Approved c changes noted on page 3 p discussion c Michelle assist CEO on 10/28/14 at 10AM

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

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WY Dept of Health
OCT 27 2014
Healthcare Licensing

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	534004	A. BUILDING ______ B. WING ______	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING BEHAVIORAL INSTITUTE	2521 EAST 15TH STREET CASPER, WY 82609

Linda Brown RN

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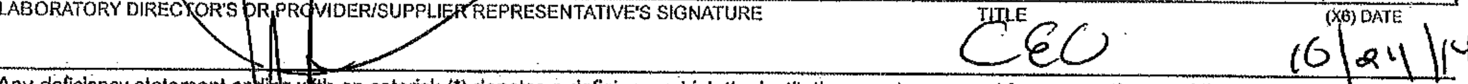
A 000	INITIAL COMMENTS This survey was conducted as a new complaint survey and done in conjunction with the revisit to the July 2, 2014 complaint survey.	A 000	**INITIAL COMMENTS:** Preparation and/or execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on staff interview, medical record review, and review of hospital policy and procedure, it was determined the hospital failed to ensure all discharge planning requirements were met. There lacked evidence of a valid and safe discharge for 3 of 7 sample patients (#2, #4, #6) (refer to A820). This system failure resulted in the inability of the hospital to meet all of the necessary requirements for the Discharge Planning Condition of Participation.	A 799		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on staff interview, medical record review, and review of hospital policy and procedure, the hospital failed to ensure a valid and safe discharge occurred for 3 of 7 sample patients (#2, #4, #6). The findings were: 1. Review of the 9/29/14 admission history and	A 820	**A 820** **PLAN OF CORRECTION A 820** **482.43(c)(3),(5)** The following corrective actions have been taken to ensure compliance with this regulation and to ensure safe discharge practices identified in the review of patients #2, #4, and #6. 1. The Director of Clinical Services and Associate Medical Director reviewed and reaffirmed that the Discharge Planning and the Discharge Protocol policies ensure all components of a safe discharge are included in policy.	10/3/14



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 10/24/14

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 820	Continued From page 1 physical (H & P) showed patient #4 was admitted to the hospital on 9/28/14 for acute stabilization after s/he attempted suicide by taking pills. The patient stated s/he ingested Percocet (narcotic pain medication), Flexeril (muscle relaxant), Tegretol (anticonvulsant), and Lisinopril (blood pressure medication). The patient had a significant past history of suicide attempts and major depressive disorder. Currently the patient was grieving the demise of his/her long term marriage. The patient was discharged on 10/1/14. The following concerns with the lack of discharge planning were identified: a. Review of the physician's progress note written on 9/30/14 showed the patient continued to be depressed, despondent, and anhedonic (loss of interest in normal activities). In addition the patient was described as excessively anxious, worried, and feeling on the edge with increased muscle tension. Review of the mental status examination showed the patient was in acute distress with poor eye contact, a fixed facial expression, and was down cast. The patient's insight and judgement continued to be "very poor." The plan was to continue with the antidepressant Lexapro at 10 mg with an anticipated increase to 20 mg, group therapy and to contact the patient's support system. However, an order for discharge of the patient was written at 9:15 AM the following morning. Review of the entire medical record showed no evidence the patient was ready for discharge. Interview with the psychiatrist on 10/2/14 at 3:10 PM revealed she did not feel the patient was ready and safe for discharge. b. Review of the discharge plan showed the patient would benefit from continued work on current stressors including the grief/loss issues and stress related to the current separation from	A 820	2. The Director of Clinical Services and the Associate Medical Director re-educated the therapists, nurses and medical staff of the Treatment Team. Re-education included: documentation requirements, after a court has dismissed the patient's involuntary detention; the policy to offer the patient the option of continuing hospitalization on a voluntary basis and documentation of the patient response to this offer; and the policy to include the family and patient in the discharge planning process. 3. A Performance Improvement Team was initiated by the CEO to further develop the process after a court dismissal of involuntary detentions. This Team also drafted a new form to document a review of risks of discharge before the Physician presents the cases in court. They also initiated a form that will be completed if there is a court dismissal, when the Treatment Team reconvenes to review readiness for discharge. They initiated a morning meeting between physicians to review	10/6/14 10/3/14 and ongoing

10/28/14
JB

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A 820

Continued From page 2

his/her spouse. Interview with the psychiatrist on 10/2/14 at 3:10 PM revealed she did not feel the patient was ready and safe for discharge but the court dropped the involuntary hold so she felt discharge was mandatory. Interview further revealed the patient was not offered the option of signing in on a voluntary basis for continued therapy and stabilization. In addition, interview at 3:10 PM on 10/2/14 with the two psychiatrists who both testified at the patient's court hearing, to make a determination of the patient's status, had differing opinions about the patient's safety and readiness for discharge. Interview revealed they had not conferred with each other prior to the hearing to discuss the patient's status or to plan for his/her continued care and/or discharge planning.

2. Review of the 9/29/14 H & P showed patient #2 was admitted to the hospital on 9/28/14 for acute stabilization after s/he had ingested Buspirone (antianxiety medication) with concurrent acute alcohol intoxication. The police found the patient unresponsive with a nearby empty bottle of whiskey and a near empty (1 pill left) bottle of Buspirone lying next to him/her. The patient's admitting diagnoses included mood disorder and anxiety disorder. The patient was discharged on 10/1/14. The following concerns with the lack of discharge planning were identified:

a. Review of the 9/30/14 physician progress notes showed the patient continued to be depressed, despondent, and anhedonic. Further review showed the patient was excessively anxious, worried and in acute distress. The patient was described to have poor eye contact, was down cast and had a fixed facial expression. The patient's insight and judgement were still "very poor." However, an order for discharge of

A 820

all identified risks for each patient before going to court. This Team is made up of the Medical Director, Associate Medical Director, Director of Clinical Medicine, Director of Nursing, Adult Unit Nurse Manager, and the Assistant Hospital Administrator/Risk Manager.

4. All patients in which the court dismisses the involuntary detention or commitment process, including patients #2, #4, #6, are being reviewed by the physician and social services staff member to determine the risks of discharge and, when appropriate, to offer the patient the option of signing in voluntarily, and review for a new treatment plan or a safe discharge plan. The Therapists and Physicians were trained on this new process by the Director of Clinical Services and Associate Medical Director. The Director of Clinical Services will monitor for full compliance. — 10/16/14 (handwritten: added c̄ phone permission of CEO on)

5. Two new forms were initiated by the new Performance Improvement Team to document the identified patient risks of discharge prior to court and the other to — 10/21/14

10/28/14 [initials]

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A 820	Continued From page 3 the patient was written at 9:30 AM the following morning. Review of the entire medical record showed no evidence the patient was ready for discharge. b. Review of the discharge plan showed the patient would benefit from continued treatment on how to deal with current stressors in a healthy manner without the benefit of alcohol and drugs. The patient continued to have significant stressors in regard to his/her mother's serious illness. Finally, the patient needed to identify triggers and coping mechanisms to prevent a similar situation from occurring. The discharge order was "Pt [patient] discharged by the judge." Interview with the patient's psychiatrist and the psychiatrist who testified at the court hearing on the patient's involuntary status on 10/2/14 at 3:10 PM revealed they had not spoken with each other or collaborated on an appropriate discharge plan for the patient prior to the court hearing. Review of the medical record showed no evidence the patient was offered the option of signing in on a voluntary basis for continued therapy and stabilization. 3. Review of the admission face sheet showed patient #6 was admitted to the hospital on 9/19/14 on a voluntary basis with diagnoses including major depressive disorder, acute stress reaction, generalized anxiety disorder, and cannabis abuse. Review of the 9/21/14 admission H & P showed the patient had posted an apology video to anyone s/he had hurt or done wrong which was interpreted as a suicide note. The patient was admitted for his/her safety. Review of the medical record showed the patient was placed on an involuntary hold on 9/21/14 at 3:35 PM because of "very poor" insight, impulse control, and judgement. The patient was depressed and	A 820	document re-assessment of risk of discharge of a patient when the court dismisses their detention to ensure all procedures are followed, risks are assessed; when further treatment is recommended by the Physician, the patient is then offered the option to sign in voluntarily; to ensure family participation in the discharge planning process, when appropriate and when the patient gives authorization to do so; and a safe discharge plan is agreed upon. The forms will be completed by the social services staff and then reviewed by and signed by the Physicians. Physicians and Therapists were trained on the new forms by the Director of Clinical Services and the Associate Medical Director. 6. The Director of Clinical Services/designee is conducting a 100% concurrent audit of all patients when the court dismisses the involuntary detention to ensure full compliance with all policies and procedures. The audit will include the documentation of the review	 10/31/14

10/28/14

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A 820	Continued From page 4 feeling guilty about a friend's recent suicide. The patient was considered to be a risk to him/herself. However, the patient was discharged home the following day, 9/22/14 at 5 PM. The following concerns with the lack of discharge planning were identified: a. Review of the medical record showed no evidence a discharge plan for aftercare was in place prior to the patient's discharge on 9/22/14. The patient's psychiatric evaluation was not performed until 9/22/14 at 7:41 AM the day of discharge. According to the evaluation the plan included admission to the acute psychiatric unit under close observation, structured milieu and safety precautions. Approximately nine hours later, the patient was discharged home without evidence of improvement in his/her mental status. b. Review of the discharge paper work showed the patient needed to work on learning to positively express his/her emotions and feelings and to continue to build and improve coping skills on his/her ability to handle stress levels. The patient would benefit from additional therapy in a structured environment. Review of the discharge notes showed the patient and family had developed a significant distrust with the hospital and was discharged because of that, however, the patient was not transferred to another inpatient setting and no discharge plans were developed prior to the discharge. Interview with the admitting psychiatrist for this patient on 10/2/14 at 3:10 PM revealed she believed the patient was a danger to him/herself and was not ready for discharge and wrote an extensive note to that effect. 4. Review of the hospital policy on Care of Patients/Discharge Planning, revised 9/14 showed the discharge plan should "Prepare	A 820	of risks of discharge after the court dismissal of the detention; family involvement in the discharge planning process, when appropriate and when the patient give authorization to do so; appointments for follow up are made; the patient/family have agreed to secure any lethal means; evidence that the patient was involved in the discharge planning process; whether the Crisis Safety Plan was completed and reviewed with the patient and support person when applicable; and whether any outpatient/referral providers were contacted. The results of this audit are reported monthly to the Performance Improvement/Safety Committee and the Medical Executive Committee. The results will also be presented quarterly to the Governing Board.	

10/28/14

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A 820	Continued From page 5 through counseling, the patient and family for the transition to the next level of care...All patient cases in which the court dismisses their involuntary detention or commitment, will be reviewed by the Treatment Team for risk of discharge. If the Team recommends continued treatment, the patient will be given the option to sign in voluntarily for continued stay. The offering of this option will be documented in the medical record, along with the patient response. In those cases when a patient refuses to sign in voluntarily, and the Team feels they are at risk to discharge, the physician will then assess for criteria for placing the patient on an involuntary hold. In those cases when a patient is assessed as not meeting criteria for an involuntary hold, the patient and family or support person(s) will be contacted to review and participate in creating a safe discharge plan."	A 820		

10/28/14