OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD, BUILDING B
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH1816

License: IFBH7476

Health Survey Comments

No deficiencies were found during the State Complaint Investigation conducted on October 05, 06 and 07, 2016 for:

Intake # AZ00135930_____
AZDHS Representative Date

OASIS BEHAVIORAL HEALTH HOSPITAL

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: MED5523

License: SH6172

Health Survey Comments

Based on the The Joint Commission (TJC) report for the hospital submitted to the Department of Health Services, Oasis Behavioral Health Hospital is found to be in compliance with the Arizona Administrative Code Title 9 Chapter 10 Hospitals. No onsite survey was conducted.

The accreditation report will expire on April 2, 2018. If a new accreditation report is not received by the Department during the licensing period, the facility is subject to a compliance survey by the Arizona Department of Health Services Bureau of Medical Facilities Licensing.

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ADHS Signature Date

Statement of Deficiencies
Survey Date - 11/21/2016

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD, BUILDING B
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH1816

License: IFBH7476

Health Survey Comments

Based on The Joint Commission (TJC) report for the Behavioral Health Inpatient facility submitted to the Department of Health Services, Oasis Behavioral Health is found to be in compliance with the Arizona Administrative Code Title 9 Chapter 10 Behavioral Health Inpatient facility. No onsite survey was conducted.

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ADHS Representative Date

Statement of Deficiencies

Survey Date - 2/9/2017

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH4558

License: CSLG6985

Health Survey Comments

Based on The Joint Commission (TJC) report for the Hospital submitted to the Department of Health Services, Oasis Behavioral Health Outpatient Services is found to be in compliance with the Arizona Administrative Code Title 9 Chapter 10 Counseling Facility. No onsite survey was conducted.

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ADHS Representative Date

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD, BUILDING B
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH1816

License: IFBH7476

Health Survey Comments

No deficiencies were found at the time of the State Complaint Investigation conducted 03/29/17 and 03/30/17 for the following two (2) intakes:

AZ00138068
AZ00138460_____
ADHS Representative: Date:

OASIS BEHAVIORAL HEALTH HOSPITAL

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: MED5523

License: SH6172

Health Survey Comments

The following deficiencies were found at the time of the State Complaint Investigation conducted for this accredited psychiatric hospital on 03/28/17 through 03/30/17, for the following five (5) intakes:

AZ00140600
AZ00138412
AZ00137762
AZ00137733
AZ00135835

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ADHS Representative: Date:

Findings Report Summary

Findings for:	**Rule/Statute:**	**Survey Text:**
Citation 1 **Corrected Date:** 05/08/2017	Administration **Rule Text:** R9-10-203. Administration C. An administrator shall ensure that: 2. Policies and procedures for hospital services are established, documented, and implemented to protect the health and safety of a patient that: i. Cover restraints that: i. Require an order, including the frequency of monitoring and assessing the restraint; or	**R9-10-203.C.2.i.i~** Based on review of hospital policies, documents, Patient #1's medical record, videos, and interviews with staff, physicians, and patients, the Department determined that administrator failed to require the staff followed policies for documenting restraints for Patient #1. This deficient practice posed the risk that the physician would not be aware and involved in the event, and that the staff would fail to identify, document, and the monitor the restraint event(s) for patient impact. Findings include: The hospital policy titled Seclusion and Restraint #PC031 (last revised 05/19/16) requires: "...Physical Escort...If the patient cannot easily remove or escape the grasp this would be a physical restraint...Physical Restraint/Hold...holding a patient to give a forced psychotropic medication in a manner that restricts his or her movement constitutes a physical restraint..." The Medical Staff Staff Rules and Regulations (last approved 05/2016) require: "...Restraints or Seclusion Used for Emergency Behavior Management Reasons Orders - A Practitioner must order the Restraints...the use of which is limited to Emergency Situations. If a Practitioner is not immediately available a specifically trained registered nurse may initiate Restraints...based on appropriate assessment of the patient. A Practitioner will be notified as soon as possible thereafter to obtain an order..." The Chief Nursing Officer

		(CNO) provided the Restraint and Seclusion Packet Checklist during an interview conducted on 03/29/17, that requires: "...This packet must be completed during the shift in which the event took place...." The Packet requires the staff complete the 5 page document and include a copy of the Medication Administration Record, copy of the medical record "Face Sheet", complete Incident Report, review/revise the patient's Psychiatric Problem Sheet for goals and interventions, and submit the Packet to the Quality/Risk Management reviewer. The document titled Provider Order requires: "...An order must be obtained for every episode of seclusion or restraint...." Patient #1 was admitted in transfer from a group home on 03/24/17, for treatment of diagnosed [suicidal gestures, depression, aggressive behavior, danger to self, and self-destructive behaviors]. The internal medicine physician and psychiatrist examined the patient, and ordered a regular diet, routine medications, and group therapy. The clinical staff performed observations/rounding every (Q) 15 minutes. The surveyors reviewed the video recording of Patient #1 in the "Quiet Room" on 03/26/17 that confirmed Behavioral Health Technician (BHT) #6 grasped the patient's right arm then picked the patient up and carried him/her to the room at 0927. RN #7 administered injectable medication at 1018 while the same BHT held the patient prone on the bed. RN #7 confirmed during an interview conducted on 03/30/17, that the on-call physician ordered injectable medication for "agitation" when the patient was placed in the Quiet Room. RN #7 confirmed that s/he did obtain a restraint order. BHT #6 confirmed during an interview conducted on 03/30/17, that he was not aware that holding the patient's arm and carrying the patient to the Quiet Room was considered a restraint. RN #7 did not complete the Restraint and Seclusion Packet Checklist documentation that requires: Provider Order details, Restraint/Seclusion Flowsheet (behavior, intervention and patient monitoring), One Hour In-Person Evaluation, Restrain/Seclusion Patient Debriefing, and Staff Team Debriefing.
Findings for: Citation 2 **Corrected Date:** 05/08/2017	**Rule/Statute:** Medical Staff **Rule Text:** R9-10-207. Medical Staff A. A governing authority shall	**Survey Text:** **R9-10-207.A.1**~ Based on review of hospital policies, medical record review, and physician interview, the

	ensure that: 1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to a patient in a hospital;	Department determined that the on-call physician wrote orders for chemical restraints in conflict with hospital policy that restricted this practice. This deficient practice violated the patient's right to be free of chemical restraints. Findings include: The hospital policy titled Seclusion and Restraint #PC031 (last revised 05/19/16) requires, "...Chemical Restraint...A drug of medication when it is used as a restriction to manage the patient's behavior or restrict the...recipient's freedom of movement and is not a standard treatment or dosage for the patient's condition. This method of restraint is not utilized at (this hospital)...." Patient #1's medical record confirmed the nurse administered the following medication as the on-call psychiatrist ordered on 03/26/17 at: Benadryl 50 mg intramuscularly (IM) and Ativan 2 mg IM now x 1 (dose) for "agitation." The hospital's Medical Director (and Patient #1's physician) Psychiatrist #1 confirmed during an interview conducted on 03/29/17, that the Benadryl and Ativan medication combination was a chemical restraint because it was not a part of the patient's standard treatment.

Statement of Deficiencies
Survey Date - 5/16/2017

OASIS BEHAVIORAL HEALTH HOSPITAL

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: MED5523

License: SH6172

Health Survey Comments

No deficiencies were found at the time of the onsite, unannounced, State Complaints Investigation Survey conducted on 05/16/2017 for the Event #PKQ211 for the following complaint intake:
AZ00141171_____
ADHS Signature: Date:

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD, BUILDING B
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH1816

License: IFBH7476

Health Survey Comments

The following deficiencies, additional findings, and Immediate Jeopardy (IJ) were found at the time of the on-site, State Complaint Investigation survey Event # CJGY11, conducted on 8/11/2017 through 8/17/2017 for the following intakes:AZ00143169
AZ00143148
AZ00143104
AZ00143045_____
ADHS Representative: Date: Immediate Jeopardy:

The surveyors contacted the Arizona Department of Health Services Medical Facilities Licensing Bureau Chief on 8/11/2017 at 1030 hours. The Bureau Chief was notified of the deficient practices that were found related to ligature points in the four psychiatric units located in the inpatient behavioral health facility. The Chief Executive Officer (CEO) and the Director of Nursing (DON) were notified of the IJ situation at 1330 hours, and were informed there needed to be: (1) a plan in place to provide specific actions taken to remove the ligature points that pose a danger to patients' safety and (2) an executed agreement to that effect.

No current patients were allowed access to the rooms that contained exposed ligature points which could not be immediately remediated.

The CEO presented a written plan and report approved by the Medical Facilities Licensing Bureau Chief and Team Leaders.

The IJ was resolved on 8/17/2017 at 1630 hours with the CEO, DON, Director of Risk Manager, Behavioral Health Inpatient Facility (BHIF) - Director of Clinical Services, Director of Physical Plant and Operation, Corporate Director of Environmental Services and Corporate Clinical Director present following an attestation by the facility that all ligature points had been removed or repaired as per the agreement.

Findings Report Summary

Findings for: Citation 1 **Corrected Date:** 12/06/2017	**Rule/Statute:** Administration **Rule Text:** R9-10-303. Administration E. An administrator shall provide written notification to the Department of a patient ' s: 2. Self-injury, within two working days after the patient inflicts a self-injury that requires immediate intervention by an emergency medical services provider.	**Survey Text:** **R9-10-303.E.2**~ Based on facility policies and procedures, medical records and staff interviews, the Department determined the administrator failed to provide written notification to the Department within two (2) working days of a patient's self injury (patient #9) requiring immediate intervention by an emergency medical provider. Findings include: The medical record revealed on 08/06/2017 at 1800 hours, patient #9 was found in bathroom with lacerations to his/her left wrist area and upper thigh. Facility document titled "Incident Accident or Death Report" revealed: "...incident type: Injury (includes self-injury) Requiring Emergency Treatment...Medical Services Received...Sent out to (name of the acute care hospital) ER (emergency room) for further medical treatment...NOTIFICATIONS: T/RBHA, DEPARTMENT OF CHILD SERVICES (DCS), AHCCCS...." Corporate

		Clinical Director (#3) confirmed, during an interview on 8/17/2017, that she was uncertain of the process which required the Department to be notified. The CEO (#1) and Director of Risk Management (#2) were unsure if the Department had been notified in writing within two (2) working days of the event involving patient #9. The surveyor asked for, and did not recieve, any documented evidence to confirm that the Department was notified of patient # 9's injury.
Findings for: Citation 2 **Corrected Date:** 12/06/2017	**Rule/Statute:** Behavioral Health Paraprofessionals, BHT **Rule Text:** R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians If a health care institution is a behavioral health facility or is authorized by the Department to provide behavioral health services, an administrator shall ensure that: 4. A behavioral health technician receives clinical oversight at least once during each two week period, if the behavioral health technician provides services related to patient care at the health care institution during the two week period;	**Survey Text:** **R9-10-115.4**~ Based on review of the facility's policies/procedures, documents, and interview, the Department determined that the administrator failed to ensure that 2 out of 5 Behavioral Health Technicians (BHTs #25 and 34) received clinical oversight at least once during each two week period if the BHT provides services related to patient care at the health care institution during the two week period. This failure poses a potential risk that staff are not adequately supervised by a Behavioral Health Professional (BHP) to provide treatment to patients. Findings include: The agency policy and procedure entitled "Clinical Oversight/Supervision" contained: " ...Clinical oversight/supervision will be a minimum of four (4) hours per month; one hour per week, by a person who is at least...The holder of an independent license...A Registered Nurse (RN) with a minimum of one (1) year work experience in a behavioral health setting...The Clinical Supervision/oversight form will include...the name signature, credentials and title of the person receiving the supervision/oversight...Identification of the topics addressed...Clinical issues and skills...Unique needs of the client and family...Record keeping and documentation...." Review of facility documents revealed the following: Employee #25 clinical oversight dated 06/14/2017 and 06/15/17, failed to contain documentation of the topics addressed including clinical issues and needs of a client on the agency's "Clinical Supervision" form. Employee #34 clinical oversight dated 06/29/2017, failed to contain documentation of the topics addressed including clinical issues and needs of a client on the facility's "Clinical Supervision" form. The facility failed to

		document clinical oversight according to their policy and procedures that include a BHP addressing clinical issues and needs of a client to the BHT's. The Clinical Director/Licensed Practical Counselor (LPC) #5 confirmed during an interview on 08/14/17, that BHTs are not receiving clinical oversight according to the facility's policies and procedures.
Findings for: Citation 3 **Corrected Date:** 12/06/2017	**Rule/Statute:** Seclusion; Restraint **Rule Text:** R9-10-316. Seclusion; Restraint C. An administrator shall ensure that: 5. An order for restraint or seclusion includes: a. The name of the physician or registered nurse practitioner ordering the restraint or seclusion;	**Survey Text:** **R9-10-316.C.5.a**~ Based on review of policies/procedures, medical records, and interviews, it was determined that the administrator failed to require that a medical provider authorizd the order for restraints/seclusion, that the order was complete. and the medical provider followed the facility "Seclusion and Restraint" policy for 3 of 3 patients (Patient #2, #6 and #11). Findings include: Review of the policy/procedure titled "Seclusion and Restraint" revealed: "...4. The provider assesses the need for restrictive intervention and a written or telephonic order is obtained from the provider for the S/R on the Seclusion & Restraint Order form as follows:...Youth 11-17 up to 2 hours...The Seclusion and Restraint orders specify the reason for restraint or seclusion usage, the type of restraint and the duration along with criteria for release. The S/R event is limited by the continued need for the intervention rather than the length of the order...In an emergency, an RN may initiate a seclusion or restraint as protective measure provided that a provider order is obtained within 1 hour after the initiation of the seclusion/restraint...." Review of the medical record for patient # 2 revealed on 8/1/2017: "...Provider Order...Type of Intervention: Physical Restraint [box is checked]...Time Initiated: 1056...Time Ended:1057...Date Ordered: 8/1/2017...Seclusion [box is checked]...Time Initiated: 1057...Time Ended: 1110...Date Ordered: 8/1/2017...Reason for Intervention: Patient pushing on exit door. Pt. sat in cabinet with peer with door closed. Pt. refused to follow prompts...." The Provider Order form indicated this was a telephone order; the signature of the nurse receiving the "Order Read Back" is documented by RN #22. The record review indicated that the physician did not sign, date and time the Physician Authentication section. Review of the medical record for patient # 6 revealed on

		8/6/2017: "...Provider Order...Type of Intervention: Seclusion [box is checked]...Time Initiated 1910...Time Ended: 2000...Date ordered: is not documented...Reason for Intervention: Patient was combative toward staff and attempting to AWOL from unit...." The Provider Order form did not indicate if this was a telephone order or verbal order; the signature of the nurse receiving the "Order Read Back" is not documented. The physician did not sign, date and time the Physician Authentication section. Review of the medical record for patient # 11 revealed on 8/12/2017: Provider Order...Type of Intervention: Physical Restraint [box is checked]...Time Initiated: 1510...Time Ended: 1512...Date Ordered: 8/12/17...Reason for Intervention: [patient name] was aggressive and combative to patient's and staff...." The Provider Order form indicated this as a telephone order; the signature of the nurse receiving the "Order Read Back" is documented by RN #28. The physician did not sign, date and time the Physician Authentication section. Chief Medical Officer, Psychiatrist #1 confirmed during an interview on 8/11/2017, that this facility tries to use restraints at a minimum. He explained with restrains/seclusions there is a trail of forms which have to be completed and thorough documentation is needed, and also that a provider's order is needed. The CEO and the Clinical Director confirmed in an interview on 08/17/2017 that the restraint and seclusion orders did not contain all the components for an order and were not authenticated by the ordering physician, as required in the Seclusion and Restraint policy/procedure.
Findings for: Citation 4 **Corrected Date:** 12/06/2017	**Rule/Statute:** Child and Adolescent Residential Treatment **Rule Text:** R9-10-318. Child and Adolescent Residential Treatment Services A. An administrator of a behavioral health inpatient facility authorized to provide child and adolescent residential treatment services shall: 9. Ensure that: d. A patient's educational needs are met by establishing and providing an educational component, approved in writing by the Arizona Department of Education;	**Survey Text:** **R9-10-318.A.9.d**~ Based on review of facility policy, medical records and staff interview, the Department determined the administrator failed to ensure that a patient's educational needs are documented in the patients medical record according to facility policy for 9 of 9 patients (Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9). This failure has the potential of harm to the patient by having a negative effect of learning for the patient/student. Findings include: Facility policy titled "Secure Residential Education" requires: "...The student's academic progress is noted in the chart on a monthly basis through the teacher progress report (TPR)...."

		Review of the medical records for Patients # 1, 2, 3, 4, 5, 6, 7, 8 and 9 revealed an educational assessment completed; however, there was no documentation of a monthly teacher progress report documented in the patients' medical records. The Clinical Director of the Residential Treatment facility confirmed during an interview conducted on 08/18/2017, that the progress reports were not documented in the patients' medical records.
Findings for: Citation 5 **Corrected Date:** 12/06/2017	**Rule/Statute:** Environmental Standards **Rule Text:** R9-10-323. Environmental Standards A. An administrator shall ensure that: 1. The premises and equipment are: a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and	**Survey Text:** **R9-10-323.A.1.a**~ Based on staff interview and observations on tour 8/11/2017, 8/14/2017 and 8/15/2017, the Department determined the administrator failed to ensure that the facility's premises are cleaned/disinfected to prevent, minimize and control illness and infection. This failure has the potential of harm to a patient by spread of infections and/or injury. Findings include: Interview with Employee # 32 on 08/15/ 2017, confirmed the facility uses a disinfectant [Re Jur Nal]. The employee also confirmed in the above interview that the patient rooms are cleaned daily and floors are swept and mopped daily. Observation conducted on 8/11/2017 at 1000 hours, revealed debris with a dead cricket and two other dead smaller bugs on the floor of the seclusion room located in the orange unit. Also, this room had visible dust and litter on the floor. Observation conducted on 8/11/2017 and 8/14/2017, revealed the patient rooms (blue unit # 910 A/B, 908 A/B, 907 A/B, 906 A/B, 904 A/B, 902 A/B, 900 A/B; green unit #801 A/B, 803 A/B, 806 A/B; yellow unit #700 A/B, 701 A/B, 702 A/B, 704 A/B and 706 A/B and orange unit #602 A/B, 603 A/B, 610 A/B, 612 A/B) were littered with trash. The showers in these patient rooms were unclean, with white scum residue and hair in the drains. Observation on 8/14/2017, of the Blue unit (seclusion room #919, consult room #917, comfort room #915, #912 dayroom #1 and dayroom #2) and the Green unit: (consult room #819, comfort room #817, #812 dayroom #1 and dayroom #2) revealed paper trash and varied debris on the floor in each room listed above. Observations conducted on 8/14/2017, revealed small black bugs crawling on the floor the orange unit hallway. The Director of Environmental services confirmed during this tour that they had sprayed the outside perimeter of the facility a

		couple of days prior to the survey.
Findings for: Citation 6 **Corrected Date:** 12/06/2017	**Rule/Statute:** Environmental Standards **Rule Text:** R9-10-323. Environmental Standards A. An administrator shall ensure that: 1. The premises and equipment are: b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;	**Survey Text:** **R9-10-323.A.1.b**~ Based on facility policies/procedures, facility documents, staff interviews, and observations, the Department determined the administrator failed to require that: 1. staff ensure that the glass nail polish bottles used by a patient (#9) during group therapy was accounted for following the therapy session. This failure resulted in a patient self-injury necessitating treatment at a local emergency medical facility. 2. patient rooms and patient areas were free of ligature points. This failure posed the potential for significant patient injury. Findings include: 1. On 8/6/2015 at 1800 hours, patient #9 suffered from a self-inflicted injury. According to the facility document, "...on 8/6/2017...[name of male BHT] was working the unit that evening and [name of female BHT] came to the unit to assist. There were nine female patients in the unit. There were 2 (two) q5 [every 5 minutes] level observations at that time and a code white [used for elopement] had recently occurred on another unit. The patients were reportedly sent to their rooms in response to the code. [Name of male BHT] was completing checks when patient's roommate informed him. [Names of the two BHTs] responded and found [name of patient] standing in the bathroom with door open with cuts on her body...." According to facility documents, "...two other patients reported that they got fingernail polish in a glass bottle, the day prior, during tranquility group...[name of patient] broke the bottle by wrapping it in a towel and hitting it on a hard surface...used a glass shard to cut her wrist...originally, the patients hid the bottles in the AC units in their room...." 2. During observation on tour of the facility conducted 08/11/2017, surveyors identified ligature points on security A/C covers in patient room #'s 602, 612, 700, 701, 704, 706, 800, 801, 802, 803, 804, 806, 900, 901, 902, 903, 904, 905, 906, and 907. Additionally, ligature points were identified on the security A/C covers in the green unit day room and the orange unit small day room. Immediate Jeopardy was called due to the ligature points as described above in the Initial Comments section.

OASIS BEHAVIORAL HEALTH HOSPITAL

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: MED5523

License: SH6172

Health Survey Comments

The following deficiencies and additional finding were found at the time of the onsite, unannounced State Complaints Investigation Survey conducted on 08/11/2017 through 08/17/2017 for the Event # PK3T11 for the following complaint intakes:AZ00143333
AZ00143019
AZ00142550
AZ00142373
AZ00141564

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ADHS Signature: Date:

Findings Report Summary

Findings for:	Rule/Statute:	Survey Text:
Citation 1 **Corrected Date:** 11/14/2017	Medical Staff **Rule Text:** R9-10-207. Medical Staff A. A governing authority shall ensure that: 1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to a patient in a hospital;	**R9-10-207.A.1**~ Based on review of hospital policies/procedures, hospital documents, medical records and interviews, the Department determined that the administrator failed to ensure that 1 of 1 patients (Patient #10) was seen and evaluated by a psychiatrist within 24 hours. This failure poses a risk to the health and safety of patients due to patient medical needs not being identified and treated in a timely manner. Findings include: The hospital's Medical Staff Bylaws require, under GENERAL RESPONSIBILITIES OF STAFF MEMBERSHIP, at 3.3.10: "...An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration...." A review of patient # 10's medical record revealed that there was no documented evidence that this patient was seen by a psychiatrist within the first 24 hours of admission as required by the hospital's Medical Staff Bylaws. Both, Psychiatrist # 1 and # 2 confirmed on 8/16/2017, in separate confidential interviews, that the expectation is for a psychiatrist to assess and evaluate a patient admitted to this acute care facility within 24 hours of admission. The Chief Executive Officer (CEO) confirmed during a confidential interview on 8/16/2017, that patient # 10 was not assessed by a psychiatrist within the first 24 hours following admission.

Findings for: Citation 2 **Corrected Date:** 11/14/2017	**Rule/Statute:** Discharge Planning; Discharge **Rule Text:** R9-10-209. Discharge Planning; Discharge B. For an inpatient discharge or a transfer of an inpatient, an administrator shall ensure that: 1. There is a discharge summary that includes: b. The signature of the medical practitioner coordinating the patient ' s medical services;	**Survey Text:** **R9-10-210.B.1.b**~ Based on review of hospital policies/procedures, hospital documents, medical records and interviews, the Department determined that the hospital failed to require that a discharge summary was completed for 1 of 1 patients (Patient #12). This failure poses a risk to the health and safety of patients by failing to ensure a complete record of the patient's care and condition upon discharge is documented and available. Findings include: Policy titled 'Discharge Summary' revealed: "...Discharge summary will be dictated by the attending physician, discharging physician, or dictation specialist by day 14 post discharge...." The medical record revealed that patient #12's admission date was on 4/19/2017, and he was discharged on 4/25/2017. Further, review of the medical record for patient #12 revealed no documentation that a discharge summary was completed as of the date of survey to include a description of the patient's medical condition and medical services provided to the patient and the signature of the medical practitioner coordinating the patient's medical services. The Chief Executive Officer (CEO) confirmed during an interview on 8/16/2017 at 1030 hours, that patient #12 was an inpatient discharge. She also confirmed that his medical record did not contain a discharge summary. Psychiatrist #2 confirmed during a confidential interview, that the medical record had the psychiatric discharge note and not the discharge summary. Psychiatrist #2 was able to provide an unauthenticated copy of the discharge summary on 8/16/2017. Psychiatrist #2 confirmed that the discharge summary was not included in the patient's record within the required time frame. Psychiatrist #2 authenticated and signed patient #12 discharge summary on 8/16/2017 at 1230 hours.

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2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: MED5523

License: SH6172

Health Survey Comments

The following deficiency was found at the time of the onsite, unannounced State Complaint Investigation Survey conducted on 09/06/2017 for the Event # GKTC11 for the following complaint intake:
AZ00143373

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ADHS Signature: Date:

Findings Report Summary

Findings for:	Rule/Statute:	Survey Text:
Citation 1 **Corrected Date:** 12/01/2017	Psychiatric Services **Rule Text:** R9-10-225. Psychiatric Services A. An administrator of a hospital that contains an organized psychiatric services unit or a special hospital licensed to provide psychiatric services shall ensure that in the organized psychiatric unit or special hospital: 5. Policies and procedures for the organized psychiatric services unit or special hospital are established, documented, and implemented that: b. Establish the process for patient assessment, including identification of a patient ' s medical conditions and criteria for the on-going monitoring of any identified medical condition;	**R9-10-225.A.5.b**~ Based on review of hospital's policies/procedures, other documents, Patient #1 medical record and interviews with personnel, the Department determined the administrator failed to ensure that the Behavioral Health Technician (BHT) properly followed their Level of Observation policy for 1 of 1 suicidal patients (target Patient #1) to ensure the patient's safety. Such failure, poses a high risk to the health and safety of the patients that require a certain level of observation to prevent self-harm, according to the physician's order. Findings include: 9 A.A.C. 10-101(111) defines "medical condition" as "...the state of a patient's physical or mental health, including the patient's illness, injury, or disease...." Hospital policy titled "Levels of Observation" revealed: "...Every 15 Minutes Observations. Minimum level of observation for all patients. Staff will observe patient and document on the Patient Observation Record every 15 minutes. Assigned staff will make direct visual contact with patients and confirm they are in no danger or distress. Staff will be vigilant for potential risk factors identified for specific patients (levels of precautions)....patients will be routinely observed in compliance with physician orders and prescribed protocols...The physician will order a level of observation at time of admission, based upon assessment: Q 15 (every 15) minute visual checks...." Medical record revealed: "...Inpatient Admit Orders...Observation: Q15 Minute Checks...." Hospital document titled 'Q15 Patient Record' for patient # 1 dated 8/22/2017 revealed: at 15:00, Location: R

(Patient Room), Behavior: 4 (Cooperative) at 15:15, Location: B (Bathroom), Behavior: 1 (Alert) at 15:30, Location: B (Bathroom), Behavior: 1 (Alert) at 15:45, Location: B (Bathroom), Behavior: 10 (Agitated).Hospital's document revealed: "...BHT found (name of patient) with sheet around the sink and around the neck laying on the floor alert. Code was called....BHT stated (name of patient) would verbally respond from behind closed bathroom door when making rounds, but heard (name of patient) gag and opened the door to find (name of patient) laying on the floor...." Hospital's document Witness Statement revealed: "...I checked (name of patient) fifteen (15) minutes prior to event, she was in her bathroom making a gagging noise, so i asked if she was alright and she said yes, that she was sick to her stomach. I told her i would come back in five minutes to make sure she was ok and she said that was fine. I came back shortly after, saying i was coming in the bathroom to see, and she said 'no', but i entered and found her laying on the ground with the sheet tied around the ridge of the sink and around her neck. I then called a code blue and the nurses came in to cut the sheet from her...." Nursing Progress Notes dated 8/22/2017, completed by RN #7 revealed: "...incident time 1540...(name of patient) was found by BHT in pt. bathroom laying on floor with sheet tied around neck and sink. BHT stated (name of patient) was verbally responding to BHT when making her Q rounds from bathroom behind closed door. When BHT made most recent rounds, (name of patient) verbally responded but BHT heard gagging. BHT opened bathroom door and saw pt. Code blue called...I responded to code and had scissors to cut sheet away from neck...Pt was crying, screaming, and gagging during this time...Vitals taken Blood Pressure 127/84, HR (heart rate) 98, O2 98%...." The RN #7 confirmed during an interview on 09/06/2017, that her Progress notes matched her recollection and that BHT #8 was verbally communicating with the patient during her Q 15 rounds behind a closed door, with patient being in the bathroom. Both, the Director of Nursing (DON) and house supervisor RN #3 confirmed during separate confidential interviews on 09/06/2017, that according to the hospital's policy, the BHT has to visually see the patient when conducting monitoring checks. During this survey, target BHT #8

		was not available for interview, as BHT # 8 was not longer was employed by this hospital. DON confirmed that the BHT had given two weeks notice prior to the occurrence of this incident and the BHT's last day was the day after this incident. Psychiatrist MD #1 confirmed during an interview on 09/06/2017, that target patient was put on Q15 checks, which is a standard level precaution. He explained that Q15 level of observation requires the BHTs to have direct visual contact with patient and monitor physical environment to ensure patient safety and safety of others.

Arizona Department of Health Services

Health and Wellness for All Arizonans

Enforcement Actions Report

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This report is published by the Arizona Department of Health Services (ADHS) Division of Licensing Services. For assistance, please contact the Office of Medical Facilities at Phone (602) 364-3030; Fax (602) 364-4764.

Enforcement Action Definitions

Provider Name:	**OASIS BEHAVIORAL HEALTH**
Provider Address:	2190 NORTH GRACE BOULEVARD, BUILDING B CHANDLER, AZ 85225
Provider Type:	BEHAVIORAL HEALTH INPATIENT FACILITY - RTC
Licensee:	IFBH7476
License:	10/19/2017
Final Enforcement Action Date:	$250
State Civil Money Penalty Assessed:	
Final Enforcement Action:	LICENSEE AGREED TO PAY $250 FOR FAILURE TO FILE AN APPLICATION FOR RELICENSURE AT LEAST SIXTY (60) BUT NOT MORE THAN ONE HUNDRED TWENTY (120) DAYS BEFORE THE EXPIRATION DATE OF THE CURRENT LICENSE. A.R.S. § 36-422.C.

For More Information, Call: (602) 364-3030

150 N. 18th Avenue, Phoenix AZ 85007 Phone: (602) 542-1025 Fax: (602) 542-0883

Arizona Department of Health Services

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Enforcement Action Definitions

Provider Name:	**OASIS BEHAVIORAL HEALTH**
Provider Address:	2190 NORTH GRACE BOULEVARD, BUILDING B CHANDLER, AZ 85225
Provider Type:	BEHAVIORAL HEALTH INPATIENT FACILITY - RTC
Licensee:	IFBH7476
License:	10/30/2017
Final Enforcement Action Date:	$1000
State Civil Money Penalty Assessed:	
Final Enforcement Action:	LICENSEE AGREED TO PAY $1000 - THE ADMINISTRATOR FAILED TO ENSURE THAT THE GLASS NAIL POLISH BOTTLES USED BY A PATIENT (#9) DURING GROUP THERAPY WERE ACCOUNTED FOR FOLLOWING THE THERAPY SESSION. THIS FAILURE RESULTED IN A PATIENT SELF-INJURY NECESSITATING TREATMENT AT A LOCAL EMERGENCY MEDICAL FACILITY. PATIENT ROOMS AND PATIENT AREAS WERE FREE OF LIGATURE POINTS. THIS FAILURE POSED THE POTENTIAL FOR SIGNIFICANT PATIENT INJURY. LICENSEE AGREED TO RETURN THE ORIGINAL STATEMENT OF DEFICIENCIES WITH THE SIGNED AND DATED ACCEPTABLE PLAN OF CORRECTION TO THE DEPARTMENT WITHIN 10 WORKING DAYS OF RECEIPT OF THE AGREEMENT.
For More Information, Call:	(602) 364-3030

150 N. 18th Avenue, Phoenix AZ 85007 Phone: (602) 542-1025 Fax: (602) 542-0883

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Enforcement Action Definitions

Provider Name:	**OASIS BEHAVIORAL HEALTH HOSPITAL**
Provider Address:	2190 NORTH GRACE BOULEVARD CHANDLER, AZ 85225
Provider Type:	HOSPITAL - PSYCHIATRIC
Licensee:	**ACADIA HEALTHCARE COMPANY, INC**
License:	SH6172
Final Enforcement Action Date:	10/30/2017
State Civil Money Penalty Assessed:	$500
Final Enforcement Action:	LICENSEE AGREED TO PAY $500 - THE ADMINISTRATOR FAILED TO ENSURE THAT THE BEHAVIORAL HEALTH TECHNICIAN (BHT) PROPERLY FOLLOWED THEIR LEVEL OF OBSERVATION POLICY FOR 1 OF 1 SUICIDAL PATIENT (PATIENT #1) TO ENSURE THE PATIENT'S SAFETY. LICENSEE AGREED TO RETURN THE ORIGINAL STATEMENT OF DEFICIENCIES WITH THE SIGNED AND DATED ACCEPTABLE PLAN OF CORRECTION TO THE DEPARTMENT WITHIN 10 WORKING DAYS OF RECEIPT OF THE AGREEMENT.
For More Information, Call:	(602) 364-3030

150 N. 18th Avenue, Phoenix AZ 85007 Phone: (602) 542-1025 Fax: (602) 542-0883

Statement of Deficiencies

Survey Date - 10/31/2017

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD, BUILDING B
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH1816

License: IFBH7476

Health Survey Comments

Based on The Joint Commission (TJC) report for the hospital submitted to the Department of Health Services, Oasis Behavioral Health is found to be in compliance with the Arizona Administrative Code Title 9 Chapter 10. No onsite survey was conducted.

The accreditation will expire on April 2, 2018. If a new accreditation report is not received by the end of the accreditation period, the facility will have a compliance survey conducted by the state agency.

_____
ADHS Representative Date

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH4558

License: CSLG6985

Health Survey Comments

Based on The Joint Commission (TJC) report for the Outpatient Treatment Center submitted to the Department of Health Services, Oasis Behavioral Health is found to be in compliance with the Arizona Administrative Code Title 9 Chapter 10 Article 10 Outpatient Treatment Center. No onsite survey was conducted.

The accreditation will expire on August 30, 2018. If a new accreditation report is not received by the end of the accreditation period, the facility will have a compliance survey conducted by the state agency._____
ADHS Representative Date

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD, BUILDING B
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH1816

License: IFBH7476

Health Survey Comments

No deficiencies were found at the time of the on-site, State Complaint Investigation survey with Event #KI7911 conducted on 11/21/2017, 11/22/2017, 11/28/2017 and 12/06/2017 for the following intakes:AZ00144953
AZ00144951
AZ00144077
AZ00144977
AZ00145193

_____
ADHS Representative: Date:

OASIS BEHAVIORAL HEALTH HOSPITAL

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: MED5523

License: SH6172

Health Survey Comments

The following deficiencies were found at the time of the on-site, State Complaint Investigation survey Event #19MY11, conducted on 11/21/2017 through 12/06/2017 for the following intakes:AZ00143748
AZ00143923
AZ00145271_____
ADHS Representative: Date:

Findings Report Summary

Findings for: Citation 1 **Corrected Date:** 01/12/2018	**Rule/Statute:** Administration **Rule Text:** R9-10-203. Administration B. An administrator: 1. Is directly accountable to the governing authority of a hospital for the daily operation of the hospital and hospital services and environmental services provided by or at the hospital;	**Survey Text:** **R9-10-203.B.1**~ Based on review of hospital policies/procedures, Patient # 1's medical record, hospital documents and staff interview, the Department determined the administrator failed to ensure that the hospital staff followed their observation policy for 1 of 1 self-harming patients and their monitoring policy to ensure the patient's safety. (Patient #1). Such failure, poses a high risk to the health and safety of a patient requiring an increased level of observation to prevent self-harming behaviors. Findings include: Hospital policy titled "Level of Precautions" requires:"...All patients admitted to...will be assessed for needs of various precautions. Precautions are identified for danger to self behavior. danger to others behavioral...Staff responsible for monitoring precautions shall maintain the patient in a safe environment and take measures to protect the patient...Other precautions for a patient with potential for self harm may include: Vigilant monitoring of environment for: Any items that are considered contraband...Patient's rooms for items that could be used for self-harm...Changes to the physical environment bent vents, missing screws/plates...." Hospital Policy titled "Levels of Patient Observation" revealed:...One to One Observation (1:1) precautions A specified and dedicated staff member will stay within approximately one arm's length of the patient on 1:1 observation. This continuous direct visual observation will continue even when patients shower, change clothes or use the bathroom...." Patient # 1's medical record revealed the patient was admitted to the facility on 06/29/2017 with a

history of self-harming behaviors. After admission the patient was sitting in the small dayroom and pulled the Wall socket down and started cutting her forearms and right arm resulting in several lacerations. The patient was transferred via ambulance to an acute care Emergency Department (ED # 1) where she received sutures to repair her lacerations. The Patient was returned to this facility and was placed on a 1:1 observation. Patient # 1's medical record revealed the following: on 06/30/17, the Patient reopened her sutures and was returned to the same acute care ED # 1; no sutures were needed, Patient was returned to this facility with bandage clean, dry and intact; the Patient placed on 2:1 observation. On 07/02/17 at 1300 hours hospital document revealed Patient # 1 was walking outside with two BHT staff members when Patient # 1, picked up some asphalt and a black colored object from the ground and put them in her mouth. The Patient was transferred to the same above acute care ED # 1. Chest x-ray impression revealed retained foreign body in the left upper abdomen. Report Patient to remain on 2:1 observation while awake; 1:1 while asleep. On 07/06/17 at 1312 hours hospital document revealed the patient indicated to staff that she had swallowed 3 metal screws; the patient was transferred to another acute care ED # 2 ; x-ray revealed no signs of metal screws. Patient was diagnosed with a urinary tract infection and placed on antibiotics. Patient returned to facility; continues close observation 1:1. Psychiatric Progress Note dated 07/17/17 revealed: Patient# 1 is no longer on 1:1 observation. On 07/17/17 at 2230 hours the Transfer Summary revealed Patient # 1, went to her room for bedtime and hit her right arm against sharp metal on the wall. The patient stated she had a flash back. Patient # 1 was transferred to another acute care ED # 3. The Patient received repair of laceration to posterior right forearm. The patient returned to this facility; placed on 1:1 observation. On 08/06/17 at 2130 hours, hospital document revealed the patient was irritated and agitated, throwing things in the day room. Patient # 1 broke a metal part of the door and took the piece into her bathroom and cut her right inner arm. Patient # 1 was transferred to acute care ED #2 for repair of lacerations and returned to this facility; remains on 1:1 observation. On 08/10 at 2100 hours the

patient 0725 hours the patient's medical record revealed the patient was in the day room watching TV, staff shut the TV off to do group wrap up. Patient # 1 became agitated. The patient calmed down and asked it use the restroom; staff accompanied the patient into the rest room and the patient stated she swallowed two AAA batteries. The patient was transferred to Acute Care ED # 2 for x-ray. The ED confirmed the ingestion of the batteries and returned the patient to the facility stating the ingestion of the batteries did not require surgical removal and the patient would pass them through her bowel. On 08/11/17 at 1815 hours the Transfer Summary revealed: Patient # 1 states she swallowed 2 thumb tacks. The Patient was transferred to Acute Care ED # 2. Patient returned to facility continues on 1:1 precautions. On 08/13/17 at 1150 hours hospital documents revealed Patient # 1 was transferred to Acute Care ED # 4 for abdominal pain , pain scale 3 out of 10 on the pain scale. Kidney Urinary Bladder (KUB) revealed x-ray was negative. The patient had passed the batteries and thumb tacks from previous incidents. On 08/23/17 hospital document revealed Patient # 1 went to the restroom at 1400 hours. The patient came out and sat down for a while and began to cry and stated "I messed up and swallowed a screw. The BHT denied seeing the patient swallow anything. The RN and Physician # 1 were notified. The Patient was transferred to Acute Care ED #4 for an immediate KUB. The Patient was returned to this facility and at 2240 hours and was instructed to follow-up with physician, take Motrin for pain and to return to the ED if having difficulty breathing or appearing lethargic. There was no documentation in the medical record regarding the x-ray result. On 08/31/17 the Patient was discharged by Physician #1 to a Long Term Care facility. Ambulance picked the Patient up at 1208 hours, and arrived at destination at 1327 hours. PA # 2 confirmed during a telephone interview conducted on 11/2117 at 1400 hours that she was unsure why there was so many self-harming incidents regarding Patient # 1. The PA confirmed that the facility would call registry staff to take care of the patients when necessary. PA # 2 also confirmed in the above interview that she does not know what the nursing staff issues were and she would not like to answer any questions of staff

		competency. RN # 11 confirmed during an interview conducted on 11/21/17 that he/she had a good rapport with the patient. This nurse confirmed the patient was very fast, very clever and may not have been a "good fit for this facility". BHT # 10 confirmed during an interview conducted on 11/21/17 that the Patient was very manipulative. The BHT confirmed he/she works with some staff members who do not perform their job well, according to his/her standards. The BHT refused to share any names. The facility failed to monitor the environment of Patient # 1 and failed to keep the 1:1 observation Patient from self harm according to hospital policies.
Findings for: Citation 2 **Corrected Date:** 01/12/2018	**Rule/Statute:** Patient Rights **Rule Text:** R9-10-212. Patient Rights B. An administrator shall ensure that: 2. A patient is not subjected to: g. Sexual assault;	**Survey Text:** **R9-10-212.B.2.g~** Based on review of hospital policies/procedures, Patient # 1's medical record, and staff interviews, the Department determined the administrator failed to ensure that the hospital staff followed their abuse policy for 1 of 1 adolescent Patient. Such failure, poses a high risk to the health and safety of the adolescent by failing to protect the child's mental and physical well being. Findings include: Hospital policy and procedure Titled "Incident Reporting" requires: "...Any facility staff member who witnesses, discovers, or has direct knowledge of an incident must complete an Incident Report before the end of the shift/work day...." Hospital policy and procedure titled "Abuse Reporting" requires:"... Allegations of suspected abuse will be reported in accordance with Arizona regulations. Reporting obligations apply regardless of where the alleged abuse/neglect occurred...The staff member who has first hand knowledge of the occurrence is expected to make the report, complete the incident report, and notify their supervisor and Risk Management...When an adolescent reports physical, sexual, or emotional abuse it is necessary to assess...if the alleged perpetrator...has access to the patient DCS must be notified...Telephone reports must be made immediately or as soon as possible to the Arizona Child Abuse Hotline...The telephone report is then documented, along with the name and phone number of the law enforcement agency and official contacted on the progress note in the patient's chart. Psychiatric Progress Note dated 07/29/17 at

		0900 by PA # 2 revealed Patient # 1 reported to the PA that male staff make her feel uncomfortable. The patient does not like men and she wants women as her 1:1. The patient also reports she was touched 10-12 days ago over her clothes by a male patient. The patient will not say what male patient touched her. The patient also states she feels safe on the unit and the male patient has not touched her again. PA # 2 confirmed during a telephone interview conducted on 11/21/17 at 1400 hours that she reported the above incident to Physician # 1, RN # 5 and the treatment team. The Risk Manager confirmed during an interview conducted on 11/22/17 at 1100 hour that she had no information regarding the above incident, there were no reports written, no documentation of phone calls made or documentation of any law enforcement agency or DCS notification documented in the Patient's medical record. The facility failed to report the patient's allegations of inappropriate touching by a male patient according to hospital polices.

OASIS BEHAVIORAL HEALTH

2190 NORTH GRACE BOULEVARD, BUILDING B
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: BH1816

License: IFBH7476

Health Survey Comments

No deficiencies were found at the time of the unannounced on-site State Complaint Investigation Survey conducted 3/15/2018-3/19/2018, with Exit Date 4/5/2018 for Event #KI2K11, pursuant to the rules found in 9 A.A.C. 10, Article 3, for the following intakes:AZ00144621
AZ00146881
AZ00144539

_____
ADHS Representative Date

Statement of Deficiencies
Survey Date - 4/5/2018

OASIS BEHAVIORAL HEALTH HOSPITAL

2190 NORTH GRACE BOULEVARD
CHANDLER, AZ 85225
(480) 917-9301

Facility ID: MED5523

License: SH6172

Health Survey Comments

The following deficiency was cited at the time of the unannounced on-site State Complaint Investigation survey conducted March 12, 2018 through April 5, 2018 for Event #PHZE11, pursuant to the rules found in 9 A.A.C. 10- Article 2, for the following Intake numbers:

AZ00146880
AZ00145701
AZ00145662
AZ00144367
AZ00146446

_____
ADHS Signature Date

Findings Report Summary

Findings for: Citation 1 **Corrected Date:** 05/11/2018	**Rule/Statute:** Patient Rights **Rule Text:** R9-10-212. Patient Rights B. An administrator shall ensure that: 1. A patient is treated with dignity, respect, and consideration;	**Survey Text:** **R9-10-212.B.1**~ Based on review of the medical record, and staff interviews, the Department determined that the Administrator failed to ensure that the patient was treated with consideration, when the staff failed to provide the patient with their personal contact lens supplies, when the patient is not permitted to sleep wearing their contact lenses. This deficient practice posed a high risk of eye infection, when the hospital failed to deliver the patient's contact lens supplies provided by the patient's parent, or the hospital not providing contact lens supplies to the patient. Findings include: Medical record review confirmed that the hospital form titled 'Personal Property/Belongings Inventory at the Time of Admission' was completed on 01/13/2018, to include that contact lens supplies were stored with Patient #3 at the time of admission. The form is signed by Intake Specialist #22. LPN #21 confirmed during an interview conducted 03/20/2018 (1233-1239), that s/he spoke with the parent of Patient #3, on 01/14/2018 (1500). The parent informed LPN #21, that s/he delivered Patient #3's contact lens supplies to the facility approximately fifteen (15) hours prior, and was informed that the contact lens supplies would be delivered immediately to Patient #3. The parent provided the description of the bag that was brought to the hospital. LPN #21 revealed that upon searching for the patient's bag, that it was located locked in the storage closet in the Admissions/Intake area, and that Patient #3's contact lens supplies were in the bag. Additionally, it was confirmed that Patient #3 had to sleep with his/her contact lens in all night, and was never provided contact lens supplies. Admissions Director #9 confirmed during an interview conducted 03/20/2018 (1315) that the Admissions/Intake area has a key-pad locked storage closet, where patient's personal belongings are stored until the patient's discharge. Additionally, it was revealed, that the patient should have been allowed to have their contact lens supplies.