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Statement of Deficiency

BEHAVIORAL HEALTH CENTER
LICENSURE SURVEY
JULY 17-20, 2017

CENTER CENSUS: 312
Sample Size: 33

Statement of Deficiency

(1) Based on documentation review and interview, the governing body failed to evaluate implementation of policies. Findings include:

(a) The Center failed to ensure consumer records contain information essential to the services or treatment and including, but not limited to identification data. Consumers affected: seven (7) of 31 active consumers in the sample. Consumer identifiers: #1, #7, #9, #13, #17, #18 and #31. (Refer to C209)

Statement of Deficiency

(1) Based on documentation review and interview, the Center failed to ensure professional and direct care staff shall begin orientation and training on treatment policies and procedures, consumer rights and the use of emergency procedures, such as crisis intervention and restraints beginning on the first day of employment. Staff affected: six (6) of six (6) staff in the sample. Staff identifiers: A through F. Findings include:

(a) Review of the personnel records for Staff A, Clinical Supervisor/Therapist, hired 01/05/15; Staff B, Medical Director, hired 04/20/09; Staff C, Therapist, hired 04/12/17; Staff D, Therapist, hired 06/26/17; Staff E, Lab Technician, hired 10/01/16 and Staff F, Licensed Practical Nurse/Nursing Supervisor hired 08/03/17 revealed no documented evidence of training in the use of emergency procedures, such as crisis intervention.

(b) Interview on 07/18/17 at 1:45 p.m. with Staff F, Licensed Practical Nurse/Nursing Supervisor confirmed Staff A, B, C, D, E and F did not receive training in the use of emergency procedures such as crisis intervention.

(c) The failure of the Center to ensure professional and direct care staff shall begin orientation and training on treatment policies and procedures, consumer rights and the use of emergency procedures, such as crisis intervention and restraints beginning on the first day of employment does not meet the intent of the regulation that beginning on the first day of employment, professional and direct care staff shall begin orientation and training on treatment policies and procedures, consumer rights and the use of emergency procedures, such as crisis intervention and restraints.

Statement of Deficiency

(1) Based on documentation review and interview, the Center failed to maintain a human rights committee. Consumers affected: all consumers served by the Center. Findings include:

(a) Review of the most current active human rights committee member list, as of 08/19/15, provided by Staff G, Clinic Director revealed the committee was made up of three (3) staff members, three (3) community members and two (2) consumers.

(b) Review of the human rights committee meeting minutes revealed two (2) meetings held in 2015, on 8/19/15 and 05/12/15. There was no documented evidence of any further human rights committee meetings after 08/19/15 through 07/18/17.

(c) Interview on 07/18/17 at 10:15 a.m. with Staff G, Clinic Director confirmed that no human rights committee meetings had been held since 08/19/15.

(d) The failure of the Center to to maintain a human rights committee does not meet the intent of the regulation that the Center shall maintain a human rights committee to hold meetings and keep written minutes of all meetings, including the names and titles of all members and guests present and members absent.

Statement of Deficiency

(1) Based on documentation review and interview, the Center failed to ensure consumer records contain information essential to the services or treatment and including, but not limited to identification data. Consumers affected: seven (7) of 31 active consumers in the sample. Consumer identifiers: #1, #7, #9, #13, #17, #18 and #31. Findings include:

(a) Review of the records for Consumer #1, admitted 06/28/17; Consumer #7, admitted 02/28/17; Consumer #9, admitted 05/30/17; Consumer #13, admitted 06/20/17; Consumer #17, admitted 05/18/17; Consumer #18, admitted 06/13/17; and Consumer #31, admitted 04/06/17,

revealed no documented evidence of identification data, including but not limited to photographic identification.

(b) The Center's policy, 4.4.4, Admitting Patients to the Medication Assisted Programs (WV), effective 1/2016, Page 72, provided by Staff G, Clinic Director as the admission policy for behavioral health, states: "3. Copies of valid personal photo identification will be obtained for the treatment record for purposes of identification, i.e., state issued identification care/driver's license or passport."

(c) Interview on 07/19/17 at 10:30 with Staff F, Licensed Practical Nurse/Nursing Supervisor confirmed there was no documented evidence of photographic identification in the records for Consumer #1, #7, #9, #13, #17, #18 or #31.

(d) The failure of the Center to ensure the consumer records contain information essential to the services or treatment and including, but not limited to identification data does not meet the intent of the regulation that the consumer records shall contain information essential to the services or treatment and including, but not limited to identification data.

Statement of Deficiency

(1) Based on documentation review and interview, the Center failed to ensure that signed and dated progress notes or other documentation regarding services provided and outcomes are in the consumer record. Consumers affected: all consumers served by the Center. Findings include:

(a) Review of the records for all consumers in the sample revealed the Admittance Screen for Opiate Maintenance Treatment (ASAM) Six-Dimensional Criteria Scale forms were not dated and the signatures of counselors, supervisors and physician staff were not legible.

(b) Review of the record for Consumer #25 admitted 12/08/16 revealed both the Transition Plan and the Discharge Plan were blank, were dated 12/08/16 and were signed by the consumer and counselor. No other information on either of these forms was documented.

(c) Further review of Consumer #25's record revealed the counselor signatures were not legible on either the Transition Plan or the Discharge Plan.

(d) Review of the record for Consumer #14 admitted 01/12/16 revealed the Initial Comprehensive Treatment Plan did not identify the consumer by name or medical record number and did not have the date that the plan was developed.

(e) Interview on 07/19/17 at 2:30 p.m. with Staff F, Licensed Practical Nurse/Nursing Supervisor confirmed the ASAM forms for all consumers served by the Center were not dated and the signatures of counselors, supervisors and physician staff were not legible. Staff F confirmed Consumer #25's record contained a Transition Plan and Discharge Plan that were blank, dated and signed by the consumer and counselor. Staff F also confirmed that the Initial

Comprehensive Treatment Plan for Consumer #14 did not identify the consumer by name or medical number, was not dated and had an illegible signature by the counselor.

(f) The failure of the Center to ensure that signed and dated progress notes or other documentation regarding services provided and outcomes are in the consumer record does not meet the intent of the regulation that the Center shall ensure that signed and dated progress notes or other documentation regarding services provided and outcomes (are in the consumer record).

Statement of Deficiency

(1) Based on documentation review and interview, the Center shall inform a consumer, or his or her legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication; and about alternate treatments and their effects. Consumers affected: six (6) of 31 active consumers in the sample. Consumer identifiers: #1, #2, #3, #4, #24 and #29. Findings include:

(a) Review of the records for Consumer #1, admitted 06/28/17; Consumer #2, admitted 04/2716; Consumer #3, admitted 04/05/17; Consumer #4, admitted 02/17/16; Consumer #24, admitted 09/14/16; and Consumer #29, admitted 04/19/17 revealed no documented evidence of medication education maintained in the consumer records.

(b) Interview on 07/19/17 at 10:45 a.m. with Staff F, Licensed Practical Nurse/Nursing Supervisor confirmed no medication education was present in the records for Consumer #1, #2, #3, #4, #24 and #29.

(c) The failure of the Center to inform a consumer, or his or her legal representative, about the medication prescribed does not meet the intent of the regulation that the Center shall inform a consumer, or his or her legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication; and about alternate treatments and their effects.