REVIEWED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454121	A. BUILDING _____ B. WING _____ JUL 21 2014	C 06/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUSTIN OAKS HOSPITAL	1407 WEST STASSNEY LANE AUSTIN, TX 78745

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A 000	INITIAL COMMENTS An unannounced entrance conference was conducted in the morning of 6/30/14 in a conference room at Austin Oaks Hospital in Austin, Texas. In attendance were the Chief Executive Officer, the Risk Manager and the Director of Nurses. The Medicare complaint survey was explained and an opportunity for questions was provided. Continued Medicare certification is recommended with an approved plan of correction. An exit conference was conducted in the afternoon of 6/30/14 in a conference room at Austin Oaks Hospital in Austin, Texas. In attendance were the Chief Executive Officer, the Director of Nurses and the Risk Manager. The preliminary findings of the Medicare complaint survey were discussed and an opportunity for questions was provided. All questions were answered.	A 000	By submitting this Plan of Correction, the Facility does not admit that it violated the regulations. The Facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency.	
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 review of documentation and interview, it was determined that the facility did not always provide patient care in a safe setting. Findings were: "Austin Oaks Staffing Grid " "Unit B: Child and Adolescent" stated that on the 7-3 shift, 16-20 patients required 4 staff. The 3-11 shift also	A 144	A144 §482.13(c)(2) – The DON has revised and re-assigned the process for staff scheduling to ensure compliance and accountability. Deployment of staff will take into account physical plant options (extending or reducing length of hallways) to optimize observation of patients and safety.	7/14/14

[redacted]

SIGNATURE [redacted] TITLE (X6) DATE 7-16-14

which the institution may be excused from correcting providing it is determined that ons.) 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.

42 CFR 401.126 and 401.133

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A 144	Continued From page 1 required 4 staff members for 16-20 patients. On the 11-7 shift, only 3 staff members were required for 16-20 patients. · On the evening of 5/16/14, there were 16 patients on the Child/Adolescent unit. One RN was assigned for the shift of 7p to 7a. Two Mental Health Technicians were assigned, leaving the staffing ratio at 16:3 · On 5/17/14, the Child/Adolescent unit had 16 patients. On the 7a-7p shift, there was one RN and 2 Mental Health Technicians assigned to the unit, leaving the staffing ratio at 3:16. · On 5/18/14, the Child/Adolescent unit had 16 patients. On the 7a-7p shift, there was one RN and 2 Mental Health Technicians, leaving the staffing ratio at 3:16. · On 5/18/14, the Child/Adolescent unit had 16 patients. On the 7p-7a shift, there was one RN and 2 Mental Health Technicians, leaving the staffing ratio at 3:16. · On 5/19/14, the Child/Adolescent unit had 16 patients. On the 7a-7p shift, there was one RN and 2 Mental Health Technicians, leaving the staffing ratio at 3:16. In an interview with the Director of Nurses on 6/30/14, it was acknowledged that the Child/Adolescent unit was not staffed according to company policy during the period of 5/16/14 through 5/19/14.	A 144		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for	A 392	A 392 §482.23(b) – The DON instructed the Nursing Supervisors to utilize Administrator On-Call, available 24/7, in the event of unexpected staffing shortage, in assisting to	7/7/14

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A 392	Continued From page 2 each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on review of documentation and interview, it was determined that the facility did not follow its own policies in regard to nursing services provided to its patients. Findings were: Facility policy entitled "Admission Assessment and Intake Process" stated in part "Once an individual is deemed medically stable, a Qualified Mental Health Professional shall conduct the Admission Assessment, in order to establish psychiatric needs. The admissions assessment shall include the following elements: a) Chief complaint b) History of present illness c) Mental status assessment d) Suicide risk assessment e) Aggression risk assessment f) Safety assessment g) Substance abuse screen h) Abuse/Neglect trauma history i) Behavioral intervention screen to include contraindications by history j) Family psychiatric history, living arrangements k) Medical and or behavioral healthcare advance directives l) Any stated alcohol use will have breathalyzer testing performed m) Other relevant information" Facility policy entitled, "Patient Valuables and Belongings" stated, in part, "Patient's belongings	A 392	maintain the requisite staffing level, to ensure "immediate availability of a registered nurse for bedside care of any patient." As shared with the surveyors at the time of survey (documentation provided), a Process Improvement Team had convened on 6/25/14, to address concerns with the intake and security of valuables procedures. Recommendations and policy revisions will be presented to the Medical Executive Committee on 7/17/14. Upon approval, the DON will conduct mandatory training sessions with all direct nursing staff to review the policy and procedure and initiate the new process. Nursing Supervisors shall conduct random audits of new admissions to ensure compliance with procedures. Audits shall be conducted for 60 days of 100% compliance.	7/28/14

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A 392	Continued From page 3 that are placed in the custody of the hospital will be logged in and secured and returned to the patient on discharge. Procedures: 1. In the admissions area, a safety check is conducted and patients are asked to turn in all contraband items ... 2. The items are placed in a container and remain with the individual conducting the admission assessment until the assessment is complete and the patient is taken to the unit. 3. When the patient is taken to the unit, the patient and any items confiscated are kept under constant observation until the unit admission process is initiated 4. The patient is taken to the exam room where two staff members are present and a search is conducted per the Search policy. 5. The person conducting the safety check removes any contraband or valuables that are not allowed on the unit and places them in a bin in the presence of the patient. 6. The patient and the staff then return to the unit, the staff inventories all items that will not be kept in custody by the patient during their stay ... 10. The patient or parent / guardian will review the inventory list and sign it; staff member doing the inventory will sign and date it." Review of eleven randomly selected patient records revealed the following: · No Intake Property Sheet was found in the medical record of Patient # 1 · No documented skin assessment was performed on Patient # 9 upon admission. No Intake Property Sheet was found in this patient ' s medical record. · Patient # 11 had no Intake Property Sheet in the medical record and no documented	A 392		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 392	Continued From page 4 Medication Reconciliation was performed upon admission. In an interview with the Medical Records Clerk and the Director of Nursing on 6/30/14, the missing documentation was confirmed.	A 392		
A 620	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: Based on a tour of the facility and staff interviews, the facility failed to ensure that the kitchen adhered to infection control practices to prevent cross contamination. Findings were: During a tour of the facility kitchen the morning of 6/30/14 accompanied by the Food Service Manager and the Director of Risk Management, the following was observed: · In the food prep table drawer, there were four large spoons placed bowl up which contained a clear liquid. This moist environment presents a risk for cross contamination due to the potential for bacterial growth. · There were two knives in the knife rack, available for use in food prep, which were in need	A 620	A 620 §482.28(a)(1) – The Registered Dietician will review with the Food Service Manager the policies and procedures related to infection control associated with food handling, equipment and storage. Documentation of review shall be evident in the HR files of the Food Service Manager. Random inspection by Registered Dietician shall be conducted for 30 days of 100% compliance	7/11/14

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A 620	Continued From page 5 of cleaning, as there was a white substance adhered to both sides of the blade. This presents a risk for cross contamination. · In the dry food storage room, there was a dirty, corrugated cardboard external shipping box with shipping label attached on the top shelf of a wire shelving unit. Underneath the dirty box were patient food supplies available for patient use, including items such as various condiment packets and packages of assorted pasta. This presents a risk for cross contamination from the dirty shipping box. · When asked by the surveyor to check the concentration of the sanitizer in the red bucket to ensure the concentration was within the proper range, the test strip indicated no sanitizer in the water. The kitchen manager added sanitizing solution, however the surveyor identified that the test strips expired on 10/13 (approximately 7 months previous). The kitchen manager then obtained test strips that were not expired and tested the solution that he had added sanitizer to and the solution at this time contained the proper concentration. However there was no way to determine that the proper concentration of sanitizer had been used to sanitize food prep surfaces as the test strips were expired. This was confirmed in an interview with the Risk Manager and the Food Service Manager.	A 620		