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IMPROVING PUBLIC UNDERSTANDING OF HEALTH AND HEALTH CARE

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

VALLEY BEHAVIORAL HEALTH SYSTEM	10301 MAYO DRIVE BARLING, AR	Sept. 3, 2015
VIOLATION: *STAFFING AND DELIVERY OF CARE*		**Tag No:** A0392

Based on review of staffing sheets and interview, it was determined the Facility failed to have a Registered Nurse staffed on each Unit for 3 (07/04/15, 08/15/15 and 08/17/15) of 63 (07/01/15 through 09/01/15) days reviewed. The failed practice did not ensure a Registered Nurse was immediately available in case of an emergency. The failed practice had the potential to affect all patients admitted to the Facility. The findings follow:

A. Review of the staffing sheets from 07/01/15 through 09/01/15 revealed there was no Registered Nurse scheduled to work on the 11P-7A shift for the Geriatric and the Adolescent Subacute Units on 07/04/15 and there was no Registered Nurse scheduled to work on the 11P-7A shift for the Geriatric and Adult Units on 08/15/15 and 08/17/15.

B. In an interview with the Director of Nursing on 09/02/15 at 1225, he stated either the Nursing Supervisor or another Registered Nurse would float between the two Units where a Registered Nurse wasn't scheduled. He confirmed a Registered Nurse was not immediately available on each Unit.

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VALLEY BEHAVIORAL HEALTH SYSTEM	10301 MAYO DRIVE BARLING, AR	Sept. 8, 2016
VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION*		**Tag No:** A0168

Based on policy and procedures review, clinical record review and interview, it was determined the Facility failed to adhere to policy and procedure in that physician ' s orders for one (#16) of two (#11 and #16) patients restrained or secluded were not signed by the physician within 24 hours of the restraint/seclusion order. Failure to ensure physician's orders were signed within 24 hours did not ensure the physician was aware of the restraint/seclusion and did not ensure the Facility followed policy. The failed practice affected Patient #16 on 09/08/16. Findings follow:

A. Review of the policy and procedure titled "Restraint" received from the Chief Operating Officer (COO) at 1130 on 09/06/16 revealed the following under PROCEDURE: ...23. Within 24 hours of the restraint episode, the physician, licensed independent practitioner, physician assistant or advanced practice nurse shall: 23.1 Authenticate any verbal/telephone order, including the date and time of signature and 23.2 Assess the patient and document a progress note regarding the restraint episode, including any changes in the treatment program as a result of the behaviors precipitating the use of restraints.

B. Review of the policy and procedure titled "Seclusion" received from the Chief Operating Officer (COO) at 1130 on 09/06/16 revealed the following under PROCEDURE: ...25. Within 24 hours of the restraint episode, the physician, licensed independent practitioner, physician assistant or advanced practice nurse shall: 25.1 Authenticate any verbal/telephone order, including the date and time of signature and 25.2 Assess the patient and document a progress note regarding the seclusion episode, including any changes in the treatment program as a result of the behaviors precipitating the use of seclusion.

C. Review of the clinical record of Patient #16 revealed a physician's protocol order timed 1645 and dated 09/06/16 for seclusion authored by Registered Nurse (RN) #2 unsigned by the physician and a second physician's protocol order for chemical restraint timed 1655, dated 09/06/16, authored by Registered Nurse #2, unsigned by the physician. The above findings were verified by the COO at 1245 on 09/08/16.

VIOLATION: *RN SUPERVISION OF NURSING CARE*	**Tag No:** A0395

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interviews and clinical record review, it was determined a Registered Nurse failed to supervise the nursing care of 13 (#2-4, #6-16) of 15 (#1-4, #6-16) patients in that vital signs were not obtained per physician's orders and hygiene was not documented as rendered or performed by patient per Facility expectations. Failure to provide care per physician's orders and per Facility expectations did not ensure patients received the highest quality of care to facilitate patient progress and be discharged . The failed practice affected Patients #2-#4 and #6-#16. Findings follow:

1. During an interview with the Chief Operating Officer (COO) at 1300 on 09/06/16 she stated the Facility did not have a policy and procedure for hygiene but she expected all patients to get a daily bath or at least be offered a bath.

2. During an interview with Registered Nurse (RN) #1 at 1345 on 09/07/16 she was asked how she knew if patient's had received a bath. RN #1 stated she "goes by look, appearance". RN #1 stated there was no sure mechanism for her to determine if patients had a bath except if she assisted them with hygiene.

3. During an interview with Behavioral Health Technician (BHT) #1 at 1410 on 09/07/16 he was asked how he knew if patient's had received a bath. BHT #1 stated patients had to ask for their hygiene boxes and towels. BHT #1 stated it is not possible to document exactly when patients had a bath and usually staff enters "R" (code for Room) to indicate a patient was in their room. BHT #1 stated every patient room has a shower so patients can take a shower in their room and staff can hear the water running.

4. During a second interview with the COO at 1200 on 09/08/16 she stated it was her expectation that all patients get a bath or be offered a bath every day.

5. Review of Patient #2's clinical record revealed physician's admission orders dated 06/29/16 with vital signs BID (twice a day) checked. Review of the clinical record revealed vital signs were not documented BID on 06/30/16, 07/01/16 - 07/04/16 and hygiene was not documented 06/30/16, 07/01/16, 07/04/16 and 07/05/16. Patient #2 was discharged on [DATE]. The above was verified by the Chief Nursing Officer (CNO) at 1155 on 09/08/16.

6. Review of Patient #3's clinical record revealed physician's admission orders dated 06/22/16 with vital signs BID checked. Review of the clinical record revealed vital signs were not documented BID on 06/28/16 through 07/02/16 and 07/04/16 through 07/06/16 and hygiene was not documented 06/22/16 through 07/04/16 and on 07/05/16 through 07/06/16. Patient #3 was discharged on [DATE]. The above was verified by the COO at 1200 on 09/08/16.

7. Review of Patient #4's clinical record revealed physician's admission orders dated 07/05/16 with vital signs BID checked. Review of the clinical record revealed vital signs were not documented BID on 07/07/16 and hygiene was not documented 07/06/16 and 07/07/16. Patient #4 was discharged on [DATE]. The above was verified by the CNO at 1200 on 09/08/16.

8. Review of Patient #6's clinical record revealed physician's admission orders dated 06/28/16 with vital signs BID checked. Review of the clinical record revealed vital signs were not documented BID on 06/30/16 through 07/02/16 and hygiene was not documented 06/29/16 through 06/30/16 and 07/02/16. Patient #6 was discharged [DATE]. The above was verified by the COO at 1205 on 09/08/16.

9. Review of Patient #7's clinical record revealed physician's admission orders dated 07/12/16 with vital signs BID checked. Review of the clinical record revealed vital signs were not documented BID 07/14/16 through 07/15/16 and 07/17/16 through 07/19/16. Patient #7 was discharged [DATE]. The above was verified by the CNO at 1205 on 09/08/16.

10. Review of Patient #8's clinical record revealed physician's admission orders dated 07/31/16 with vital signs every shift checked. Review of the clinical record revealed vital signs were not documented every shift from 08/01/16 through 08/10/16 and hygiene was not documented 08/01/16 through 08/02/16 and 08/04/16 through 08/09/16. Patient #8 was discharged [DATE]. The above was verified by the CNO at 1220 on 09/08/16.

11. Review of Patient #9's open clinical record revealed physician's admission orders dated 09/02/16 with vital signs every shift checked. Review of the clinical record revealed vital signs were not documented every shift from 09/03/16 through 09/07/16 and hygiene was not documented 09/03/16 through 09/05/16 and 09/07/16. The above was verified by the COO at 1210 on 09/08/16.

12. Review of Patient #10's open clinical record revealed physician's orders dated 09/02/16 with vital signs every shift checked. Review of the clinical record revealed vital signs were not documented every shift on 09/03/16 through 09/07/16 and hygiene was not documented 09/03/16 through 09/05/16. The above was verified by the COO at 1215 on 09/08/16.

13. Review of Patient #11's open clinical record revealed physician's orders dated 08/10/16 with vital signs every shift checked. Review of the clinical record revealed vital signs were not documented every shift from 08/11/16 through 09/07/16. The above was verified by the COO at 1228 on 09/08/16.

14. Review of Patient #12's open clinical record revealed physician's orders dated 08/30/16 with vital signs every shift checked. Review of the clinical record revealed vital signs were not documented every shift from 08/31/16 through 09/07/16 and hygiene was not documented 08/31/16 through 0909/07/16. The above was verified by the CNO at 1235 on 09/08/16.

15. Review of Patient #13's open clinical record revealed physician' orders dated 09/02/16 with vital signs every shift checked. Review of the clinical record revealed vital signs were not documented every shift from 09/03/16 through 09/07/16 and hygiene was not documented 09/02/16 through 09/07/16. The above was verified by the COO at 1230 on 09/08/16.

16. Review of Patient #14's open clinical record revealed physician's orders dated 09/02/16 with vital signs every shift checked. Review of the clinical record revealed vital signs were not documented every shift from 09/03/16 through 09/07/16 and hygiene was not documented 09/03/16 through 09/07/16. The above was verified by the COO at 1238 on 09/08/16.

17. Review of Patient #15's open clinical record revealed undated physician's admission orders with vital signs every shift checked. Patient sticker revealed admission date of [DATE]. Review of the clinical record revealed vital signs were not documented every shift on 09/06/16 and 09/07/16. Hygiene was not documented 09/06/16 and 09/07/16. The above was verified by the CNO at 1240 on 09/08/16.

18. Review of Patient #16's open clinical record revealed physician's orders dated 08/29/16 with vital signs BID checked. Review of the clinical record revealed vital signs were not documented BID on 08/30/16 through 09/07/16 and hygiene was not documented 08/30/16 through 09/07/16. The above was verified by the COO at 1245 on 09/08/16.