisis, severe suicidal attempts...only used in extreme situations...physician's order." The policy and procedure entitled, "Patient Rights and Responsibilities" with an edit date of 02/2015 reflected, "Care in a safe and sanitary setting."	A 144		
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. This CONDITION is not met as evidenced by:	A 263		

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A 263	Continued From page 11 Based on observations, interviews, and records review, the hospital quality improvement and performance program failed to ensure current and previously identified patient safety risks were addressed from 05/2014 through 02/18/15. Safety measures were not implemented for 2 of 12 patients (Patient #1 and Patient #12). (A) (Patient #1) passed away from hanging self on a closet door knob on 12/03/14, on the Trauma Unit. The hospital anomalies list dated 05/16/14, identified patient room door knobs/handles as a ligature risk. (Refer to A0286) B) (Patient #12) was brought to the hospital on Emergency Detention 02/17/15, for suicidal thoughts. (Patient #12's) every fifteen minute observation round record was left incomplete on 02/18/15, at 1145. (Patient #12's) location and behavior was not monitored. (Refer to A0286) (C) Observations conducted in the Hospital Lobby, Trauma and Geriatric Unit on 02/18/15, revealed the continued presence of unsafe items accessible to psychiatric patients for potential harm which included plastic liners in trash cans, electrical cords and phone cords. (Refer to A0286)	A 263		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY	A 286		

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A 286	Continued From page 12 (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: Based on observations, interviews, and records review, the hospital quality improvement and performance program failed to ensure current and previously identified patient safety risks were addressed from 05/2014 through 02/18/15. Safety measures were not implemented for 2 of 12 patients (Patient #1 and Patient #12). (A) (Patient #1) passed away from hanging self	A 286		

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A 286	Continued From page 13	A 286		

on a closet door knob on 12/03/14, on the Trauma Unit. The hospital anomalies list dated 05/16/14, identified patient room door knobs/handles as a ligature risk.

B) (Patient #12) was brought to the hospital on Emergency Detention 02/17/15, for suicidal thoughts. (Patient #12's) every fifteen minute observation round record was left incomplete on 02/18/15 at 1145. (Patient #12's) location and behavior was not monitored.

(C) Observations conducted in the Hospital Lobby, Trauma and Geriatric Unit on 02/18/15, revealed the continued presence of unsafe items accessible to psychiatric patients for potential harm which included plastic liners in trash cans, electrical cords and phone cords.

Findings Included:

A) (Patient #1's) Integrated Assessment dated 12/01/14, timed 2330, revealed, "37 year old female positive suicidal ideations with plan to hang self, OD (over dose) on medications, other plans...history of attempts, "a lot of times" by OD and attempted hanging...positive for homicidal ideations (to unnamed person does not want to say who)...hold them hostage and possibly kill them...says she hears people talking, mumbling but says destructive things, positive depression, positive anxiety...nightmares...history PTSD (post-traumatic stress disorder)...stressful work environment plus family stressors...does not want to discuss...plan to hang self, delusional in

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TIMBERLAWN MENTAL HEALTH SYSTEM	4600 SAMUELL BLVD PO BOX 151489 DALLAS, TX 75315

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content...means ropes and medications...rapid mood shifts, anxiety, blunted affect, paranoid ideation...mental status...guarded, depressed, poor judgment and insight, justification for admission...diagnostic evaluation, drug therapy or treatment requiring continuous observation, impaired social...high risk for self-harm or suicide risk."

The Psychiatric Evaluation dated 12/02/14, timed at 1000, revealeded, "Suicidal ideation, thoughts of hanging herself...here for depression, dissociative disorder, suicidal ideation...decided to come to hospital from Montana in order to get treatment...depressed, anxious, some fear of others, suicidal ideations...hanging, homicidal ideations."

The multidisciplinary progress note dated 12/02/14, timed at 2300, revealeded, "Depression and anxiety...feels disconnected...patient positive for auditory hallucinations but cannot make out what voices are saying...poor eye contact...will continue to monitor."

The Precaution Checklist dated 12/03/14, revealed, "Close observation, suicide precautions...at 0630 P4 which means, (Sleeping, patient room)...(marked over with an X written in, CPR (cardiopulmonary resuscitation) started at 0636) initialed by nurse."

The multidisciplinary progress notes dated 12/03/14, timed at 0636, revealed, "Completing shift change rounds with oncoming nurse...patient

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A 286	Continued From page 15 was on floor, sitting against closet door...turned light on...patient had a strip of her torn bed sheet around her neck and attached to door knob...unresponsive...face was pale and lips were slightly dusky...RN (registered nurse) pulled patient up off door knob and placed on floor in CPR position...loosened cloth around neck and assessed for pulse...no pulse and no respirations assessed...CPR chest compressions immediately started...code blue called and 911 notified...EMS (emergency medical services) arrived at 0649 and took over chest compressions, oxygen with bag and mask ...at 0651 suctioned...contents contained thick saliva..." The Hospital Plant Anomalies dated 05/16/14, revealed, "Trauma unit...patient door handles and closet door handles could be a ligature risk...Lewis I...patient door handles and closet door handles could be a ligature risk...is a list of plant anomalies...please familiarize yourself with the plant anomalies for each unit and throughout the facility." The performance improvement minutes from 05/2014 through 12/03/14, did not address any concerns regarding potential ligature risks for patient rooms which included door and closet knobs/handles. On 02/17/15, at 1415, Personnel #1 was interviewed. Personnel #1 stated that in May 2014, the hospital came up with a list of plant anomalies and the closet door knobs/handles and patient room door knobs were identified as a ligature risk. Personnel #1 was asked if the	A 286		

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A 286	Continued From page 16 hospital took action on the identified door knobs and closet knobs/handles. Personnel #1 stated no not until after the event occurred with Patient #1. On 02/25/15, at 1500, the surveyor spoke with Personnel #1 by telephone. Personnel #1 stated that performance improvement did not address potential ligature devices identified by the facility in 05/2014, on the plant anomalies list. Personnel #1 stated performance improvement did not address the potential ligature risks on the patient care units until after 12/03/14, when (Patient #1) hung herself with a piece of a torn bed sheet on a closet knob. B) On 02/18/15, at 1400, observation rounds were conducted with Personnel #1 on the Bloss Unit. Personnel #10 was asked by the surveyor to review the patient close observation rounds records. The surveyor found one patient rounds record (Patient #12's) with a blank section timed at 1145 (15 minutes) which did not account for Patient #12's whereabouts. Personnel #10 stated he was new. Personnel #11 was standing next to Personnel #10 when the surveyor questioned why the 15 minute close observation was not completed. Personnel #11 said "it is only 15 minutes." Personnel #1 said rounds were supposed to be done every fifteen minutes. (Patient #12's) notification of emergency detention dated 02/17/15, timed at 1400, revealed, "Patient stated he has been off his medication for several days and stated he wants to kill himself..."	A 286		

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The Precaution checklist dated 02/18/15 revealed, "Close observation 15 minute checks...the 1145 round was left blank." The every 15 minute check was not completed and did not document (Patient #12's) behavior or location.

The policy and procedure entitled, "Patient Observation/Level of Observation" with an edit date of 02/2015 reflected, "Observe each patient, a minimum of every 15 minutes and/or according to precaution level and document observation on the patient observation form concurrently while doing rounds...document patient location and behavior when observation occurs on the patient observation form..."

C) On 02/18/15, at 0900, the lobby of the main entrance to the hospital was observed. Multiple people greater than 6 were observed sitting in the lobby either to visit and/or to have an assessment completed. A plastic trash can was observed in the lobby with a plastic liner inside it. Two wall mounted lamps were observed one on each side of the fireplace. The cord attached to the lamps was approximately two feet in length. A second plastic trash can was observed against the wall behind the desk with a plastic liner inside it. At 0910 Personnel #1 was notified regarding the above safety concerns. Personnel #1 left and returned to the conference room at 0930. Personnel #1 verified the above safety concerns.

On 02/18/15, at 1331, observation rounds were

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A 286	Continued From page 18 conducted with Personnel #1 on the Trauma Unit. A telephone was observed sitting on the ledge of the nursing station counter. The window to the nursing station was three quarters of the way closed leaving approximately a two inch open gap. The phone cord was easily removed from the nursing station counter. The phone cord was greater than two feet in length. Personnel #1 verified the above safety concern. On 02/18/15, at 1345, observation rounds were conducted with Personnel #1 on the Geriatric unit. A telephone was observed sitting on the desk. The telephone cord was greater than one foot. The cord was within the reach of any patient standing at the desk. Personnel #1 verified the above safety concern. The policy and procedure entitled, "Patient Observation/Level of Observation" with an edit date of 02/2015 reflected, "Observe each patient, a minimum of every 15 minutes and/or according to precaution level and document observation on the patient observation form concurrently while doing rounds...document patient location and behavior when observation occurs on the patient observation form...levels of observation...close observation...all inpatient admissions will be on close observation with minimum of observation to be completed every 15 minutes...heightened level of observation...5 minute observation...where the patient is visualized and monitored for safety at least every 5 minutes ...nurse must receive a physician's order for the 5 minute close observation...the 5 minute level of observation is ordered but not limited to...suicidal ideation, serious threats or actual attempts...extreme	A 286		

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A 286	Continued From page 19 withdrawn or isolating behavior...1:1 Observation...is used when a situation involves a potential clinical crisis, severe suicidal attempts...only used in extreme situations...physician's order."	A 286		