*Pennsylvania Department of Health*
# Inspection Results

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## BELMONT BEHAVIORAL HOSPITAL, LLC
4200 MONUMENT ROAD
PHILADELPHIA, PA 19131

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/16/2016

**INITIAL COMMENTS**

This report is a result of a review of the policies and procedures for Belmont Behavioral Health, LLC and the result of an on-site inspection previously conducted on November 18 and 19, 2015 relative to the physical plant by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection and review of the policies and procedures, Belmont Behavioral Health, LLC was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. Therefore, no deficiencies were identified during this inspection and review and no plan of correction is required.

As this was the initial inspection conducted, not all regulations were reviewed. During future inspections, all regulations will be reviewed for compliance.

**Plan of Correction**

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# Inspection Results

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## BELMONT BEHAVIORAL HOSPITAL, LLC
4200 MONUMENT ROAD
PHILADELPHIA, PA 19131

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/17/2016

**INITIAL COMMENTS**

This report is a result of an on-site licensure renewal inspection conducted on November 14, 2016 through November 17, 2016 by staff from the Department of Drug and Alcohol Programs, Bureau of Quality Assurance for Prevention and Treatment, Program Licensure Division. Based on the findings of the on-site inspection, Belmont Behavioral Hospital, LLC was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

**Plan of Correction**

### 704.12(a)(6) LICENSURE OutPatient Caseload

704.12. Full-time equivalent (FTE) maximum client/staff and client/counselor ratios. (a) General requirements. Projects shall be required to comply with the client/staff and client/counselor ratios in paragraphs (1)-(6) during primary care hours. These ratios refer to the total number of clients being treated including clients with diagnoses other than drug and alcohol addiction served in other facets of the project. Family units may be counted as one client. (6) Outpatients. FTE counselor caseload for counseling in outpatient programs may not exceed 35 active clients.

**Observations**

The Staffing Requirements Facility Summary Report was completed and reviewed on November 14, 2016. Employee #11 was hired as a counselor on 12/21/2015 and was still acting in that position. Employee #11 was reported to have 20 hours per week devoted to their 27 patients on their caseload.

The counselor Full Time Equivalent (FTE) is determined by dividing the total number of hours the counselor devotes to their patients by 35. Then, in order to obtain the counselor ' s ratio, the total number of patients on the counselor ' s caseload is divided by the FTE.

The FTE counselor ' s caseload calculation is as follows: 20/35 = .5714(FTE); 27/.5714 = 47.2, which equals to a patient/counselor ratio of 48:1.

These findings were reviewed with facility staff during the licensing process.

**Plan of Correction**

The Facility Director adjusted employee #11's caseload from 27 patients to 18 patients. Before assigning cases going forward, the Facility Director will review the caseload grid with intake staff, to ensure all staff are at or under the DDAPL regulation for FTEs.

### 709.123(c) LICENSURE Client records

709.123. Treatment and rehabilitation. (c) Client records. There shall be a complete client record on an individual which includes information relative to the client's involvement with the project. This shall include, but not be limited to, the following:

**Observations**

Based on a review of client records, the facility failed to provide a complete client record, which is to include follow up information, in client records #8, 10 and 18.

Patient #8 was admitted to the Psychiatric Hospital level of care on 7/7/16 and discharged 7/18/16. The patient record did not contain any documentation of follow-up information as of the date of the inspection.

Patient #10 was admitted to the Psychiatric Hospital level of care on 3/27/16 and discharged 4/15/16. The patient record did not contain any documentation of follow-up information as of the date of the inspection.

Patient #18 was admitted to the Psychiatric Hospital level of care on 9/30/16 and discharged 10/28/16. The patient record did not contain any documentation of follow-up information as of the date of the inspection.

These findings were reviewed with facility staff during the licensing process.

**Plan of Correction**

Follow-up calls were completed and documented on 12/19/16 for patients #8, 10 and 18.

The Director of Social Services re-educated case managers on the standards of documentation of follow-up information. The Director of Social Services created an electronic aftercare log, accessible to all case managers, to document the outcomes of aftercare follow-up. By centralizing the placement of the log, the Director of Social Services will provide oversight to ensure its completion going forward.

The Director of Social Services is responsible for implementing this corrective action.

### 705.8 (2) LICENSURE Heating and cooling.

705.8. Heating and cooling. The residential facility: (2) May not permit in the facility heaters that are not permanently mounted or installed.

**Observations**

Based on a physical plant inspection conducted on November 15, 2016 at approximately 12:30 pm, it was observed that the facility failed to ensure that there weren't any heaters not permanently mounted or installed in the campus's outpatient building. Specifically, one space heater was discovered in outpatient room #M337C and a second space heater was found in an unmarked office directly next to the outpatient receptionist desk in the main lobby.

These findings were reviewed with facility staff during the licensing inspection.

**Plan of Correction**

The two space heaters discovered in the outpatient area were removed. The Director of Facilities updated Policy # 620.20 Portable Heaters which will be distributed to all staff following the approval of the Policy and Procedure Committee on 1/5/17. The Director of Facilities added questions to the EOC Patient Room and Common Area Risk Assessment forms (completed by facilities staff at minimum semi-annually) to ensure that no portable heaters are in use going forward. The Director of Facilities is responsible for ensuring that these actions are implemented.

### 709.28 (c) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record.

**Observations**

Based on a review of patient records, the facility failed to keep disclosures of patient identifying information within the limits established by 4 Pa. Code 255.5 (b) for releases of information in patient record # 7. Additionally, patient record # 3 had two consent to release information forms that were

**Plan of Correction**

Although patient #3 was active at the time of inspection, she was discharged on 11/17/16 (the date of the survey exit). Therefore unfortunately patient #3's releases of information could not be updated.

missing the specific information to be released and the purpose of the disclosure. Also, the facility had disclosed information prior to the patient signing an informed and voluntary consent to release form in patient record #'s 8 and 10.

Patient #3 was admitted to the outpatient drug-free activity on 7/10/13 and was active at the time of inspection. Consent to release information forms to a funding source and an outside agency, both dated 10/6/2016, did not include what information was to be released and the purpose of disclosure.

Patient #7 was admitted to the outpatient drug-free activity on 03/30/2016 and was discharged on 8/1/16. A consent to release form to the funding source, signed and dated on 03/30/16, allowed for the release of the Psychiatric Evaluation, treatment/individualized service plan, UDS results and attendance, which exceeds the limits established by 4 Pa. Code 255.5 (b) for releases of information.

Patient #8 was admitted to the Psychiatric Hospital level of care on 7/7/16 and discharged on 7/18/16. There was documentation that a facsimile was sent to another treatment provider on 7/8/16; however, there was not consent to release information form documented in the patient record at the time of the inspection.

Patient #10 was admitted to the Psychiatric Hospital level of care on 3/27/16 and discharged on 4/15/16. There was documentation of a meeting that occurred on 4/4/16 between the patient, the counselor and another treatment provider. However, the patient record did not contain a client-signed release of information form for the other treatment provider.

The findings were reviewed with facility staff during the licensing inspection.

The Facility Director re-educated outpatient staff on confidentiality and limitations set forth in 4 Pa. Code 255.5 (b) on 11/17/16. The Director of Facilities will audit 5 charts per month for 4 months at 90% compliance consistently to ensure compliance with standards.

The Director of Social Services re-educated inpatient case managers on confidentiality and limitations set forth in 4 Pa. Code 255.5 (b) on 12/7/16. As their departmental 2016 PI Goal, the Director of Social Services audits 3 records per case manager each month to ensure compliance with standards.

The Facility Director and the Director of Social Services are responsible for implementation of this corrective action.

### 709.34 (a) (4) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day.

**Observations**

On November 16, 2016, the facility ' s Unusual Incident Reporting policy was reviewed and it was discovered that the facility failed to develop and implement in their policy and procedures, a response to two of the eight unusual incidents. The two incidents not included are 1) any significant disruption of services that would close the facility for more than 1 day and 2) any event at the facility requiring the presence of police, fire, or ambulance personnel.

**Plan of Correction**

Belmont Behavioral Hospital's Incident Report is a standardized corporate form which cannot be modified to add additional categories. However, Belmont's Incident Reporting policy has been revised to specify that any significant disruption of services that would close the facility for more than 1 day and any event at the facility requiring the presence of policy, fire, or ambulance personnel will be captured under the category "12k Security."

Program Directors will ensure staff submit incident reports for the above listed categories. The Risk Manager will ensure

These findings were reviewed with project and facility staff during the licensing process.

that all unusual incidents are reported to DDAP within the specified timeframe.

### 709.34 (c) (2) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (c) To the extent permitted by State and Federal confidentiality laws, the project shall file a written unusual incident report with the Department within 3 business days following an unusual incident involving: (2) Death or serious injury due to trauma, suicide, medication error or unusual circumstances.

**Observations**

On November 16, 2016, it was discovered that since the previous licensing inspection the facility had 5 patient deaths while they were active patients and 1 patient death that the facility learned of shortly after the patient had discharged from the facility. The first 5 patient deaths were active patients in the outpatient level of care and the 1 after-discharge patient death was from the psychiatric hospital level of care. The dates that the facility was notified of each death were 12/18/15, 5/5/16, 6/6/16, 6/22/16, 7/5/16, and 11/15/16. Upon further inspection, it was discovered that the facility had not submitted a written unusual incident report to the Department within the regulatory timeframe for any of the 6 deaths.

**Plan of Correction**

Unusual Incident Reports were submitted on 11/16/16 to the Department of Drug and Alcohol Programs for the 6 deaths which occurred since the previous licensing inspection. Going forward, the Risk Manager will submit a written unusual incident report with the Department within 3 business days following an unusual incident as identified in Pa Code 709.34. The Risk Manager is responsible for ensuring this corrective action is completed.

These findings were reviewed with project and facility staff during the licensing process.

### 709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

**Observations**

Based on a review of patient records, record #'s 3, 13, 14, 15 and 16 had treatment plan updates that were either completed after the regulatory timeframe or not completed at all.

Patient #3 was admitted to the outpatient drug-free activity on 7/10/13 and was an active patient at the time of inspection. A treatment plan update was completed on 3/11/15 and the next update was due no later than 5/11/15. However, the update was not completed until 1/7/16.

Patient #13 was admitted to the outpatient drug-free activity on 3/17/16 and was an active patient at the time of inspection. The comprehensive treatment plan was completed on 3/17/16 and the next update was due no later than 5/17/16. However, the update was not completed until 6/23/16. Additionally, there were no more treatment plan updates completed since 6/23/16.

Patient #14 was admitted to the outpatient drug-free activity on 8/12/15 and was an active patient at the time of inspection. The comprehensive treatment plan was completed 8/12/15 and the next update was due no later than 10/12/15. However, the update was not completed until

**Plan of Correction**

Patient #13 had a Recovery Plan Update dated 4/17/16 in the chart which means that the next plan would have been due 6/17/16. There is a progress note from 6/17/16 indicating that the patient was not in program on that date. The Recovery Plan Update was completed 6/24/16 when the patient returned to program.

Patient #16 had a Recovery Plan Update date 7/28/16 in the chart.

The Facility Director will re-educate outpatient staff on the treatment planning process, including timeframes for completion. The Facility Director will audit 5 charts for 4 months at 90% compliance consistently to ensure that treatment plans are completed within required timeframes.

The Facility Director is responsible for the completion of this corrective action.

1/22/16.

Patient #15 was admitted to the outpatient drug-free activity on 1/1/15 and was discharged on 5/30/16. The comprehensive treatment plan was completed on 1/1/15 and the next update was due no later than 3/1/15. However, the next update was not completed until 12/11/15.

Patient #16 was admitted to the outpatient drug-free activity on 6/29/16 and was discharged on 9/15/16. The comprehensive treatment plan was completed on 6/29/16 and the next update was due no later than 8/29/16. However, there was no update completed with the client prior to discharge.

These findings were reviewed with facility staff during the licensing process.

### 709.93(a) LICENSURE Client records

709.93. Client records. (a) There shall be a complete client record on an individual which includes information relative to the client's involvement with the project. This shall include, but not be limited to, the following:

**Observations**

Based on a review of patient records, the facility failed to provide a complete client record, which is to include a record of services, case consultation notes, and follow up information, in patient record #'s 3, 5, 7 and 16.

Patient #3 was admitted to the outpatient drug-free activity on 7/10/13 and was an active patient at the time of inspection. The record contained incomplete record of services as of the date of the inspection.

Patient #5 was admitted to the outpatient drug-free activity on 11/23/15 and was discharged 2/26/16. The record contained incomplete record of services as of the date of the inspection.

Patient #7 was admitted to the outpatient drug-free activity on 03/30/2016 and was discharged on 8/1/16. The record did not contain documentation of case consultation notes as of the date of the inspection.

Patient #16 was admitted to the outpatient drug-free activity on 6/29/16 and was discharged on 9/15/16. The record did not contain documentation of any follow-up information as of the date of the inspection.

These findings were reviewed with facility staff during the licensing process.

**Plan of Correction**

Patient #3's record of services was corrected on 11/18/16. Patient #5's record of services was corrected on 12/22/16.

For patient #16, the counselor completed the follow-up call on 11/18/16 and confirmed that patient had engaged with the next provider. This has been documented on the follow-up log.

The Facility Director re-trained outpatient staff on the Follow-up policy, Case Consultations and Record of Service on 11/21/16.

The Facility Director will audit 5 charts per month for 4 months at 90% compliance consistently to ensure compliance with records of service, case consultations, and follow-up information going forward.

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## BELMONT BEHAVIORAL HOSPITAL, LLC
4200 MONUMENT ROAD
PHILADELPHIA, PA 19131

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 12/06/2017

**INITIAL COMMENTS**

This report is a result of an on-site licensure renewal inspection conducted on December 4, 2017 through December 6, 2017 by staff from the Department of Drug and Alcohol Programs, Bureau of Quality Assurance for Prevention and Treatment, Program Licensure Division. Based on the findings of the on-site inspection, Belmont Behavioral Hospital, LLC., was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

**Plan of Correction**

### 704.11(c)(1) LICENSURE Mandatory Communicable Disease Training

704.11. Staff development program. (c) General training requirements. (1) Staff persons and volunteers shall receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

**Observations**

Based on a review of personnel records and the facility's Staffing Requirement Facility Summary Report (SRFSR) form, the facility failed to ensure that employee #6 received the minimum of 6 hours of HIV/AIDS training and at least 4 hours of TB/STD and other health related topics within the regulatory timeframe.

Employee #6 was hired as the project director on 01/05/15 and was due to have the communicable disease trainings no later than 01/05/17. There was no documentation in the personnel file of the completion of the required 6 hours of HIV/AIDS training and the required 4 hours of TB/STD training as of the date of the inspection.

These findings were reviewed with facility staff during the licensing process.

**Plan of Correction**

Employee #6 was hired on 1/5/15 as a Behavioral Health Associate (BHA) assigned to an adult general psychiatric unit. It was not until the 8/21/17 that employee #6 began working shifts on Belmont's co-occurring unit (3C). This places her within the required timeframe (2 years) for obtaining 6 hours of HIV/AIDS training and 4 hours of TB/STD training. Employee #6 resigned from Belmont on 12/26/17.

Going forward, in addition to having the option to attend department-approved external trainings, Belmont will offer internal HIV/AIDS and TB/STD training to staff.

Department managers will ensure that their respective staff working on 3C receive the department-required trainings within the designated timeframes.

### 709.28 (b) LICENSURE Confidentiality

§ 709.28. Confidentiality. (b) The project shall secure hard copy client records within locked storage containers. Electronic records must be stored on secure, password protected data bases.

**Observations**

Based on the physical plant inspection conducted on 12/5/17, it was discovered that the facility failed to maintain

**Plan of Correction**

A memo was sent to all staff on regulation §709.28. Confidentiality, reminding them that if they need to walk

client records in locked storage containers at all times as a client's record was found unattended and sitting on the nursing station desk.

The findings were reviewed with facility staff during the licensing process.

away from the nursing station while working on a record, they should return it to the locked chart room or place it in a locked drawer/storage area behind the nursing station.

The Privacy Officer will conduct a walk-through of the co-occurring unit (3C) once a month for 4 consecutive months with no findings to ensure that no confidential information is left unattended.

### 709.30 (3) LICENSURE Client rights

709.30. Client rights. The project shall develop written policies and procedures on client rights and document written acknowledgement by clients that they have been notified of those rights. (3) Clients have the right to inspect their own records. The project, facility or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented in the record.

**Observations**

After a review of the project's client rights policy, the project failed to include the following elements:

1) Clients have the right to inspect their own records. The project, facility, or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. The reasons for removing those sections must be documented in the record.

2) Clients have the right to appeal a decision limiting access to their records to the director.

3) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records.

4) Clients have the right to submit rebuttal data or memoranda to their own records.

These findings were reviewed with facility staff.

**Plan of Correction**

PRS Rights and Responsibilities Policy 360.12, Section IV, 16 was revised to include:

"'Health information' includes records pertaining to drug and alcohol treatment. According to PA Code 709.30 Client Rights:

1) Clients have the right to inspect their own records. The project, facility, or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. The reasons for removing those sections must be documented in the record.

2) Clients have the right to appeal a decision limiting access to their records to the director.

3) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records.

4) Clients have the right to submit rebuttal data or memoranda to their own records."

The revised policy was distributed to all staff via email.

### 709.34 (b) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (b) Policies and procedures must include the following: (1) Documentation of the unusual incident.

**Observations**

After a review of the project's unusual incident policy, the project failed to develop, include, and implement the following as part of the project's policies:

**Plan of Correction**

Incident Reporting Policy 150.01 was revised to include under section 5.2, "The Manager or Department Director will document preliminary incident review and implement timely and appropriate corrective action to be documented in the

(1)The implementation of a timely and appropriate corrective action plan, when indicated.

(2)A way to document the ongoing monitoring of the corrective action plan.

These findings were reviewed with facility staff.

'Actions Taken/Follow-Up Info/Recommendations as a result of the Incident' section on page #2 of the Incident Report, when indicated. The responsible manager will maintain documentation of the ongoing monitoring of the action plan, if required."

The revised policy was distributed to Belmont's leadership team with a reminder to maintain documentation of ongoing monitoring of incident action plans when required.

### 709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

**Observations**

Based on a review of 14 client records, 5 client records had treatment plan updates that were completed after the regulatory timeframe.

Client #1 was admitted on 6/29/16 and was an active client at the time of inspection. A treatment plan update was completed on 2/9/1717 and the next update was due no later than 4/9/17. However, the update was not completed until 4/20/17.

Client #3 was admitted on 1/30/17 and was an active client at time of inspection. A treatment plan update was completed on 5/4/17 and the next update was due no later than 7/4/17. However, the update was not completed until 7/13/17.

Client #4 was admitted on 8/8/16 and was discharged on 8/29/17. A treatment plan update was completed on 11/9/16 and the next update was due no later than 1/9/17. However, the update was not completed until 1/31/17.

Client #5 was admitted on 10/24/17 and was discharged on 7/21/17. A treatment plan update was completed on 3/24/17 and the next update was due no later than 5/24/17. However, the update was not completed until 6/15/17.

Client #7 was admitted on 8/11/16 and was discharged on 8/25/17. A treatment plan update was completed on 9/14/16 and the next update was due no later than 11/14/16. However, that update was not completed until 2/3/17. Additionally, another treatment plan update was completed on 2/3/17 and the next update was due no later than 4/3/17. However, the update was not completed until 4/20/17.

These findings were reviewed with facility staff during the

**Plan of Correction**

The Program Director educated staff on 12/21/17 on regulation 709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

The Program Director will randomly select one chart from each therapist (6) biweekly to ensure compliance with timeliness of treatment plan updates. Compliance issues will be addressed with individual therapists as identified. The audit will continue until 90% compliance is achieved for 4 consecutive months.

licensing process.

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