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A 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted 01/13/2015 through 01/15/2015. An Immediate Jeopardy situation was identified to the Administrative staff on 01/14/2015 based on an incident occurring on 01/14/2015 when the staff failed to apply, monitor and assess for least restrictive and excessive use of restrictive interventions for the management of patients in the Emergency Department (ED) under Involuntary Commitment (IVC) orders. Findings of the investigation revealed 4 of 4 observed current patients in the ED under IVC were restrained with forensic metal restraints and the nursing staff failed to provide ongoing assessment and monitoring of the condition of the patients during restraint. Investigative findings revealed a 9 year old child presenting to the ED on 12/12/2014 for IVC due to agitated aggressive behavior. The child was placed in forensic restraints (at times 4 point) and the staff failed to provide ongoing assessment and monitoring of the condition of child during restraint or seclusion during the ED stay from 12/12/2014 until 12/20/2014. Interview with the hospital's Administrative Nursing, ED Administrative Nursing staff and the ED Medical Director revealed the ED staff did not view the forensic restraints applied by Law Enforcement Officers on patients under IVC as restrictive interventions and therefore did not provide ongoing assessment and monitoring of the condition of the patients per the hospital policy. Based on the investigative findings immediate	A 000	The following is Maria Parham Medical Center's response to all deficiencies cited in the Department of Health & Human Services/Center for Medicare & Medicaid Services survey completed January 13-15, 2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 corrective actions implemented and lack of evidence of monitoring by the hospital staff, the immediate jeopardy was ongoing. Condition level deficiencies were cited in 482.12 Governing Body, 482.13 Patients Rights, 482.21 Quality Assessment Performance Improvement, 482.23 Nursing Services, and 485.55 Emergency Services.	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on hospital policy reviews, observations during tours, medical record reviews, grievance/complaint reviews, grievance log reviews, restraint list/log reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews the hospital's leadership failed to provide oversight and have systems in place to ensure the protection and promotion of Patients' Rights; an effective Quality Assurance Performance Improvement (QAPI) program; an organized Nursing Service; provide Emergency Services to meet the patients needs; and to maintain the facilities, supplies, and equipment at an acceptable level of safety and quality. The findings include: 1. The hospital failed to protect and promote	A 043	A043 – Maria Parham Medical Center does and will continue to protect and promote each patient's rights. This is evidenced by the Board of Trustees at Maria Parham Medical Center maintaining oversight and legal responsibility for the provision of Patient Rights, an effective Quality Assurance/Performance Improvement Program, an organized Nursing Service and the provision of Emergency Services. The following actions have been implemented in support of A043: • The process for ensuring Patient Rights for Emergency Department patients with psychiatric emergencies placed under involuntary commitment was reviewed by the Chief Nursing Officer and the Nursing Director of the Emergency Department during the survey January 13 – 15, 2015 by CMS. . Prior to the surveyors' departure a preliminary action plan was developed and implemented. **Monitoring**: Reporting to the Governing Board, Maria Parham Medical Center will report all corrective action monitoring though the Patient Safety Clinical Quality Committee at a minimum of 10 meetings per year.	

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A 043	Continued From page 2 patients' rights in the Emergency Department (ED) for patients with psychiatric emergencies placed under Involuntary Commitment (IVC). ~cross refer to 482.13 Patient Rights Condition - Tag A0115. 2. The hospital failed to maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement (QAPI) program for monitoring restraint in the ED. ~cross refer to 482.21 Quality Assessment and Performance Improvement (QAPI) Condition - Tag A0263. 3. The hospital nursing staff failed to ensure nursing supervision of care per the hospital policy and procedure when the staff failed to provide ongoing assessment and monitoring of the condition of patients during restraint or seclusion in the ED who were under IVC and for intensive care unit (ICU) patients not under IVC. ~cross refer to 482.23 Nursing Condition - Tag A0385. 4. The hospital failed to meet the emergency needs of behavioral health patients in accordance with the hospital's policy and procedures. ~cross refer to 482.55 Emergency Services Condition - Tag A1100. 5. The hospital's ED staff failed to maintain the facilities, supplies, and equipment in an manner to ensure an acceptable level of safety and	A 043	Continued from page 2 • These include the conditions of participations for 42 CFR 482.12 Governing Body, 42 CFR 482.13 Patient Rights, 42 CFR 482.21 Quality Assessment Performance Improvement, 42 CFR 482.23 Nursing Services, 42 CFR 482.55 Emergency Services Responsible Person; Director of Quality	

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A 043	Continued From page 3 quality for 1 of 1 ED toured. ~cross refer to 482.41 Physical Environment Standard - Tag A0724.	A 043	A115 – Maria Parham Medical Center meets and continues to meet the regulations that require a hospital to protect and promote each patient's rights.	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on hospital policy and procedure reviews, observations during tours, medical record reviews, complaint/grievance form reviews, grievance log reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews, the hospital failed to protect and promote patients' rights in the Emergency Department (ED) for patients with psychiatric emergencies placed under Involuntary Commitment (IVC). The findings include: 1. The hospital's staff failed to provide a written notice of the hospital's decision to a grievance for 1 of 3 patient grievances reviewed (#1). ~cross refer to 482.13(a)(2)(iii) Patient Rights Standard - Tag A0123. 2. The hospital's ED staff failed to ensure exam rooms provided a safe environment for 4 of 4 patient's under IVC who were observed restrained in the ED (#14, #13, #16, #17). ~cross refer to 482.13(c)(2) Patient Rights Standard - Tag A0144.	A 115	The hospital's staff failed to provide a written notice of the hospital's decision to a grievance for1 of 3 patient grievances reviewed (#1). See Tag A0123 The following actions have been implemented in support of See Tag A115: • There is a bi-monthly review of all grievances to assure all appropriate time lines are met for initial, 7 day and 30 day responses to the patients. This is measured by review of the Grievance Log. • Prior to the survey, the Risk Manager, Chief Nursing Officer, Nursing Director ED and Medical Director of ED put in place a process whereby the Nursing Director of ED and Medical Director of ED can access the network Grievance Log. This allows them immediate access to all grievances for timely resolution. A complete review of our policy was reviewed by the Grievance Committee. **Monitoring:** Grievance processes are reported to Patient Safety Clinical Quality Committee at a minimum of 10 meetings annually. • Responsible person: Risk Manager.	

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A 115	Continued From page 4 3. The hospital's ED staff failed to ensure the least restrictive intervention to protect the patient or others from harm for 6 of 6 patients under IVC who were restrained in the ED (#14, #16, #13, #17, #12, #9). ~cross refer to 482.13(e)(3) Patient Rights Standard - Tag A0165. 4. The hospital's nursing staff failed to obtain a physician's order after placing a patient in restraints in 1 of 1 Intensive Care Unit (ICU) patients (#2). ~cross refer to 482.13(e)(5) Patient Rights Standard - Tag A0168. 5. The hospital's ED staff failed to ensure a physician's restraint order was time limited for no longer than four (4) hours for 1 of 1 adult patient (#9) age 18 years or older and for no longer than two (2) hours for 1 of 1 child and adolescent patient 9 to 17 years of age (#12) that was restrained or secluded for the management of violent or self-destructive behaviors. ~cross refer to 482.13(e)(8) Patient Rights Standard - Tag A0171. 6. The hospital's nursing staff failed to provide ongoing assessment and monitoring of the condition of a patient during restraint or seclusion for 6 of 6 ED patients (#14, #13, #16, #17, #12, #9) under IVC and 1 of 1 ICU patients not under IVC (#2). ~cross refer to 482.13(e)(10) Patient Rights Standard - Tag A0175.	A 115	Continued from page 4 Grievances will be sent to all patients who file a grievance regardless of disposition (to include psychiatric facilities). Policy for grievances has been revised to reflect this change in process. Policy Complaint and Grievance Resolution for Patients ORG 11 (Attachment G) 2. The hospital's ED staff failed to ensure exam rooms provided a safe environment for 4 of 4 patient's under IVC who were observed restrained in the ED (#14, #13, #16, #17). See Tag A0144 3. The hospital's ED staff failed to ensure the least restrictive intervention to protect the patient or others from harm for 6 of 6 patients under IVC who were restrained in the ED (#14, #16, #13, #17, #12, #9). See Tag A0165 4. The hospital's nursing staff failed to obtain a physician's order after placing a patient in restraints in 1 of 1 Intensive Care Unit (ICU) patients (#2).See Tag A0168 5. The hospital's ED staff failed to ensure a physician's restraint order was time limited for no longer than four (4) hours for 1 of 1 adult patient (#9) age 18 years or older and for no longer than two (2) hours for 1 of 1 child and adolescent patient 9 to 17 years of age (#12) that was restrained or secluded for the management of violent or self-destructive behaviors. See Tag A0171 Continued on page 6	1/27/2015

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A 115	Continued From page 5 7. The hospital's ED staff failed to ensure a 1-hour face-to-face evaluation was performed by a qualified physician or other licensed independent practitioner (LIP) or trained Registered Nurse (RN) after the initiation of restraint for 2 of 2 patients restrained in the ED for management of violent or self-destructive behaviors (#12, #9). ~cross refer to 482.13(e)(12) Patient Rights Standard - Tag A0178. 8. The hospital's ED staff failed to ensure the physician or other licensed independent practitioner (LIP) or trained RN conducting the face-to-face evaluation within 1 hour after the initiation of restraint evaluated the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint for 2 of 2 patients (#12, #9) restrained for the management of violent or self-destructive behaviors. ~cross refer to 482.13(e)(12) Patient Rights Standard - Tag A0179.	A 115	Continued from page 5 6. The hospital's nursing staff failed to provide ongoing assessment and monitoring of the condition of a patient during restraint or seclusion for 6 of 6 ED patients (#14, #13, #16, #17, #12, #9) under IVC and 1 of 1 ICU patients not under IVC (#2). See Tag A0175 7. The hospital's ED staff failed to ensure a 1-hour face-to-face evaluation was performed by a qualified physician or other licensed independent practitioner (LIP) or trained Registered Nurse (RN) after the initiation of restraint for 2 of 2 patients restrained in the ED for management of violent or self-destructive behaviors (#12, #9).see Tag A0178 8. The hospital's ED staff failed to ensure the physician or other licensed independent practitioner (LIP) or trained RN conducting the face-to-face evaluation within 1 hour after the initiation of restraint evaluated the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint for 2 of 2 patients (#12, #9) restrained for the management of violent or self-destructive behaviors. See Tag A0179	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	A 123		

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A 123	Continued From page 6 This STANDARD is not met as evidenced by: Based on hospital policy and procedure review, medical record reviews, complaint/grievance form reviews, grievance log review, and staff interviews the hospital's staff failed to provide a written notice of the hospital's decision to a grievance for 1 of 3 patient grievances reviewed (#1). The findings include: Review of current hospital policy, "Complaint and Grievance Resolution for Patients, ORG-11" with a revision date of 04/2012 revealed, "POLICY: [hospital name] maintains a process for addressing a patient's concerns regarding care of services rendered by the hospital in a timely, reasonable and consistent manner. ...PURPOSE: To provide a timely, courteous and personalized framework for problem resolution, service recovery and information sharing between [hospital name] and its patients, their family, significant others, employees and the medical staff. ...DEFINITIONS: ...Patient Complaint: ... Patient Grievance: ...Resolved: ...PROCEDURE: ...Complaint Procedure: ...Grievance Procedure: ...6. The Grievance Committee will review the grievance for appropriate follow-up and any needed action to resolve the grievance and will provide a written response to the patient and/or their representative within 7 days... 8. In extreme circumstance, if the grievance cannot be resolved in the seven (7) days required, the patient or the patient's representative must be informed that the hospital is still working to resolve the grievance and the that the hospital will follow-up with a written response within 30 days of receipt of the grievance. ..."	A 123	Continued from page 6 Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to promote and protect patient rights. The following actions have been implemented in support of Tag A123: Prior to the survey, the Risk Manager, Chief Nursing Officer, Nursing Director ED and Medical Director of ED put in place a process whereby the Nursing Director of ED and Medical Director of ED can access the Grievance Log. This allows them immediate access to all grievances for timely resolution. A complete review of our policy was reviewed by the Grievance Committee. • There is a bi-monthly review of all grievances to assure all appropriate time lines are met. This is measured by review of the Grievance log with documentation on the Grievance log. • Grievances will be sent to all patients who file a grievance regardless of disposition (to include psychiatric facilities). Policy for grievances was revised on January 30, 2015 to reflect this change in process. **Monitoring**: Grievance processes are reported to Patient Safety Clinical Quality Committee at a minimum of 10 meetings per year. Responsible person: Risk Manager.	

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Closed medical record review on 01/13/2015 revealed on 08/22/2013, Patient #1, a 55-year-old presented to the hospital ED (Emergency Department), while in the custody of [city] Police Department, as an IVC (Involuntary Commitment) due to mental illness and dangerous to self or others. Review revealed at 1645, the patient was evaluated by the mid-level provider. Review revealed at 2000, the patient received a mental health evaluation. Review revealed 08/23/2013 at 0400, an ED staff member was called to the patient room by LEO (Law Enforcement Officer) because the patient had [urinated] on the floor. Review revealed the patient "was screaming for 30 minutes," but no one responded when the patient was screaming. Review revealed on 08/23/2014 at 1310, the patient was accepted to a Psychiatric hospital for treatment. Review revealed at 1444, the patient was transported to the accepting hospital by the [county name] Sheriff Department.

Grievance Log review on 01/13/2015 revealed on 10/14/2014, Patient #1's grievance was logged. Review of the grievance details revealed the event occurred in the ED. Review revealed Patient #1 was "chained" to the bed and had to "holler for hours for someone to come" because the patient had to urinate. Review revealed Patient #1 urinated on the floor because no one would help the patient to the bathroom. Review revealed no documentation the hospital staff sent Patient #1 a written notice of the hospital determination to the grievance.

Interview on 01/15/2015 at 0900 with Director of Quality revealed Patient #1 was transferred to a Psychiatric hospital; therefore, no written notice of the hospital determination to the grievance was

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A 123	Continued From page 8 sent to the patient. Complaint/Grievance Form review on 01/14/2015 revealed on 07/21/2014, Patient #1 filed a grievance related to being "chained to the bed" and "screamed and hollered for hours" because the patient had to go to the bathroom and no one would help the patient. Review revealed as a result, the patient urinated on the floor. Review revealed the event occurred in the ED. Review revealed no documentation the hospital staff sent Patient #1 a written notice of the hospital determination to the grievance. Interview on 01/15/2015 at 0900 with Director of Quality revealed Patient #1 was transferred to a Psychiatric hospital; therefore, no written notice of the hospital determination the grievance was sent to the patient.	A 123		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based upon policy and procedure reviews, observations during tours, medical record reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews, the hospital's Emergency Department (ED) staff failed to ensure exam rooms provided a safe environment for 4 of 4 patient's under involuntary commitment who were observed restrained in the ED. (#14, #13, #16, #17) The findings include:	A 144	A144 – Maria Parham Medical Center meets and continues to meet the regulations that require a hospital to ensure the patient has the right to receive care in a safe setting. The following actions have been implemented in support of Tag A144: • Nursing Director of the Emergency Department revised and implemented ED Policy #140 includes (Attachment A) which is Behavioral Health Patient Safety & Environmental Checklist on January 30, 2015 for behavioral health, IVC and psychiatric patients. (Attachment A).	

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A 144	Continued From page 9 Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. ...POLICY: It is the policy of (Hospital name) Medical Center to: ...2. Protect the patient and preserve the patient's rights, dignity and well being during restraint use by: ...b. maintaining a clean and safe environment..." Interview on 01/14/2015 at 1420 during tour of the ED (1420-1500) with the Charge Nurse #2 revealed the ED had three (3) patients currently under involuntary commitment (IVC) in exam rooms #1, #5, #17 and one (1) patient pending IVC in exam room #7. 1. Observation during ED tour on 01/14/2015 at 1427 of exam room #17 revealed the room was located across from the nursing station. Observation revealed the room had a sliding glass door. Observation revealed inside the room was: a stretcher on wheels; a chair in the corner; a bed side table on wheels; removable wall mounted Oxygen, Medical Air, and Suction regulators; a disposable wall mounted suction canister and tubing; a wall mounted otoscope and ophthalmoscope with cords (each approximately 2-4 feet long); a wall mounted cardiac monitor with cardiac leads, blood pressure cuff, and pulse oximetry cords (each approximately 4-6 feet long) dangling from the monitor; and a wall mounted computer charting station. Further observation revealed a male patient (Patient #14) wearing green disposable scrubs and sitting on the end of the stretcher leaning over a bedside table. Observation revealed the stretcher's two side rails were up and in the locked position. Observation	A 144	Continued from page 9 • Each patient will have the Behavioral Health Safety and Environmental Checklist as a permanent part of the medical record. ED Policy 140 (Attachment E) Responsible Persons: Care Nurse - checklist will be initiated by each care nurse for every patient presenting with a behavioral health complaint. Each shift the ED Charge Nurse and the Nursing House Supervisor will review the Behavioral Health Patient Safety and Environmental the checklist. (Attachment A) • ED Room #7, a room ready for psychiatric and mental health patients, will be used for these patients when at all possible as this room remains compliant with the Behavioral Health and Patient Safety and Environmental Checklist. (Attachment A) • If a room other than #7 is used, the room is prepared using the Behavioral Health Patient Safety and Environmental Checklist. (Attachment A) Responsible Person: Nursing ED Director	

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A 144	Continued From page 10 revealed a hand held call bell device (attached to the wall with an approximately 4-6 foot long cord) draped across the head of the stretcher onto the mattress within arms reach of the patient. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right leg/ankle was chained to the stretcher's frame with a metal shackle/cuff (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO or nursing staff. At 1433, observation revealed Patient #14 stood up off the end of the stretcher and pivoted around to the side of the stretcher without difficulty or assistance. Observation revealed the patient was within arms reach of the wall mounted medical equipment. Open medical record review on 01/14/2015 revealed Patient #14, a 60 year old male presented to the hospital's ED on 01/13/2015 at 1820 accompanied by Law Enforcement under IVC petition. Review revealed the patient's chief complaint was IVC-Crisis Evaluation Referral. Review of triage nurse documentation at 1827 revealed "IVC, per caregiver pt (patient) with bizarre behavior, pt walking around showing genitals [sic], pt endorses auditory hallucinations, pt with rambling thoughts in triage, pt states he will only hurt someone if they try to hurt him." Review of triage assessment documentation revealed the patient was alert, oriented x 3 (person, place, time) and anxious. Review revealed the patient was evaluated by a physician at 1908. Review revealed a chief complaint of being agitated and exposing genitals. Review revealed the patient was assessed as no acute	A 144		

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A 144	Continued From page 11	A 144		

distress, awake and alert, slightly agitated, pressured speech, and directable. Review revealed the patient was "cooperative." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 01/13/2015 at 1541 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #14) is probably: [X] 1. mentally ill and dangerous to self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness. ..." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 01/13/2015 at 2345 revealed "Description of Findings" with "...presenting for agitation, exposing himself inappropriately to others. On evaluation, pt is disorganized with pressured speech. Oriented to location but not situation. Is currently a danger to himself due to psychosis."

Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed "seclusion (exam room #7) is the only room we can remove everything to make it safe." Interview revealed with IVC patient's the ED staff does not necessarily remove all equipment from the room. Interview revealed ED staff are looking at processes to make a consistent decision point as to making a safe environment. Interview revealed "In reality it is a general ED and not a psychiatric unit." Interview revealed all the equipment in the exam rooms can be removed except for wall mounted computers and the call bell which has to be plugged into the wall. Interview revealed the ED "needs to improve the process to standardize

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A 144	Continued From page 12 versus being an individual decision" for making rooms safe. 2. Observation during ED tour on 01/14/2015 at 1430 of exam room #1, revealed an ante room was located diagonally across from the nursing station. Observation revealed the room was an isolation room. Observation revealed to view a patient required walking into the ante room, turning right and proceeding approximately 4 feet to enter the isolation room proper. Observation revealed a male patient (Patient #13) wearing green disposable scrubs and laying supine on the stretcher with both hands across his abdomen. Observation revealed the stretcher's two side rails were up. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right ankle was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the isolation room alone and without direct supervision of a LEO. Observation revealed an ABC City Police Department officer was sitting behind the nursing station in a cubical and due to location he could not observe the patient. Observation revealed from the LEO's location the ante room could be observed only. Observations from 1430 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #7. Open medical record review on 01/14/2015 for Patient #13 revealed a 26 year old male presented to the hospital ED on 01/13/2015 at 0125 with thoughts of suicide and for substance abuse detoxification. Review revealed at 0127, the patient was triaged by a RN and at 0234, the	A 144		

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A 144	Continued From page 13 patient was assessed by a ED Physician. Review revealed at 0840, the patient was assessed by a mobile crisis worker and was admitted for suicidal thoughts. Review revealed at 1600, the patient was IVC'd due to mentally ill and dangerous to self and others. Further review revealed when the patient was IVC'd, a LEO placed the patient in leg shackles (restraint). Review revealed at 1800 and 2000, the patient's behavior was documented as calm and resting with eyes closed with the right ankle in shackled. Review revealed on 01/14/2015 at 0000, 0200, 0430, 0600, 0735 and 0935, the patient behavior was documented as asleep and resting quietly with the right ankle shackled. Review revealed at 1645, the patient was transferred to a psychiatric hospital for further treatment. Review revealed no documentation the patient demonstrated violent or self-destructive behaviors. Record review failed to reveal any available documentation Patient #13 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 0125 through discharge on 01/14/2015 at 1645. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed "seclusion (exam room #7) is the only room we can remove everything to make it safe." Interview revealed with IVC patient's the ED staff does not necessarily remove all equipment from the room. Interview revealed ED staff are looking at processes to make a consistent decision point as to making a safe environment. Interview revealed "In reality it is a general ED and not a psychiatric unit." Interview revealed all the equipment in the exam rooms can be removed except for wall mounted computers and the call bell which has to be plugged into the wall. Interview revealed the ED	A 144		

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A 144	Continued From page 14 "needs to improve the process to standardize versus being an individual decision" for making rooms safe. 3. Observation during ED tour on 01/14/2015 at 1438 of exam room #5, revealed the room was located diagonally across from the nursing station. Observation revealed the room had a wood door. Observation revealed inside the room was: a stretcher on wheels; a chair in the corner; a bed side table on wheels; removable wall mounted Oxygen, Medical Air, and Suction regulators; a disposable wall mounted suction canister and tubing; a wall mounted otoscope and ophthalmoscope with cords (each approximately 2-4 feet long); a wall mounted cardiac monitor with cardiac leads, blood pressure cuff, and pulse oximetry cords (each approximately 4-6 feet long) dangling from the monitor; and a wall mounted computer charting station. Further observation revealed a female patient (Patient #16) wearing green disposable scrubs and laying on her left side on the stretcher, watching television. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed a hand held call bell device (attached to the wall with an approximately 4-6 foot long cord) draped across the left side rail of the stretcher within arms reach of the patient. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's left wrist was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO or nursing staff.	A 144		

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A 144	Continued From page 15 Open medical record review on 01/15/2015 for Patient #16 revealed an 18 year old female presented to the Hospital's ED on 01/13/2015 at 1726 for "potential drug overdose." Review revealed the patient was triaged by a RN at 1732 and was assessed by a ED Physician at 1734. Review revealed the patient was assessed at 1912 by a mobile crisis worker. Review revealed on 01/14/2015 at 0050, the patient was placed under IVC for being mentally ill and dangerous to self and others. Review revealed at on 01/15/2015 at 0835, the patient was transferred to a Psychiatric hospital. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed "seclusion (exam room #7) is the only room we can remove everything to make it safe." Interview revealed with IVC patient's the ED staff does not necessarily remove all equipment from the room. Interview revealed ED staff are looking at processes to make a consistent decision point as to making a safe environment. Interview revealed "In reality it is a general ED and not a psychiatric unit." Interview revealed all the equipment in the exam rooms can be removed except for wall mounted computers and the call bell which has to be plugged into the wall. Interview revealed the ED "needs to improve the process to standardize versus being an individual decision" for making rooms safe. 4. Observation during ED tour on 01/14/2015 at 1430 of the seclusion room #7 revealed a room with a solid wood door and window with blinds and the blinds were outside covering the window. Observation revealed on the left side of the room at the head of the stretcher a metal plate with two sharp pointed corners partially attached to the wall. Observation revealed the metal plate could	A 144	A144 –Corrective Action: (completed 1/15/15) Metal plate with two sharp pointed corners has been secured to the wall thus assuring no danger to patient. Responsible person: Nursing Director Emergency Department	

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A 144	Continued From page 16 be easily pulled further off of the wall. When exiting the room a male patient (Patient #17) was observed standing calmly beside with door EMS personnel at his side. Observation revealed the patient was escorted into the seclusion room along with the Mental Health Nurse (MHRN). Approximately 10 minutes later 2 City LEOs were observed entering the seclusion room and the MHRN standing out side of the room. The door and the blinds were closed. Interview with the MHRN during the observation revealed City LEO were in the room searching the patient, putting the patient in scrubs and cuffing (restraints) the patient. The interview revealed the LEO cuffed the patient because the patient was IVC. The interview revealed that even if the patient is calm and cooperative the patient is always cuffed. The interview revealed the MHRN had training on the Hospital policy and procedure for restraining patients in October, 2014. The interview revealed she was also aware of the revision of the restraint and seclusion policy completed in December, 2014. Patient #17 was observed during the interview with both wrist cuffed with metal cuffs. Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed "seclusion (exam room #7) is the only room we can remove everything to make it safe." Interview revealed with IVC patient's the ED staff does not necessarily remove all equipment from the room. Interview revealed ED staff are looking at processes to make a consistent decision point as to making a safe environment. Interview revealed "In reality it is a general ED and not a psychiatric unit." Interview revealed all the equipment in the exam rooms can be removed except for wall mounted	A 144		

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A 144	Continued From page 17 computers and the call bell which has to be plugged into the wall. Interview revealed the ED "needs to improve the process to standardize versus being an individual decision" for making rooms safe.	A 144		
A 165	482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based upon policy and procedure reviews, observations during tours, medical record reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews, the hospital's Emergency Department (ED) staff failed to ensure the least restrictive intervention to protect the patient or others from harm for 6 of 6 patients under involuntary commitment who were restrained in the ED. (#14, #16, #13, #17, #12, #9) The findings include: Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. The decision to use a restraint is driven by a comprehensive individual assessment. This document is used to provide consistent guidelines for the safe use of chemical and physical restraints and seclusion, if alternatives, as determined by an interdisciplinary	A 165	A165 – Maria Parham Medical Center does and will continue to protect and promote each patient's rights during restraint or seclusion. This is evidenced by our practice of not applying metal shackles in the treatment of any of our patients. It is only the Law Enforcement Officers (LEOs) who apply forensic restraints which include handcuffs, other chain-type restraint devices and other restrictive devices which are used for custody, detention and public safety and are not involved in the provision of health care. Forensic Standard Policy EOC 66 (Attachment F) Restraint of Patients Policy PC 17. Maria Parham Medical Center has had numerous discussions with LEO regarding their practice of applying forensic restraints, but they will not alter this practice/policy. Corrective Action: On January 28, 2015 the Emergency Department implemented the "Behavioral Management/Forensic Restraint Flow Record" (Attachment C) to monitor and observe patients in restraints. Language includes forensic restraints and	

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A 165	Continued From page 18 team, have proven to be clinically ineffective to provide a safe environment for the patient. ...DEFINITIONS: Restraint - is the direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof. Physical Restraints - any manual method or physical/mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. ...Restraint to Promote Medical Recovery (non-violent): refers to the use of restraints in those patients who require various medically essential therapies while hospitalized and who demonstrate a state of confusion or altered cognition that puts those therapies at risk OR those patients who require management of non-psychiatric behaviors that put them at risk for injury. Restraints for Violent or Self-Destructive Behavior: refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting. ...Restrictive Devices Applied by Law Enforcement Officials - handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons and is not involved in the provision of health care; no considered restraints. ...Seclusion - seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.	A 165	Continued from page 18 A165 - defines violent and non-violent behaviors to guide care as stated in Patient Care Policy #17 - "Restraint of Patients" (Attachment B). Responsible Person: Nursing Director of ED. Corrective Action: Nursing Supervisors will include in their hand off a discussion of patients in restraints and are expected to review documentation of every patient in restraints and appropriateness of the restraints based on behavior. Care nurses will include in their hand off/shift huddle a review of the previous shift's documentation for completeness and continued need for restraints based on behavior. Monitoring will be through daily review of all patients in restraints for safety or behavioral by Director of Quality. Time frame for this monitor is three consecutive months of 100% compliance. Further monitoring will be based in the results of the 3 months review and the recommendations from Patient Safety Clinical Quality Committee, that reports director to the Board of Trustees. Responsible Person: Chief Nursing Officer	

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A 165	Continued From page 19 The following interventions are not considered seclusion: 1. a patient physically restrained alone in an unlocked room. ...POLICY: It is the policy of (Hospital name) Medical Center to: 1. Prevent, reduce and eliminate the use of restraints by: a. preventing emergencies that have the potential to lead to the use of restraints, b. limiting the use of restraints to emergencies where there is a risk of the patient harming himself/herself or others. c. using the least restrictive method. ...CLINICAL JUSTIFICATION FOR USE OF RESTRAINT AND/OR SECLUSION: ...Unless there is an immediate and overriding concern for safety, the restraint procedure is utilized only after all alternatives, less restrictive treatment interventions have been tried without success. Prior to implementation of any restraint, care team members will confer to determine that appropriate alternative measures have been attempted. Using the decision flowcharts for patient behaviors and alternatives for use of restraint, clinical assessment and utilization of restraint should be based on patient's behavior that may place the patient or others at risk for harm. Situations in which restraints are clinically justified include: *Threatens placement and/or patiency of necessary therapeutic lines/tubs, interfering with necessary medical treatment, and appropriate alternative measures have been attempted. ...*Unable to follow directions to avoid self-injury, and appropriate protective, alternative measures have been attempted. ...LEAST RESTRICTIVE RESTRAINT/SAFE APPLICATION: Assessment and reassessment processes should include the appropriateness of the choice of restraint and/or seclusion. ...ALTERNATIVE THERAPY: Prior to physically restraining a patient, restraint-free interventions such as (but not limited to) the	A 165		

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A 165	Continued From page 20 following are attempted: *Provide safe environment, i.e., bed in low position, clutter free environment *Diversonal Activity *Assess for continued need for medical device ...*Telephone limit setting/redirection *Enhanced observation *Address comfort needs... *Ask/allow family to stay with patient - family interaction *Relaxation aids... *Limiting visitors *Bed alarms *Provide exercise/ambulation if condition warrants *Eliminate unnecessary medications *Mittens... *Move patient to a room closer to nurse's station *Provide increased physical contact... *Camouflage lines/tubes *Personal space for placing belongings or pictures within ease reach *Listening and exploring feelings ...Pain management *Music/TV *Reassurance *Sitter *Change of Environment ...MONITORING, ASSESSING, AND CARE OF THE PATIENT IN RESTRAINTS: When restraints are used there is an increased need for patient monitoring and assessment to assure patient safety, that the less restrictive methods are used when possible, and that restraint is discontinued as soon as possible. ...DOCUMENTATION: The medical record should document: ...Documentation within the patient's record should indicate a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more restricted measure. ..." Interview on 01/14/2015 at 1420 during tour of the ED (1420-1500) with the Charge Nurse #2 revealed the ED had three (3) patients currently under involuntary commitment (IVC) in exam rooms #1, #5, #17 and one (1) patient pending IVC in exam room #7. 1. Observation during ED tour on 01/14/2015 at	A 165		

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A 165	Continued From page 21 1427 of exam room #17, revealed the room was located across from the nursing station. Observation revealed the room had a sliding glass door. Observation revealed a male patient (Patient #14) wearing green disposable scrubs and sitting on the end of the stretcher leaning over a bedside table. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right leg/ankle was chained to the stretcher's frame with a metal shackle/cuff (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. At 1433, observation revealed Patient #14 stood up off the end of the stretcher and pivoted around to the side of the stretcher without difficulty or assistance. At 1434, observation revealed XYZ County Sheriff Deputy (CSD) #1 was sitting behind the nursing station in a cubical. Observation revealed the cubical was on the opposite side of the nursing station, away from exam room #17. Observation revealed CSD #1 stood up and exited the cubical and walked down the hallway on the opposite side of the nursing station, away from exam room #17 and exited the emergency department treatment area through a set of double doors. Observation revealed Patient #14 was alone in exam room #17 unsupervised by a LEO. At 1436, observation revealed CSD #1 returned to the cubical in the nursing station and sat down. Observations from 1427 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #14 while being restrained in exam room #17.	A 165		

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A 165	Continued From page 22 Open medical record review on 01/14/2015 revealed Patient #14, a 60 year old male presented to the hospital's ED on 01/13/2015 at 1820 accompanied by Law Enforcement under IVC petition. Review revealed the patient's chief complaint was IVC-Crisis Evaluation Referral. Review of triage nurse documentation at 1827 revealed "IVC, per caregiver pt (patient) with bizarre behavior, pt walking around showing gentials [sic], pt endorses auditory hallucinations, pt with rambling thoughts in triage, pt states he will only hurt someone if they try to hurt him." Review of triage assessment documentation revealed the patient was alert, oriented x 3 (person, place, time) and anxious. Review revealed the patient was evaluated by a physician at 1908. Review revealed a chief complaint of being agitated and exposing genitals. Review revealed the patient was assessed as no acute distress, awake and alert, slightly agitated, pressured speech, and directable. Review revealed the patient was "cooperative." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 01/13/2015 at 1541 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #14) is probably: [X] 1. mentally ill and dangerous to self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness. ..." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 01/13/2015 at 2345 revealed "Description of Findings" with "...presenting for agitation, exposing himself inappropriately to others. On evaluation, pt is	A 165		

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A 165	Continued From page 23 disorganized with pressured speech. Oriented to location but not situation. Is currently a danger to himself due to psychosis." Review of nursing documentation at 2235 revealed "Resting quietly in bed. No aggressive behaviors, no self-injurious behavior. ..." At 1215 (01/14/2015) "...Pt unshackled while bed was exchanged." At 1330 "Pt sitting at end of bed. No c/o voiced. No distress noted." At 1500 "Pt sitting on bed c (with) no distress noted." At 1845 "Pt transported to (hospital name)....ambulated to police care no distress noted." Review of "Suicide Precautions Flow sheet" documentation on 01/13/2015 from 1900 to 2300 and 01/14/2015 from 0715 to 1845 revealed the patient's behavior was documented by staff as calm or cooperative. Review revealed no documentation the patient was violent or aggressive. Review revealed on 01/14/2015 at 1430, 1445, and 1500 (corresponding timeframe to Surveyor's observation [1427-1500] of the patient cuffed/shackled to the stretcher) as being cooperative. Record review failed to reveal any available documentation Patient #14 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 1820 through discharge on 01/14/2015 at 1845. Record review failed to reveal documentation prior to physically restraining Patient #14 of all restraint-free alternatives and less restrictive interventions such as (but not limited to) the following were attempted: provide safe environment, diversional activity, assessment for continued need for any medical devices, telephone limit setting/redirection, enhanced observation, addressing comfort needs, asking/allowing family to stay with patient - family interaction, relaxation aids, limiting visitors, bed alarms, providing exercise/ambulation if condition warrants,	A 165		

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A 165	Continued From page 24 eliminating unnecessary medications, mittens, moving the patient to a room closer to nurse's station, providing increased physical contact, camouflaging lines/tubes, personal space for placing belongings or pictures within ease reach, listening and exploring feelings, pain management, music/TV, reassurance, sitter, change of environment, that were tried without success; nor documentation within the patient's record indicating a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more restricted measure per hospital policy. Interview on 01/14/2015 at 1442 with CSD #1 revealed he was a Deputy Sheriff with the XYZ County Sheriff's Department. Interview revealed he was present in the ED for a "10-73" (mental subject). Interview revealed the patient (#14) in exam room #17 was under IVC. Interview revealed the patient was brought to the ED on 01/13/2015. Interview revealed he relieved the previous Deputy this morning (01/14/2015) at shift change. Interview revealed the previous Deputy placed the patient into "ankle shackles." Interview revealed the "officer makes the decision wither or not the patient needs to be handcuffed or shackled." Interview revealed Patient #14 was not going to jail and was not under arrest. Interview revealed he (CSD #1) was on standby until a mental health facility could be found for the patient. Interview revealed because the patient was in his custody, he was responsible for any of the patient's actions. Interview revealed when the patient complains the cuffs/shackles are too tight or hurting, he will use 2-3 fingers to check to see if the cuffs/shackles are too tight. Interview revealed there was no set schedule for	A 165		

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A 165	Continued From page 25 periodically removing the cuffs/shackles or checking for tightness. Interview revealed the "patient lets me know if they are too tight." Interview revealed if the patient needed to go to the restroom, the cuffs/shackles are removed. Interview revealed he does not check pulses or skin for circulation. Interview revealed the nurse is responsible for taking care of the patient's medical needs. Interview revealed he does not document in the patients ED medical record. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED	A 165		

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A 165	Continued From page 26 Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #14 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 2. Observation during ED tour on 01/14/2015 at 1438 of exam room #5, revealed the room was located diagonally across from the nursing station. Observation revealed the room had a wood door. Observation revealed a female patient (Patient #16) wearing green disposable scrubs and laying on her left side on the stretcher, watching television. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's left wrist was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. Observation revealed an ABC City Police Department officer was sitting behind the nursing station in a cubical,	A 165		

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A 165	Continued From page 27 reading a magazine. Observations from 1438 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #5. Open medical record review on 01/15/2015 for Patient #16 revealed an 18 year old female presented to the Hospital's ED on 01/13/2015 at 1726 for "potential drug overdose." Review revealed the patient was triaged by a RN at 1732 and was assessed by a ED Physician at 1734. Review revealed the patient was assessed at 1912 by a mobile crisis worker. Review revealed on 01/14/2015 at 0050, the patient was IVC for being mentally ill and dangerous to self and others. Review revealed at 0200 and 0400, the patient's behavior was documented as asleep with parent and LEO at bedside. Review revealed from 0600 to 01/15/2015 at 0515, the patient's behavior was documented as asleep, tearful, and resting quietly in bed, resting in bed with eyes closed and laying in bed with eyes closed. Review revealed at 0536, the patient requested the "shackle" (restraint) be loosened and the hospital staff informed the LEO. Review revealed at 0725, the patient behavior was documented as alert and oriented with right lower extremity "cuffed" (restraint) to bed frame. Review revealed at 0835, the patient was transferred to a Psychiatric hospital. Record review failed to reveal any available documentation Patient #16 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 1726 through discharge on 01/15/2015 at 0835. Record review failed to reveal documentation prior to physically restraining Patient #16 of all restraint-free alternatives and less restrictive interventions such	A 165		

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A 165	Continued From page 28 as (but not limited to) the following were attempted: provide safe environment, diversional activity, assessment for continued need for any medical devices, telephone limit setting/redirection, enhanced observation, addressing comfort needs, asking/allowing family to stay with patient - family interaction, relaxation aids, limiting visitors, bed alarms, providing exercise/ambulation if condition warrants, eliminating unnecessary medications, mittens, moving the patient to a room closer to nurse's station, providing increased physical contact, camouflaging lines/tubes, personal space for placing belongings or pictures within ease reach, listening and exploring feelings, pain management, music/TV, reassurance, sitter, change of environment, that were tried without success; nor documentation within the patient's record indicating a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more restricted measure per hospital policy. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police."	A 165		

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A 165	Continued From page 29 Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #16 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 3. Open medical record review on 01/14/2015 for Patient #13 revealed a 26 year old male presented to the hospital ED (Emergency Department) on 01/13/2015 at 0125 with thoughts of suicide and for substance abuse detoxification. Review revealed at 0127, the patient was triaged by a RN and at 0234, the patient was assessed by a ED Physician. Review revealed at 0840, the patient was assessed by a mobile crisis worker and was admitted for suicidal thoughts. Review revealed at 1600, the patient was IVC (Involuntary Commitment) due to mentally ill and dangerous to self and others. Further review revealed when the patient was IVC, LEO (Law Enforcement Officer) placed the patient in leg shackles. Review revealed at 1800 and 2000, the patient's behavior was documented as calm and resting with eyes closed with "lower	A 165		

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extremity" (leg) shackled (restraint). Review revealed on 01/14/2015 at 0000, 0200, 0430, 0600, 0735 and 0935, the patient behavior was documented as asleep and resting quietly with the right ankle shackled. Review revealed at 1645, the patient was transferred to a Psychiatric hospital for treatment. Review revealed no documentation the patient demonstrated violent or self-destructive behaviors. Record review failed to reveal any available documentation Patient #13 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 0125 through discharge on 01/14/2015 at 1645. Record review failed to reveal documentation prior to physically restraining Patient #13 of all restraint-free alternatives and less restrictive interventions such as (but not limited to) the following were attempted: provide safe environment, diversional activity, assessment for continued need for any medical devices, telephone limit setting/redirection, enhanced observation, addressing comfort needs, asking/allowing family to stay with patient - family interaction, relaxation aids, limiting visitors, bed alarms, providing exercise/ambulation if condition warrants, eliminating unnecessary medications, mittens, moving the patient to a room closer to nurse's station, providing increased physical contact, camouflaging lines/tubes, personal space for placing belongings or pictures within ease reach, listening and exploring feelings, pain management, music/TV, reassurance, sitter, change of environment, that were tried without success; nor documentation within the patient's record indicating a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more

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A 165	Continued From page 31 restricted measure per hospital policy. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #13 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 4. Observation during ED tour on 01/14/2015 at 1430 of the seclusion room #7 revealed a room	A 165		

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A 165	Continued From page 32 with a solid wood door and window with blinds and the blinds were outside covering the window. Observation revealed on the left side of the room at the head of the stretcher a metal plate with two sharp pointed corners partially attached to the wall. Observation revealed the metal plate could be easily pulled further off of the wall. When exiting the room a male patient (Patient #17) was observed standing calmly beside with door EMS personnel at his side. Observation revealed the patient was escorted into the seclusion room along with the Mental Health Nurse (MHRN). Approximately 10 minutes 2 City LEOs were observed entering the seclusion room and the MHRN standing out side of the room. The door and the blinds were closed. Interview with the MHRN during the observation revealed City LEO were in the room searching the patient, putting the patient in scrubs and cuffing the patient. The interview revealed the LEO cuffed the patient because the patient was IVC. The interview revealed that even if the patient is calm and cooperative the patient is always cuffed. The interview revealed the MHRN had training on the Hospital policy and procedure for restraining patients in October, 2014. The interview revealed she was also aware of the revision of the restraint and seclusion policy completed in December, 2014. Patient #17 was observed during the interview with both wrist cuffed with metal cuffs Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or	A 165		

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shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles.

Interview with ABC Police Officer #1 on 01/14/2015 at 1435 revealed he was responsible for 3 patients under IVC in the ED at this time. The interview revealed he stations himself at an area in the corner. The interview revealed he can observe the patient in the seclusion room and the patient in room #5. The interview revealed Officer # 1 was not allowed to answer any further questions. The interview revealed a phone number to two Lieutenant at the City Police Department if further questions needed to be asked.

Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police."

Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in

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handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring patients while restrained in the ED with metal cuffs/shackles placed by a law enforcement officer.

5. Closed medical record review of Patient #12 revealed a 9 (nine) year old child presenting to the Emergency Department with mother on 12/12/2014 at 2001 with a chief complaint of "Pt (patient) with hx (history) of ADHD (Attention Deficient Hyperactivity Disorder) seen by daymark and referred to ER for psych eval. (evaluation). Mother sts (states) pt acting out when not getting 'his way'. Mother sts pt using foul language, and damaging property at home. Pt age appropriate, resp (respirations) even and unlabored, NAD (no acute distress)." Medical record review revealed documentation by nursing staff that triage was conducted at 2003 and the child was alert responded to voice and was oriented to person, time and place. Review of nursing documentation at 2002 revealed the "Pt ambulated to ER-1 - Pt very agitated and uncontrollable. Pt screaming, constantly in motion and tearing up thins at home. Pt using foul language". Medical record review revealed documentation of the physician's medical screening exam (MSE) on 12/12/2014 at 2010 in room 1. Review of the MSE revealed the parent was with the patient during the exam and the

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child was "angry, frustrated, agitated". Review of the MSE revealed the clinical impression by the physician was ADHD. Review of nursing documentation revealed at 2140 the patient was"very agitated - screaming, rolling around on floor, slapping at wall and not following instructions. Medical record review revealed the patient was administered per physician's order Ativan (medication for treatment of anxiety disorders) 1 mg IM at 2219 and Benadryl 25 (medication used for psychiatric symptoms) mg IM at 2213. Medical record review revealed documentation on the "Appropriateness/Justification for Acute Medical/Surgical Restraint" form of a physician's order for the patient to be physically restrained due to "Pt's (patient's) behavior uncontrollable - spitting, scratching- trying to bite, cursing- uncontrollable with meds." Further review of the physician's order for restraint revealed the restraint type was ordered "Soft limb holders...Four Side Rails". Review of the type order revealed no documentation of which limbs or how many limbs were to be restrained. Review of the order revealed the restraint was initiated on 12/12/ 2014 at 2248 and the order was signed by the physician at 2250. Review of the order did not reveal any documentation of the time limit for restraining the child. Medical record review revealed documentation at 2254 the restraint was discontinued. Medical record review did not reveal any documentation of a one hour face to face examination after the child was placed in restraints. Review of nursing documentation revealed at 2230 "mental health case worker in to evaluate pt". Review of the mental health staff documentation at 2300 revealed "client was being placed in a four point restrain by hospital staff. Client was displaying aggressive behaviors to his

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mother and medical staff...Client damaged hospital property...Client had to be move to the seclusion room where all items were removed including bed...Client continued his aggressive behavior for about two hours which led to the doctor giving client 25 mg Benedryl IM at 10:10 pm and 1 mg ativan IM at 10:30 pm due to client continue disruptive behavior client was given 2 mg of Haldol IM at 11:10 pm...continue disruptive behavior for about thirty minutes before calming down at that time XXX County Officer arrived and placed patient into custody. Medical staff place bed back into seclusion room at that time...Client had to be place in four point restraints by medical staff." Record review revealed documentation of "Petition for involuntary commitment" dated 12/12/2014 and completed by the physician stating the patient was agitation and a danger to self and others and requested inpatient treatment and stabilization. Nursing documentation at 2254 revealed "Pt got himself out of restrains, still out of control. Nursing documentation revealed at 2306 the patient was moved to room 7 for seclusion and at 2314 the patient was hitting the door. Nursing documentation at 2309 revealed the patient was kicking scratching and spitting and trying to "break down door, Haldol (antipsychotic medication) 2 mg IM" was given. Further review of nursing documentation revealed the patient calmed down at 2340, "resting on floor...placed on cardiac monitor" and was placed in bed. Documentation by nursing staff revealed at 2345 the patient was "IVC'd and restrained by law enforcement with ankle cuff to left ankle and bed. Pt sleeping without distress". Nursing documentation revealed on 12/13/2014 at 0100, 0200, 0300, 0400 and 0600 the patient was sleeping without distress. Documentation revealed the patient was offered water at 0300,

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refused and took sips of water at 0600. Review of nursing documentation revealed no documentation of assessment at 0500. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/12/2014 from 2350 until 12/13/2014 at 0720 revealed the patient was " A-resting in bed". Review of nursing documentation on 12/13/2014 at 0730 revealed law enforcement was present and the child's "left ankle cuffed to bed rail per law enforcement protocol." Nursing documentation revealed at 0810 the patient was yelling "I'm hungry" and the staff "encouraged to relax breakfast will be coming soon." Documentation at 0835 revealed the child continued yell for the nurse and the child was given orange juice and peanut butter crackers. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/13/2014 from 0900 until 12/14/2014 at 0716 revealed the patient was " A-resting in bed". Documentation at 0900 revealed the breakfast tray was made available to the child and at 0940 he was asleep. Nursing documentation at 1100 revealed the child told nursing staff that heard and sees the devil telling him to do it". Review of nursing documentation at 1300 revealed the patient was released from forensic restraints by the LEO and the patient ran. Documentation revealed "the officer captured pt and brought back to room pt began banging forensic restraints PRN (as needed) given at 1322". Nursing documentation at 1400 revealed the patient was medicated due to the patient not taking redirection. Nursing documentation revealed the patient slept until 1905 when he awoke and asked for dinner. Nursing documentation at 1951 revealed the patient was placed in "4 pt (point) forensic restraints after "slamming upon bed and jumping up and down,

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cursing and threatening staff." Nursing documentation revealed at 2000 "remains in 4 pt restraints...Ativan was given, at 2012 "remains in 4 pt restraint, at 2033 "Forensic arm restraint removed. Leg shackles remain...Pt being monitored by nurses and officer." Documentation at 2045 revealed the patient was placed back in 4 point restraints due to cursing and yelling. documentation at 2118 revealed the patient remained in 4 point restraints and "Haldol given as ordered". Documentation at 2215 revealed the patient remained in 4 point restraints. review of nursing documentation on 12/14/2014 at 0615 revealed the patient slept since being medicated at "midnight" and "remains in restraints". Documentation by nursing staff at 0820 revealed the "pt yelling out 'I'm wet' In room to assess pt. pt voided self and floor. Officer in room to uncuff pt...pt c/o (complained of) 'my moms gonna be so mad I pissed myself'." Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/14/2014 from 0830 until 12/16/2014 at 0630 revealed the patient was " A-resting in bed". Documentation revealed the patient was cleaned and rested quietly until 1345. Documentation at 1345 revealed an attempt was made to remove one restraint "Pt climbing over bed. Forensic restraint had to be reapplied "Pt cursing, yelling, urinated on self". Record review revealed the patient was administered Haldol IM at 1415 and was documented resting at 1455 (40 minutes after medication), 1548 (53 minutes after previous assessment), 1639 (1 hour later) and at 1730 (51 minutes later). Nursing documentation revealed the patient rested quietly from 12/15/2014 at 2400 through 1319 (13 hours) with law enforcement. Nursing documentation revealed the patient cried at intervals for his mother. Nursing documentation at 1500 revealed

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the patient was up to the bathroom "for BM (bowel movement) x1. Shackles on." Review of nursing documentation did not reveal any documentation of the patient having disruptive or aggressive behaviors prior to or after going to the bathroom. Nursing documentation revealed no documentation of aggressive, agitated or self destructive behavior from 1600 on 12/15/2014 through 12/16/2014 at 0710. Documentation at 0710 revealed the LEO was at the bedside. Nursing documentation on 12/16/2014 at 1100 revealed "Patient kept yelling out 'Nurse, Nurse'...mental health,charge nurse and writer in room to talk to patient that if he stops yelling out loud he could be able to talk to his mother and will be moved to a room with tv". Documentation at 1140 revealed the patient vomited yellowish emesis on the floor and told the nurse he "does not feel good". Documentation revealed the nurse notified the physician and at 1315 the patient continued to yell out for the Nurse. Documentation at 1500 revealed the patient vomited a second time and the physician was made aware. Documentation revealed Zofran (antiseptic) IV was administered at 1830 and Normal Saline infused at a "bolus rate". Record reviewed revealed nursing documentation at 2030 (2 hours after medication) that the patient was resting. Record review revealed on 12/17/2014 at 1045 the patient was administered Ativan 1 mg IM, Zofran by mouth and the patient had pulled out his IV. Record review revealed at 1055 the patient was placed in 4 point restraints by LEO for yelling, not following directions and "pulling the stretcher to the door." Review of documentation by mental health staff on 12/17/2014 at 1120 revealed "Client pulled out his IV in his hand and made himself vomit. Client has escalated to where he is yelling constantly

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and has had both hands and one leg put in restraints." Nursing documentation revealed at 1357 the patient remained in "2 pt forensic restraints" (3 hours since last documentation). Review of nursing documentation on 12/18/2014 at 1110 revealed the patient remained in 2 point forensic restraints. Nursing documentation revealed at 1230 the patient complained of urinating on self. Review of documentation by mental health staff at 1400 revealed "Reassessment completed. Client continues to yell and have outburst. Staff not able to redirect. Client has been medicated and is still in restrains. Client now has a one on one staff member sitting with him. Client has been calmer when staff person is sitting with him." Documentation by nursing at 1445"staff member sitting with pt 1:1". Nursing documentation at 1645 and 1755 revealed a staff member sat with the patient 1:1 and the patient was "pleasant & cooperative." Documentation by nursing on 12/18/2014 revealed the "officer" was at the bedside and the patient "remains cooperative.' Review of nursing documentation on 12/19/2014 at 0730 revealed "Pt unshackled by officer so RN could assist pt with bath...Pt states 'these cuffs make my feet hurt'. " Record review did not reveal any documentation of an assessment of the patient's feet after he complained of hurting due to the "cuffs". Review of documentation by mental health staff at 1010 revealed "Reassessment completed. Client continues to yell out and not follow directions. Client is still in restraint." Review of nursing documentation at 1845 revealed LEO was at the hospital to transport the patient to an acute psychiatric hospital. Medical record review revealed documentation on 12/20/2014 at 1200, a written physician certification order for the transfer of the child to a

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A 165	Continued From page 41 psychiatric acute hospital for psychiatric services not available at the hospital. Review of the certification revealed the patient remained under IVC and was transported by law enforcement officer. Record review failed to reveal documentation prior to physically restraining Patient #12 of all restraint-free alternatives and less restrictive interventions such as (but not limited to) the following were attempted: provide safe environment, diversional activity, assessment for continued need for any medical devices, telephone limit setting/redirection, enhanced observation, addressing comfort needs, asking/allowing family to stay with patient - family interaction, relaxation aids, limiting visitors, bed alarms, providing exercise/ambulation if condition warrants, eliminating unnecessary medications, mittens, moving the patient to a room closer to nurse's station, providing increased physical contact, camouflaging lines/tubes, personal space for placing belongings or pictures within ease reach, listening and exploring feelings, pain management, music/TV, reassurance, sitter, change of environment, that were tried without success; nor documentation within the patient's record indicating a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more restricted measure per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring	A 165		

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A 165	Continued From page 42 and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #12 while he was restrained in the ED with metal cuffs/shackles placed by a law	A 165		

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A 165	Continued From page 43 enforcement officer. 6. Closed medical record review on 01/14/2015 revealed Patient #9 presented to the hospital's ED on 11/01/2013 at 1106 via private transportation accompanied by group home staff. Review revealed the patient's chief complaint was Crisis Evaluation Referral. Review of triage nurse documentation at 1116 revealed "pt admitted to new group home Monday, staff reports pt made threats to 'kill himself and everybody else.' Stated pt attempted to run away." Review of initial nursing assessment documentation revealed the patient was alert, awake, responsive to voice, oriented to person, time, and place. Review of a ED risk screen revealed the patient was assessed as "No" for risk for self harm/elopement. Record review revealed the patient was initially placed in exam room #20. Review revealed the patient was evaluated by a ED physician at 1109. Review revealed a chief complaint of suicidal thoughts, expressing SI (suicidal ideation) and HI (homicidal ideation). Review revealed a past medical history of bipolar disorder, schizophrenia, and moderate mental retardation (MR). Review revealed the patient was assessed as no acute distress; awake and alert; oriented X4 (person, place, time, and situation); mood and affect normal. Extremities non-tender and no signs of injury. Review of a Affidavit and Petition For Involuntary Commitment form dated 11/01/2013 (note timed) revealed the Respondent was Patient #9 and the Petitioner was ED Physician A. Review revealed "The facts upon which this opinion is based are as follows....Patient is mentally challenged with history of Bipolar D/O (disorder) and Schizophrenia who is very unstable at this time. He is making threats that he will kill others at the	A 165		

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group home and himself." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 11/01/2013 at 1200 revealed "Description of Findings" with "...Patient is mentally challenged with history of Bipolar and Schizophrenia who is very unstable at this time. He is making threats to kill himself and others - needs in-patient stabilization." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 11/01/2013 at 1258 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #9) is probably: [X] 1. mentally ill and dangerous to self or others...." Review revealed the respondent was taken into custody by ABC City Police Officer on 11/01/2013 at 1336 (Patient in ED when taken into custody). Review of a Computerized Physician's Order Entry (CPOE) report, Order # 26, CPOE #398912, revealed a physician's order entered by ED Physician A on 11/01/2013 at 1358 for "Restraints, Place in", Frequency: "ONCE", Priority: "Routine". Review of a Comprehensive Assessment Tool-Intake form dated 11/01/2013 at 1452 revealed "...presents to (Hospital A) - ED c group staff. Staff from group home report clt (client) was trying to run away this am and threatened to kill self as well as staff. Upon admission clt was making a gun with his fingers and placing it to the head of staff, threatening to stab another staff c a plastic fork and being verbally abusive. ...Clt was restrained on admission c forensic restraints and required pepper spray p (after) refusing chemical restraint. ..." Review of nursing documentation revealed on 11/01/2013 at 1106 "Pt cc HI. Pt @ (at) group

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home. MR high functioning w (with)/Psychosis + (and) Bipolar. Pt pretending to shoot staff + 'flipping off' other patients from room." At 1245, "Pt moved to isolation room (Exam Room #1), IVC in place, officer @ bedside. Pt acting iriatic [sic], cuffed (restraint) to bed, Pt had previously tried to hang self w/belt. Now threatening officer + trying to bite him, Pt trying to break free from cuffs, bed now broken, officer warning pt of violent behavior." At 1400, "Pt out of control, violent, calling everyone 'F**king Bi**hs.' Broke posey chest vest....threatening to kill officer. Pt sprayed w/pepper spray @ close range." At 1410, "Pt refusing flushing treatment. V/S (vital signs) WNL (within normal limits), resting in bed with eyes open, resp (respirations) nonlabored." At 1600, "Pt starting to yell out again, HPD (ABC City Police Department) at bedside." At 1755, "Pt resp WNL..." Review of Crisis Assessment documentation by mobile crisis management staff for Patient #9 dated 11/01/2013 at 1800 revealed the reason for referral was physical aggression, property destruction, threats of physical aggression, running away, verbal aggression, hallucinations or delusions, homicidal and suicidal. Review revealed "Became aggressive at GH (group home). Threatened to stab + shoot self + others. Ran to neighbors. Upon entering ED he refused meds + put a belt around his neck. He had to be pepper sprayed + put in 4 point restraints. ..." Review of mental status examination revealed the patient was disheveled with poor hygiene, and in 4 point restraints. Review revealed the patient had good eye contact, was calm, and had no impairment with communication and appropriate speech. Review revealed the patient's mood was depressed, slightly withdrawn, and cooperative. Review of nursing documentation revealed at 1900, "...Pt

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sleeping on bed in 4 point restraints. HPD c (with) patient." At 2230, "Sleeping. Quiet and cooperative." At 0100 (11/02/2013), Pt continues to sleep soundly." At 0300, "Pt. continues to sleep with restraints to wrist." At 0730, "Observed asleep. Law enforcement present. ..." At 0930, "Mental Health Services cont. (continue) to evaluate for mental health facility placement." At 1050, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1330, "...Remains cooperative. No suicidal or homicidal gestures." At 1440, "...Remains cooperative..." At 1555, "Law enforcement remains present. ...No suicidal or homicidal gestures." At 1900, "Pt moved to room 7 (Seclusion Room). Police officer remains @ bedside..." At 2000 to 0200 (11/03/2013) continued observation by police officer. At 0327, "...Pt calm + cooperative...." At, 0600 "...Calm Cooperative....Officer outside of rm (room)." At 0705, "...Pt calm + cooperative..." At 0930, "...HPD officer sitting outside of rm..." At 1330, "Pt remains calm + cooperative..." At 2055, "Pt. calm + cooperative...Rt. ankle remains shackled to stretcher by HPD. Good PMS (pulse, motor, sensation). Pt remains IVC'd." At 2300, "Pt continues to watch TV..." At 1130 (11/04/2013), "...cooperative..." At 0810, "Remains cooperative..." At 0900, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1545, "...Remains Cooperative...No suicidal/homicidal gestures. ..." At 1800, "Remains cooperative..." At 2040, "...Pt. pleasant + cooperative..." At 0140 (11/05/2013), "Resting c eyes closed....Law enforcement present." At 0815, "...Remains cooperative." At 1400, "...Law enforcement remains present. No suicidal/homicidal gestures." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form

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dated 11/05/2013 at 1745 revealed "Description of Findings" with "...Pt now stabilized, A+OX4, (No) HI, SI. D/W (discussed with) group home for disposition. Does not currently meet IVC criteria." Review of ED physician reassessment documentation at 1755 (11/05/2013) revealed the patient was re-examined and has improved, AOX4, Stable, No homicidal or suicidal ideation. Group home agrees to assume care. Review revealed a clinical impression of Psychosis, Schizophrenia, acute exacerbation. Review of nursing documentation revealed at 1858, "...Taken back to group home per law enforcement. ..." Record review failed to reveal documentation prior to physically restraining Patient #9 of all restraint-free alternatives and less restrictive interventions such as (but not limited to) the following were attempted: provide safe environment, diversional activity, assessment for continued need for any medical devices, telephone limit setting/redirection, enhanced observation, addressing comfort needs, asking/allowing family to stay with patient - family interaction, relaxation aids, limiting visitors, bed alarms, providing exercise/ambulation if condition warrants, eliminating unnecessary medications, mittens, moving the patient to a room closer to nurse's station, providing increased physical contact, camouflaging lines/tubes, personal space for placing belongings or pictures within ease reach, listening and exploring feelings, pain management, music/TV, reassurance, sitter, change of environment, that were tried without success; nor documentation within the patient's record indicating a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more restricted

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A 165	Continued From page 48 measure per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any	A 165		

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A 165	Continued From page 49 documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #9 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer.	A 165	A168 – Maria Parham Medical Center does and will continue to ensure that the patient has the right to receive care in a safe setting.	
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based upon policy and procedure reviews, medical record reviews, and staff interviews the hospital's nursing staff failed to obtain a physician's order after placing a patient in restraints in 1 of 1 intensive care unit (ICU) patients (#2). The findings include: Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. The decision to use a restraint is driven by a comprehensive individual	A 168	Corrective action: If, upon the care nurses' assessment, the patient needs and has an order by a MD, LIP or trained individual type of restraint, the nursing supervisor will be notified. The nursing supervisor will do a face-to-face assessment and validate appropriateness of restraint. This information is added to the ED Restraint Log. (Attachment D) Responsible Person: Chief Nursing Officer **Monitored** by Director of Quality and reported to Patient Safety and Clinical Quality Committee a minimum of ten times a year with report going to the Board of Trustees.	

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A 168	Continued From page 50 assessment. This document is used to provide consistent guidelines for the safe use of chemical and physical restraints and seclusion, if alternatives, as determined by an interdisciplinary team, have proven to be clinically ineffective to provide a safe environment for the patient. ...DEFINITIONS: Restraint - is the direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof. Physical Restraints - any manual method or physical/mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. PROCEDURE FOR USE OF RESTRAINT: Initiation and Renewal of Orders Standing orders, protocols, and/or PRN orders are not permitted. When initiating the use of a restraint, the appropriate restraint physician's order form (Nonviolent or Violent/Self Destructive) must be completed and placed on the chart within 30 minutes. This original order is time-limited based on type of restraint and age of patient. When use of restraints is contemplated, a physician/LIP or RN who has been trained in restraint application must document a face-to-face assessment prior to applying restraints, and document the need for restraint within the 1 hour time frame. The physician's/LIP's order must specify: *the restraint type *the justification for the restraint *date and time ordered *duration ...The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following: *an evaluation of the patient's immediate situation	A 168		

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A 168	Continued From page 51 *the patient's reaction to the restraint *the patient's medical and behavioral condition *the need to continue or terminate the restraint or seclusion ...The Nonviolent Restraint Physician's Orders: Orders for nonviolent restraints must be renewed each calendar day by the patient's attending physician or other designated LIP based on his or her examination of the patient. It is not necessary for the renewal to be completed within a 24-hour time-frame as the physician can re-evaluate the patient and need for non-violent/self-destructive restraints during routine rounds. If restraints for nonviolent behavior purposes are anticipated to be continued beyond the maximum time limit of the order, a restraint renewal sticker is placed on the physician order form and must be completed by the LIP before the original order expires. Its use is based on his or her face-to-face examination of the patient. Closed medical record review revealed Patient #2 was admitted on 09/11/2014 with a diagnosis of anemia and gastrointestinal bleeding (GI Bleed). Medical record review revealed on 09/14/2014 at 0700 the patient was placed in soft upper limb restraints with all 4 side rails of the bed in the up position. Medical record review revealed no documentation of a physician order for the restraints. Interview on 09/14/2015 at 0930 with Regulatory Compliance Officer revealed there was no initial order for the restraint. The interview revealed "There's no order, I don't see any orders for this patient."	A 168		
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 171		

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A 171	Continued From page 52 Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: Based on hospital policy review, medical record reviews, and staff interviews, the hospital's Emergency Department (ED) staff failed to ensure a physician's restraint order was time limited for no longer than four (4) hours for 1 of 1 adult patients (#9) age 18 years or older and for no longer than two (2) hours for 1 of 1 child and adolescent patients 9 to 17 years of age (#12) that was restrained or secluded for the management of violent or self-destructive behaviors. The findings include: Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. ...DEFINITIONS: ...Physical Restraints - any manual method or physical/mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body,	A 171	A171 – Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to protect and promote each patient's rights. The following actions have been implemented in support of Tag A171: • Physician documentation will include their reassessment of appropriateness of continuing restraints using the Mental Health Reassessment Form (Attachment E). Reassessment is based on the patient's age; every four hours for adults 18 years or older, every two hours for children ages 9 – 17, every hour for children under 9. • Responsible person Nursing Director ED • **Monitoring:** Quality Director or designee conducts Monday - Friday restraint rounds in the Emergency Department and Nursing Supervisors Saturday - Sunday. Any deficiencies are immediately reported to the Nursing Director of the ED for resolution.	2/2/2015

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A 171	Continued From page 53 or head freely. ...Restraints for Violent or Self-Destructive Behavior: refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting. ...Seclusion - seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. The following interventions are not considered seclusion: 1. a patient physically restrained alone in an unlocked room. ...PROCEDURE FOR USE OF RESTRAINT: Initiation and Renewal of Orders Standing orders, protocols, and/or PRN orders are not permitted. When initiating the use of a restraint, the appropriate restraint physician's order form (Nonviolent or Violent/Self Destructive) must be completed and placed on the chart within 30 minutes. This original order is time-limited based on type of restraint and age of patient. ...The physician's/LIP's order must specify: *the restraint type *the justification for the restraint *date and time ordered *duration ...For Violent/Self-Destructive Restraints [V/SD] ..The time limit for Violent/Self-Destructive Restraints is: *4 hours for adults (18 years of age or older) *2 hours for children (ages 9-17) *1 hour for children under age of 9 ...DOCUMENTATION: ...Each episode of restraint/seclusion use is to be recorded in the medical record. Documentation will include: ...*each telephone order received from a physician/LIP ..."	A 171	Continued from page 53 • The Emergency Department staff, including physicians, were re-educated on restraint usage and the Restraint of Patients PC17 policy (Attachment B) Surgical, Medical, Progressive Care Unit (PCU) and ICU staffs received re-education on Restraint of Patients PC17 Policy. (Attachment B) Responsible person: Nursing Director ED **Monitoring:** Quality Director will continue to audit 100% of restraint patient charts to assure appropriate time limited orders. Restraint audits will be reported to the Patient Safety & Clinical Quality Committee at a minimum of ten times a year with minutes of this committee going to the Board of Trustees.	1/22/2015 2/2/2015

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A 171	Continued From page 54 1. Closed medical record review of Patient #12 revealed a 9 (nine) year old child presenting to the Emergency Department with mother on 12/12/2014 at 2001 with a chief complaint of "Pt (patient) with hx (history) of ADHD (Attention Deficient Hyperactivity Disorder) seen by daymark and referred to ER for psych eval. (evaluation). Mother sts (states) pt acting out when not getting 'his way'. Mother sts pt using foul language, and damaging property at home. Pt age appropriate, resp (respirations) even and unlabored, NAD (no acute distress)." Medical record review revealed documentation by nursing staff that triage was conducted at 2003 and the child was alert responded to voice and was oriented to person, time and place. Review of nursing documentation at 2002 revealed the "Pt ambulated to ER-1 - Pt very agitated and uncontrollable. Pt screaming, constantly in motion and tearing up thins at home. Pt using foul language". Medical record review revealed documentation of the physician's medical screening exam (MSE) on 12/12/2014 at 2010 in room 1. Review of the MSE revealed the parent was with the patient during the exam and the child was "angry, frustrated, agitated". Review of the MSE revealed the clinical impression by the physician was ADHD. Review of nursing documentation revealed at 2140 the patient was"very agitated - screaming, rolling around on floor, slapping at wall and not following instructions. Medical record review revealed the patient was administered per physician's order Ativan (medication for treatment of anxiety disorders) 1 mg IM at 2219 and Benadryl 25 (medication used for psychiatric symptoms) mg IM at 2213. Medical record review revealed documentation on the "Appropriateness/Justification for Acute	A 171		

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A 171	Continued From page 55 Medical/Surgical Restraint" form of a physician's order for the patient to be physically restrained due to "Pt's (patient's) behavior uncontrollable - spitting, scratching- trying to bite, cursing- uncontrollable with meds." Further review of the physician's order for restraint revealed the restraint type was ordered "Soft limb holders...Four Side Rails". Review of the type order revealed no documentation of which limbs or how many limbs were to be restrained. Review of the order revealed the restraint was initiated on 12/12/2014 at 2248 and the order was signed by the physician at 2250. Review of the order did not reveal any documentation of the time limit for restraining the child. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of a physician's order for restraint because ED physician's do not order forensic restraints and the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview confirmed the documentation of the physician's order for restraint signed by the ED physician on 12/12/2014 at 2250. Interview confirmed the order was not time limited up to 2 hours for children or adolescents age 9 to 17 years of age. Interview confirmed the ED staff did not follow the hospital's Restraint of Patient policy for time limited restraint orders. 2. Closed medical record review on 01/14/2015	A 171		

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A 171	Continued From page 56	A 171		

for Patient #9, revealed an 18 year old male who presented to the hospital's ED on 11/01/2013 at 1106 via private transportation accompanied by group home staff. Review revealed the patient's chief complaint (cc) was Crisis Evaluation Referral. Review of triage nurse documentation at 1116 revealed "pt admitted to new group home Monday, staff reports pt made threats to 'kill himself and everybody else.' Stated pt attempted to run away." Review of initial nursing assessment documentation revealed the patient was alert, awake, responsive to voice, oriented to person, time, and place. Review of a ED risk screen revealed the patient was assessed as "No" for risk for self harm/elopement. Review revealed the patient was evaluated by a ED physician at 1109. Review revealed a chief complaint of suicidal thoughts, expressing SI (suicidal ideation) and HI (homicidal ideation). Review revealed a past medical history of bipolar disorder, schizophrenia, and moderate mental retardation (MR). Review revealed the patient was assessed as no acute distress; awake and alert; oriented X4 (person, place, time, and situation); mood and affect normal. Extremities non-tender and no signs of injury. Review of a Affidavit and Petition For Involuntary Commitment form dated 11/01/2013 (note timed) revealed the Respondent was Patient #9 and the Petitioner was ED Physician A. Review revealed "The facts upon which this opinion is based are as follows....Patient is mentally challenged with history of Bipolar D/O (disorder) and Schizophrenia who is very unstable at this time. He is making threats that he will kill others at the group home and himself." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 11/01/2013 at 1258 by a Magistrate. Review revealed "The

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A 171	Continued From page 57 Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #9) is probably: [X] 1. mentally ill and dangerous to self or others...." Review revealed the respondent was taken into custody by ABC City Police Officer on 11/01/2013 at 1336 (Patient in ED when taken into custody). Review of a Computerized Physician's Order Entry (CPOE) report, Order # 26, CPOE #398912, revealed a physician's order entered by ED Physician A on 11/01/2013 at 1358 for "Restraints, Place in", Frequency: "ONCE", Priority: "Routine". Review of nursing documentation revealed on 11/01/2013 at 1106 "Pt cc HI. Pt @ (at) group home. MR high functioning w (with)/Psychosis + (and) Bipolar. Pt pretending to shoot staff + 'flipping off' other patients from room." At 1245, "Pt moved to isolation room, IVC in place, officer @ bedside. Pt acting iriatic [sic], cuffed (restraint) to bed, Pt had previously tried to hang self w/belt. Now threatening officer + trying to bite him, Pt trying to break free from cuffs, bed now broken, officer warning pt of violent behavior." At 1400, "Pt out of control, violent, calling everyone 'F**king Bi**hs.' Broke posey chest vest....threatening to kill officer. Pt sprayed w/pepper spray @ close range." At 1410, "Pt refusing flushing treatment. V/S (vital signs) WNL (within normal limits), resting in bed with eyes open, resp (respirations) nonlabored." Review of a Comprehensive Assessment Tool-Intake form dated 11/01/2013 at 1452 revealed "...presents to (Hospital A) - ED c (with) group staff. Staff from group home report clt (client) was trying to run away this am and threatened to kill self as well as staff. Upon admission clt was making a gun with his fingers and placing it to the head of staff, threatening to	A 171		

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A 171	Continued From page 58 stab another staff c a plastic fork and being verbally abusive. ...Clt was restrained on admission c forensic restraints and required pepper spray p (after) refusing chemical restraint. ..." Review of nursing documentation revealed at 1600, "Pt starting to yell out again, HPD (ABC City Police Department) at bedside." At 1755, "Pt resp WNL..." Review of Crisis Assessment documentation by mobile crisis management staff for Patient #9 dated 11/01/2013 at 1800 revealed the reason for referral was physical aggression, property destruction, threats of physical aggression, running away, verbal aggression, hallucinations or delusions, homicidal and suicidal. Review revealed "Became aggressive at GH (group home). Threatened to stab + shoot self + others. Ran to neighbors. Upon entering ED he refused meds + put a belt around his neck. He had to be pepper sprayed + put in 4 point restraints. ..." Review of mental status examination revealed the patient was disheveled with poor hygiene, and in 4 point restraints. Review of nursing documentation revealed at 1900, "...Pt sleeping on bed in 4 point restraints. HPD c (with) patient." Record review failed to reveal documentation the CPOE order entered by ED Physician A on 11/01/2013 at 1358 for restraints was time limited up to 4 hours for adults 18 years of age or older for Patient #9. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement.	A 171		

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A 171	Continued From page 59 Interview revealed there would not be any documentation of a physician's order for restraint because ED physician's do not order forensic restraints and the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview confirmed the documentation of the CPOE order for restraint entered by ED Physician A on 11/01/2013 at 1358. Interview confirmed the order was not time limited up to 4 hours for adults age 18 years of age or older. Interview revealed "at the time we were using paper and not CPOE, I can't explain why there is a CPOE order" for restraint Interview confirmed the ED staff did not follow the hospital's Restraint of Patient policy for time limited restraint orders.	A 171		
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based upon hospital policy and procedure reviews, observations during tours, medical record reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews, the hospital's nursing staff failed to provide ongoing assessment and monitoring of the condition of a patient during restraint or seclusion for 6 of 6 emergency department (ED) patients (#14, #16, #13, #17, #12, #9) under involuntary commitment (IVC) and 1 of 1 intensive care unit (ICU) patients not under IVC (#2).	A 175	A175 - Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to protect and promote each patient's rights. The following actions have been implemented in support of Tag A175: • The ED staff, including physicians were re-educated on Restraint of Patients PC 17 usage and the restraint policy (Attachment B). Surgical, Medical, Progressive Care (PCU) and ICU staffs received re-education on restraint usage and the restraint policy. • Responsible Person: Nursing Director ED	

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A 175	Continued From page 60 The findings include: Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. The decision to use a restraint is driven by a comprehensive individual assessment. ...DEFINITIONS: Restraint - is the direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof. Physical Restraints - any manual method or physical/mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. ...Restraint to Promote Medical Recovery (non-violent): refers to the use of restraints in those patients who require various medically essential therapies while hospitalized and who demonstrate a state of confusion or altered cognition that puts those therapies at risk OR those patients who require management of non-psychiatric behaviors that put them at risk for injury. Restraints for Violent or Self-Destructive Behavior: refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting. ...Restrictive Devices Applied by Law Enforcement Officials - handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons and is not involved in the provision of health care; not considered	A 175	Continued from page 60 **Monitoring:** Quality Director or designee conducts Monday - Friday restraint rounds in the Emergency Department and Nursing Supervisors Saturday - Sunday. Any deficiencies are immediately reported to the Nursing Director of the ED for resolution. Quality Director will continue to audit 100% of restraint patient charts to assure ongoing assessment and monitoring of the patient's condition meets standards specified in Restraint of Patients PC 17 (Attachment B). A restraint report will be reported to Patient Safety & Clinical Quality at a minimum of ten times each year with minutes of this committee going to the Board of Trustees. • When restrictive devices have been applied by LEO, these patients must be observed 100% of the time by the law enforcement official. • Responsible person: Chief Operating Officer • **Monitoring**: Any deviation in Law enforcement practice will be reported to the Nursing Supervisor who will contact the Administrator on Call with report to the Chief Operating Officer	

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A 175	Continued From page 61 restraints. ...Seclusion - seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. The following interventions are not considered seclusion: 1. a patient physically restrained alone in an unlocked room. ...POLICY: It is the policy of (Hospital name) Medical Center to: 1. Prevent, reduce and eliminate the use of restraints by: a. preventing emergencies that have the potential to lead to the use of restraints, b. limiting the use of restraints to emergencies where there is a risk of the patient harming himself/herself or others. c. using the least restrictive method. 2. Protect the patient and preserve the patient's rights, dignity and well being during restraint use by: a. respecting the patient as an individual; b. maintaining a clean and safe environment; ...d. maintaining the patient's modesty, preventing visibility to others, and maintaining comfortable body temperature is maintained. 3. Provide for safe application and removal of the restraint by qualified staff. 4. Monitor and meet the patient's needs while in restraints. 5. Re-assess and encourage release of restraints as soon as possible. ...Restraints will be used only in situations where the patient is demonstrating observable behaviors that indicate he/she is at risk of injuring himself/herself or others. Restraints are not to be used for punishment, coercion, discipline, or retaliation of the patient or for staff convenience. This policy does not apply to devices....used by law enforcement officials although the standards of care stated within this document may be applicable. ...LEAST	A 175		

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A 175	Continued From page 62 RESTRICTIVE RESTRAINT/SAFE APPLICATION: Assessment and reassessment processes should include the appropriateness of the choice of restraint and/or seclusion. Physical restraints will be loosened periodically to evaluate skin integrity and circulation while the patient is in restraints. ...Discontinuing Restraint Once restraint is applied or initiated, the patient should be monitored and evaluated for the continued need of the intervention and the continued appropriateness of the type of intervention. ...The restraint should be discontinued as soon as the patient meets the behavior criteria for its discontinuation. The assessment of the continued need for restraint to determine early release should be documented at a minimum of every two hours or more often as the patient's condition improves. ...MONITORING, ASSESSING, AND CARE OF THE PATIENT IN RESTRAINTS: When restraints are used there is an increased need for patient monitoring and assessment to assure patient safety, that the less restrictive methods are used when possible, and that restraint is discontinued as soon as possible. Immediately after restraints are applied an assessment should be made to ensure that the restraints were properly and safely applied so as to not cause the patient harm or pain. Documentation should include this assessment as well as the patient's response, any adjustments made. The frequency of monitoring the patient must be made on an individual basis, which includes a rationale that reflects consideration of the individual patient's medical needs and health status. The assessment includes, as appropriate to the type of restraint used: *signs of injury associated with the restraints *nutrition/hydration *circulation and range of motion in the extremities *vital signs	A 175		

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A 175	Continued From page 63 *hygiene and elimination *physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being) *readiness for release from restraints *patient's understanding of the reasons for restraint and requirements for release ...PATIENT/FAMILY EDUCATION: ...For Non-Violent restraints, reassessment and documentation is required at least every 2 hours and for Violent/Self-Destructive restraints, it is required every 15 minutes. Interview on 01/14/2015 at 1420 during tour of the ED (1420-1500) with the Charge Nurse #2 revealed the ED had three (3) patients currently under involuntary commitment (IVC) in exam rooms #1, #5, #17 and one (1) patient pending IVC in exam room #7. 1. Observation during ED tour on 01/14/2015 at 1427 of exam room #17, revealed the room was located across from the nursing station. Observation revealed the room had a sliding glass door. Observation revealed a male patient (Patient #14) wearing green disposable scrubs and sitting on the end of the stretcher leaning over a bedside table. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right leg/ankle was chained to the stretcher's frame with a metal shackle/cuff (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. At 1433, observation revealed Patient #14 stood up off the end of the	A 175		

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A 175	Continued From page 64 stretcher and pivoted around to the side of the stretcher without difficulty or assistance. At 1434, observation revealed XYZ County Sheriff Deputy (CSD) #1 was sitting behind the nursing station in a cubical. Observation revealed the cubical was on the opposite side of the nursing station, away from exam room #17. Observation revealed CSD #1 stood up and exited the cubical and walked down the hallway on the opposite side of the nursing station, away from exam room #17 and exited the emergency department treatment area through a set of double doors. Observation revealed Patient #14 was alone in exam room #17 unsupervised by a LEO. At 1436, observation revealed CSD #1 returned to the cubical in the nursing station and sat down. Observations from 1427 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #14 while being restrained in exam room #17. Open medical record review on 01/14/2015 revealed Patient #14, a 60 year old male presented to the hospital's ED on 01/13/2015 at 1820 accompanied by Law Enforcement under IVC petition. Review revealed the patient's chief complaint was IVC-Crisis Evaluation Referral. Review of triage nurse documentation at 1827 revealed "IVC, per caregiver pt (patient) with bizarre behavior, pt walking around showing gentials [sic], pt endorses auditory hallucinations, pt with rambling thoughts in triage, pt states he will only hurt someone if they try to hurt him." Review of triage assessment documentation revealed the patient was alert, oriented x 3 (person, place, time) and anxious. Review revealed the patient was evaluated by a physician at 1908. Review revealed a chief complaint of being agitated and exposing genitals. Review	A 175		

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A 175	Continued From page 65	A 175		

revealed the patient was assessed as no acute distress, awake and alert, slightly agitated, pressured speech, and directable. Review revealed the patient was "cooperative." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 01/13/2015 at 1541 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #14) is probably: [X] 1. mentally ill and dangerous to self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness. ..." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 01/13/2015 at 2345 revealed "Description of Findings" with "...presenting for agitation, exposing himself inappropriately to others. On evaluation, pt is disorganized with pressured speech. Oriented to location but not situation. Is currently a danger to himself due to psychosis." Review of nursing documentation at 2235 revealed "Resting quietly in bed. No aggressive behaviors, no self-injurious behavior. ..." At 1215 (01/14/2015) "...Pt unshackled while bed was exchanged." At 1330 "Pt sitting at end of bed. No c/o voiced. No distress noted." At 1500 "Pt sitting on bed c (with) no distress noted." At 1845 "Pt transported to (hospital name)....ambulated to police care no distress noted." Review of "Suicide Precautions Flow sheet" documentation on 01/13/2015 from 1900 to 2300 and 01/14/2015 from 0715 to 1845 revealed the patient's behavior was documented by staff as calm or cooperative. Review revealed no documentation the patient was violent or aggressive. Review revealed on 01/14/2015 at

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A 175	Continued From page 66 1430, 1445, and 1500 (corresponding timeframe to Surveyor's observation [1427-1500] of the patient cuffed/shackled to the stretcher) as being cooperative. Record review failed to reveal any available documentation Patient #14 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 1820 through discharge on 01/14/2015 at 1845. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy. Interview on 01/14/2015 at 1442 with CSD #1 revealed he was a Deputy Sheriff with the XYZ County Sheriff's Department. Interview revealed he was present in the ED for a "10-73" (mental subject). Interview revealed the patient (#14) in exam room #17 was under IVC. Interview revealed the patient was brought to the ED on 01/13/2015. Interview revealed he relieved the previous Deputy this morning (01/14/2015) at shift change. Interview revealed the previous Deputy placed the patient into "ankle shackles." Interview revealed the "officer makes the decision wither or not the patient needs to be handcuffed	A 175		

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A 175	Continued From page 67 or shackled." Interview revealed Patient #14 was not going to jail and was not under arrest. Interview revealed he (CSD #1) was on standby until a mental health facility could be found for the patient. Interview revealed because the patient was in his custody, he was responsible for any of the patient's actions. Interview revealed when the patient complains the cuffs/shackles are too tight or hurting, he will use 2-3 fingers to check to see if the cuffs/shackles are too tight. Interview revealed there was no set schedule for periodically removing the cuffs/shackles or checking for tightness. Interview revealed the "patient lets me know if they are too tight." Interview revealed if the patient needed to go to the restroom, the cuffs/shackles are removed. Interview revealed he does not check pulses or skin for circulation. Interview revealed the nurse is responsible for taking care of the patient's medical needs. Interview revealed he does not document in the patients ED medical record. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the	A 175		

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A 175	Continued From page 68 IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #14 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 2. Observation during ED tour on 01/14/2015 at 1438 of exam room #5, revealed the room was located diagonally across from the nursing station. Observation revealed the room had a wood door. Observation revealed a female patient (Patient #16) wearing green disposable scrubs and laying on her left side on the stretcher, watching television. Observation	A 175		

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A 175	Continued From page 69 revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's left wrist was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. Observation revealed an ABC City Police Department officer was sitting behind the nursing station in a cubical, reading a magazine. Observations from 1438 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #5. Open medical record review on 01/15/2015 for Patient #16 revealed an 18 year old female presented to the Hospital's ED on 01/13/2015 at 1726 for "potential drug overdose." Review revealed the patient was triaged by a RN at 1732 and was assessed by a ED Physician at 1734. Review revealed the patient was assessed at 1912 by a mobile crisis worker. Review revealed on 01/14/2015 at 0050, the patient was IVC for being mentally ill and dangerous to self and others. Review revealed at 0200 and 0400, the patient's behavior was documented as asleep with parent and LEO at bedside. Review revealed from 0600 to 01/15/2015 at 0515, the patient's behavior was documented as asleep, tearful, and resting quietly in bed, resting in bed with eyes closed and laying in bed with eyes closed. Review revealed at 0536, the patient requested the "shackle" (restraint) be loosened and the hospital staff informed the LEO. Review revealed at 0725, the patient behavior was documented as alert and oriented with right lower	A 175		

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A 175	Continued From page 70 extremity "cuffed" (restraint) to bed frame. Review revealed at 0835, the patient was transferred to a Psychiatric hospital. Record review failed to reveal any available documentation Patient #16 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 1726 through discharge on 01/15/2015 at 0835. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED	A 175		

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A 175	Continued From page 71 Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #16 while she was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 3. Observation during ED tour on 01/14/2015 at 1430 of exam room #1, revealed an ante room was located diagonally across from the nursing station. Observation revealed the room was an	A 175		

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A 175	Continued From page 72 isolation room. Observation revealed to view a patient required walking into the ante room, turning right and proceeding approximately 4 feet to enter the isolation room proper. Observation revealed a male patient (Patient #13) wearing green disposable scrubs and laying supine on the stretcher with both hands across his abdomen. Observation revealed the stretcher's two side rails were up. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right ankle was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the isolation room alone and without direct supervision of a LEO. Observation revealed an ABC City Police Department officer was sitting behind the nursing station in a cubical and due to location he could not observe the patient. Observation revealed from the LEO's location the ante room could be observed only. Observations from 1430 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #7. Open medical record review on 01/14/2015 for Patient #13 revealed a 26 year old male presented to the hospital ED (Emergency Department) on 01/13/2015 at 0125 with thoughts of suicide and for substance abuse detoxification. Review revealed at 0127, the patient was triaged by a RN and at 0234, the patient was assessed by a ED Physician. Review revealed at 0840, the patient was assessed by a mobile crisis worker and was admitted for suicidal thoughts. Review revealed at 1600, the patient was IVC (Involuntary Commitment) due to mentally ill and dangerous to self and others. Further review	A 175		

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revealed when the patient was IVC, LEO (Law Enforcement Officer) placed the patient in leg shackles. Review revealed at 1800 and 2000, the patient's behavior was documented as calm and resting with eyes closed with the right ankle in shackled (restraint). Review revealed on 01/14/2015 at 0000, 0200, 0430, 0600, 0735 and 0935, the patient behavior was documented as asleep and resting quietly with the right ankle shackled. Review revealed at 1645, the patient was transferred to a Psychiatric hospital for treatment. Review revealed no documentation the patient demonstrated violent or self-destructive behaviors. Record review failed to reveal any available documentation Patient #13 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 0125 through discharge on 01/14/2015 at 1645.

Interview with ABC Police Officer #1 on 01/14/2015 at 1435 revealed he was responsible for 3 patients under IVC in the ED at this time. The interview revealed he stations himself at an area in the corner. The interview revealed he can observe the patient in the seclusion room and the patient in room #5. The interview revealed Officer # 1 was not allowed to answer any further questions. The interview revealed a phone number to two Lieutenant at the City Police Department if further questions needed to be asked.

Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview

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revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles.

Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police."

Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #13 while he was restrained in

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A 175	Continued From page 75 the ED with metal cuffs/shackles placed by a law enforcement officer. 4. Observation during ED tour on 01/14/2015 at 1430 of the seclusion room #7 revealed a room with a solid wood door and window with blinds and the blinds were outside covering the window. Observation revealed on the left side of the room at the head of the stretcher a metal plate with two sharp pointed corners partially attached to the wall. Observation revealed the metal plate could be easily pulled further off of the wall. When exiting the room a male patient (Patient #17) was observed standing calmly beside with door EMS personnel at his side. Observation revealed the patient was escorted into the seclusion room along with the Mental Health Nurse (MHRN). Approximately 10 minutes 2 City LEOs were observed entering the seclusion room and the MHRN standing out side of the room. The door and the blinds were closed. Interview with the MHRN during the observation revealed City LEO were in the room searching the patient, putting the patient in scrubs and cuffing the patient. The interview revealed the LEO cuffed the patient because the patient was IVC. The interview revealed that even if the patient is calm and cooperative the patient is always cuffed. The interview revealed the MHRN had training on the Hospital policy and procedure for restraining patients in October, 2014. The interview revealed she was also aware of the revision of the restraint and seclusion policy completed in December, 2014. Patient #17 was observed during the interview with both wrist cuffed with metal cuffs Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft	A 175		

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A 175	Continued From page 76 limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview with ABC Police Officer #1 on 01/14/2015 at 1435 revealed he was responsible for 3 patients under IVC in the ED at this time. The interview revealed he stations himself at an area in the corner. The interview revealed he can observe the patient in the seclusion room and the patient in room #5. The interview revealed Officer # 1 was not allowed to answer any further questions. The interview revealed a phone number to two Lieutenant at the City Police Department if further questions needed to be asked. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into	A 175		

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A 175	Continued From page 77 the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring patients while restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 5. Closed medical record review of Patient #12 revealed a 9 (nine) year old child presenting to the Emergency Department with mother on 12/12/2014 at 2001 with a chief complaint of "Pt (patient) with hx (history) of ADHD (Attention Deficient Hyperactivity Disorder) seen by daymark and referred to ER for psych eval. (evaluation). Mother sts (states) pt acting out when not getting 'his way'. Mother sts pt using foul language, and damaging property at home. Pt age appropriate, resp (respirations) even and unlabored, NAD (no acute distress)." Medical record review revealed documentation by nursing staff that triage was conducted at 2003 and the child was alert responded to voice and was oriented to person, time and place. Review of nursing documentation at 2002 revealed the "Pt ambulated to ER-1 - Pt very agitated and uncontrollable. Pt screaming, constantly in motion and tearing up thins at home. Pt using foul	A 175		

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language". Medical record review revealed documentation of the physician's medical screening exam (MSE) on 12/12/2014 at 2010 in room 1. Review of the MSE revealed the parent was with the patient during the exam and the child was "angry, frustrated, agitated". Review of the MSE revealed the clinical impression by the physician was ADHD. Review of nursing documentation revealed at 2140 the patient was"very agitated - screaming, rolling around on floor, slapping at wall and not following instructions. Medical record review revealed the patient was administered per physician's order Ativan (medication for treatment of anxiety disorders) 1 mg IM at 2219 and Benadryl 25 (medication used for psychiatric symptoms) mg IM at 2213. Medical record review revealed documentation on the "Appropriateness/Justification for Acute Medical/Surgical Restraint" form of a physician's order for the patient to be physically restrained due to "Pt's (patient's) behavior uncontrollable - spitting, scratching- trying to bite, cursing- uncontrollable with meds." Further review of the physician's order for restraint revealed the restraint type was ordered "Soft limb holders...Four Side Rails". Review of the type order revealed no documentation of which limbs or how many limbs were to be restrained. Review of the order revealed the restraint was initiated on 12/12/ 2014 at 2248 and the order was signed by the physician at 2250. Review of the order did not reveal any documentation of the time limit for restraining the child. Medical record review revealed documentation at 2254 the restraint was discontinued. Medical record review did not reveal any documentation of a one hour face to face examination after the child was placed in restraints. Review of nursing documentation

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revealed at 2230 "mental health case worker in to evaluate pt". Review of the mental health staff documentation at 2300 revealed "client was being placed in a four point restrain by hospital staff. Client was displaying aggressive behaviors to his mother and medical staff...Client damaged hospital property...Client had to be move to the seclusion room where all items were removed including bed...Client continued his aggressive behavior for about two hours which led to the doctor giving client 25 mg Benedryl IM at 10:10 pm and 1 mg ativan IM at 10:30 pm due to client continue disruptive behavior client was given 2 mg of Haldol IM at 11:10 pm...continue disruptive behavior for about thirty minutes before calming down at that time XXX County Officer arrived and placed patient into custody. Medical staff place bed back into seclusion room at that time...Client had to be place in four point restraints by medical staff." Record review revealed documentation of "Petition for involuntary commitment" dated 12/12/2014 and completed by the physician stating the patient was agitation and a danger to self and others and requested inpatient treatment and stabilization. Nursing documentation at 2254 revealed "Pt got himself out of restrains, still out of control. Nursing documentation revealed at 2306 the patient was moved to room 7 for seclusion and at 2314 the patient was hitting the door. Nursing documentation at 2309 revealed the patient was kicking scratching and spitting and trying to "break down door, Haldol (antipsychotic medication) 2 mg IM" was given. Further review of nursing documentation revealed the patient calmed down at 2340, "resting on floor...placed on cardiac monitor" and was placed in bed. Documentation by nursing staff revealed at 2345 the patient was "IVC'd and restrained by law enforcement with ankle cuff to left ankle and

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A 175	Continued From page 80 bed. Pt sleeping without distress". Nursing documentation revealed on 12/13/2014 at 0100, 0200, 0300, 0400 and 0600 the patient was sleeping without distress. Documentation revealed the patient was offered water at 0300, refused and took sips of water at 0600. Review of nursing documentation revealed no documentation of assessment at 0500. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/12/2014 from 2350 until 12/13/2014 at 0720 revealed the patient was " A-resting in bed". Review of nursing documentation on 12/13/2014 at 0730 revealed law enforcement was present and the child's "left ankle cuffed to bed rail per law enforcement protocol." Nursing documentation revealed at 0810 the patient was yelling "I'm hungry" and the staff "encouraged to relax breakfast will be coming soon." Documentation at 0835 revealed the child continued yell for the nurse and the child was given orange juice and peanut butter crackers. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/13/2014 from 0900 until 12/14/2014 at 0716 revealed the patient was " A-resting in bed". Documentation at 0900 revealed the breakfast tray was made available to the child and at 0940 he was asleep. Nursing documentation at 1100 revealed the child told nursing staff that heard and sees the devil telling him to do it". Review of nursing documentation at 1300 revealed the patient was released from forensic restraints by the LEO and the patient ran. Documentation revealed "the officer captured pt and brought back to room pt began banging forensic restraints PRN (as needed) given at 1322". Nursing documentation at 1400 revealed the patient was medicated due to the patient not taking redirection. Nursing documentation	A 175		

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revealed the patient slept until 1905 when he awoke and asked for dinner. Nursing documentation at 1951 revealed the patient was placed in "4 pt (point) forensic restraints after "slamming upon bed and jumping up and down, cursing and threatening staff." Nursing documentation revealed at 2000 "remains in 4 pt restraints...Ativan was given, at 2012 "remains in 4 pt restraint, at 2033 "Forensic arm restraint removed. Leg shackles remain...Pt being monitored by nurses and officer." Documentation at 2045 revealed the patient was placed back in 4 point restraints due to cursing and yelling. documentation at 2118 revealed the patient remained in 4 point restraints and "Haldol given as ordered". Documentation at 2215 revealed the patient remained in 4 point restraints. review of nursing documentation on 12/14/2014 at 0615 revealed the patient slept since being medicated at "midnight" and "remains in restraints". Documentation by nursing staff at 0820 revealed the "pt yelling out 'I'm wet' In room to assess pt. pt voided self and floor. Officer in room to uncuff pt...pt c/o (complained of) 'my moms gonna be so mad I pissed myself'." Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/14/2014 from 0830 until 12/16/2014 at 0630 revealed the patient was " A-resting in bed". Documentation revealed the patient was cleaned and rested quietly until 1345. Documentation at 1345 revealed an attempt was made to remove one restraint "Pt climbing over bed. Forensic restraint had to be reapplied "Pt cursing, yelling, urinated on self". Record review revealed the patient was administered Haldol IM at 1415 and was documented resting at 1455 (40 minutes after medication), 1548 (53 minutes after previous assessment), 1639 (1 hour later) and at 1730 (51 minutes later). Nursing documentation

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revealed the patient rested quietly from 12/15/2014 at 2400 through 1319 (13 hours) with law enforcement. Nursing documentation revealed the patient cried at intervals for his mother. Nursing documentation at 1500 revealed the patient was up to the bathroom "for BM (bowel movement) x1. Shackles on." Review of nursing documentation did not reveal any documentation of the patient having disruptive or aggressive behaviors prior to or after going to the bathroom. Nursing documentation revealed no documentation of aggressive, agitated or self destructive behavior from 1600 on 12/15/2014 through 12/16/2014 at 0710. Documentation at 0710 revealed the LEO was at the bedside. Nursing documentation on 12/16/2014 at 1100 revealed "Patient kept yelling out 'Nurse, Nurse'...mental health,charge nurse and writer in room to talk to patient that if he stops yelling out loud he could be able to talk to his mother and will be moved to a room with tv". Documentation at 1140 revealed the patient vomited yellowish emesis on the floor and told the nurse he "does not feel good". Documentation revealed the nurse notified the physician and at 1315 the patient continued to yell out for the Nurse. Documentation at 1500 revealed the patient vomited a second time and the physician was made aware. Documentation revealed Zofran (antemetic) IV was administered at 1830 and Normal Saline infused at a "bolus rate". Record reviewed revealed nursing documentation at 2030 (2 hours after medication) that the patient was resting. Record review revealed on 12/17/2014 at 1045 the patient was administered Ativan 1 mg IM, Zofran by mouth and the patient had pulled out his IV. Record review revealed at 1055 the patient was placed in 4 point restraints by LEO for yelling, not following directions and

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A 175	Continued From page 83 "pulling the stretcher to the door." Review of documentation by mental health staff on 12/17/2014 at 1120 revealed "Client pulled out his IV in his hand and made himself vomit. Client has escalated to where he is yelling constantly and has had both hands and one leg put in restraints." Nursing documentation revealed at 1357 the patient remained in "2 pt forensic restraints" (3 hours since last documentation). Review of nursing documentation on 12/18/2014 at 1110 revealed the patient remained in 2 point forensic restraints. Nursing documentation revealed at 1230 the patient complained of urinating on self. Review of documentation by mental health staff at 1400 revealed "Reassessment completed. Client continues to yell and have outburst. Staff not able to redirect. Client has been medicated and is still in restrains. Client now has a one on one staff member sitting with him. Client has been calmer when staff person is sitting with him." Documentation by nursing at 1445"staff member sitting with pt 1:1". Nursing documentation at 1645 and 1755 revealed a staff member sat with the patient 1:1 and the patient was "pleasant & cooperative." Documentation by nursing on 12/18/2014 revealed the "officer" was at the bedside and the patient "remains cooperative.' Review of nursing documentation on 12/19/2014 at 0730 revealed "Pt unshackled by officer so RN could assist pt with bath...Pt states 'these cuffs make my feet hurt'. " Record review did not reveal any documentation of an assessment of the patient's feet after he complained of hurting due to the "cuffs". Review of documentation by mental health staff at 1010 revealed "Reassessment completed. Client continues to yell out and not follow directions. Client is still in restraint." Review of nursing documentation at 1845	A 175		

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A 175	Continued From page 84 revealed LEO was at the hospital to transport the patient to an acute psychiatric hospital. Medical record review revealed documentation on 12/20/2014 at 1200, a written physician certification order for the transfer of the child to a psychiatric acute hospital for psychiatric services not available at the hospital. Review of the certification revealed the patient remained under IVC and was transported by law enforcement officer. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles.	A 175		

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A 175	Continued From page 85 Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #12 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 5. Closed medical record review on 01/14/2015 revealed Patient #9 presented to the hospital's ED on 11/01/2013 at 1106 via private	A 175		

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A 175	Continued From page 86 transportation accompanied by group home staff. Review revealed the patient's chief complaint was Crisis Evaluation Referral. Review of triage nurse documentation at 1116 revealed "pt admitted to new group home Monday, staff reports pt made threats to 'kill himself and everybody else.' Stated pt attempted to run away." Review of initial nursing assessment documentation revealed the patient was alert, awake, responsive to voice, oriented to person, time, and place. Review of a ED risk screen revealed the patient was assessed as "No" for risk for self harm/elopement. Record review revealed the patient was initially placed in exam room #20. Review revealed the patient was evaluated by a ED physician at 1109. Review revealed a chief complaint of suicidal thoughts, expressing SI (suicidal ideation) and HI (homicidal ideation). Review revealed a past medical history of bipolar disorder, schizophrenia, and moderate mental retardation (MR). Review revealed the patient was assessed as no acute distress; awake and alert; oriented X4 (person, place, time, and situation); mood and affect normal. Extremities non-tender and no signs of injury. Review of a Affidavit and Petition For Involuntary Commitment form dated 11/01/2013 (note timed) revealed the Respondent was Patient #9 and the Petitioner was ED Physician A. Review revealed "The facts upon which this opinion is based are as follows....Patient is mentally challenged with history of Bipolar D/O (disorder) and Schizophrenia who is very unstable at this time. He is making threats that he will kill others at the group home and himself." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 11/01/2013 at 1200 revealed "Description of Findings" with "...Patient is mentally challenged	A 175		

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with history of Bipolar and Schizophrenia who is very unstable at this time. He is making threats to kill himself and others - needs in-patient stabilization." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 11/01/2013 at 1258 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #9) is probably: [X] 1. mentally ill and dangerous to self or others...." Review revealed the respondent was taken into custody by ABC City Police Officer on 11/01/2013 at 1336 (Patient in ED when taken into custody). Review of a Computerized Physician's Order Entry (CPOE) report, Order # 26, CPOE #398912, revealed a physician's order entered by ED Physician A on 11/01/2013 at 1358 for "Restraints, Place in", Frequency: "ONCE", Priority: "Routine". Review of a Comprehensive Assessment Tool-Intake form dated 11/01/2013 at 1452 revealed "...presents to (Hospital A) - ED c group staff. Staff from group home report clt (client) was trying to run away this am and threatened to kill self as well as staff. Upon admission clt was making a gun with his fingers and placing it to the head of staff, threatening to stab another staff c a plastic fork and being verbally abusive. ...Clt was restrained on admission c forensic restraints and required pepper spray p (after) refusing chemical restraint. ..." Review of nursing documentation revealed on 11/01/2013 at 1106 "Pt cc HI. Pt @ (at) group home. MR high functioning w (with)/Psychosis + (and) Bipolar. Pt pretending to shoot staff + 'flipping off' other patients from room." At 1245, "Pt moved to isolation room (Exam Room #1), IVC in place, officer @ bedside. Pt acting iriatic

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[sic], cuffed (restraint) to bed, Pt had previously tried to hang self w/belt. Now threatening officer + trying to bite him, Pt trying to break free from cuffs, bed now broken, officer warning pt of violent behavior." At 1400, "Pt out of control, violent, calling everyone 'F**king Bi**hs.' Broke posey chest vest....threatening to kill officer. Pt sprayed w/pepper spray @ close range." At 1410, "Pt refusing flushing treatment. V/S (vital signs) WNL (within normal limits), resting in bed with eyes open, resp (respirations) nonlabored." At 1600, "Pt starting to yell out again, HPD (ABC City Police Department) at bedside." At 1755, "Pt resp WNL..." Review of Crisis Assessment documentation by mobile crisis management staff for Patient #9 dated 11/01/2013 at 1800 revealed the reason for referral was physical aggression, property destruction, threats of physical aggression, running away, verbal aggression, hallucinations or delusions, homicidal and suicidal. Review revealed "Became aggressive at GH (group home). Threatened to stab + shoot self + others. Ran to neighbors. Upon entering ED he refused meds + put a belt around his neck. He had to be pepper sprayed + put in 4 point restraints. ..." Review of mental status examination revealed the patient was disheveled with poor hygiene, and in 4 point restraints. Review revealed the patient had good eye contact, was calm, and had no impairment with communication and appropriate speech. Review revealed the patient's mood was depressed, slightly withdrawn, and cooperative. Review of nursing documentation revealed at 1900, "...Pt sleeping on bed in 4 point restraints. HPD c (with) patient." At 2230, "Sleeping. Quiet and cooperative." At 0100 (11/02/2013), Pt continues to sleep soundly." At 0300, "Pt. continues to sleep with restraints to wrist." At 0730,

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"Observed asleep. Law enforcement present. ..." At 0930, "Mental Health Services cont. (continue) to evaluate for mental health facility placement." At 1050, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1330, "...Remains cooperative. No suicidal or homicidal gestures." At 1440, "...Remains cooperative..." At 1555, "Law enforcement remains present. ...No suicidal or homicidal gestures." At 1900, "Pt moved to room 7 (Seclusion Room). Police officer remains @ bedside..." At 2000 to 0200 (11/03/2013) continued observation by police officer. At 0327, "...Pt calm + cooperative...." At, 0600 "...Calm Cooperative....Officer outside of rm (room)." At 0705, "...Pt calm + cooperative..." At 0930, "...HPD officer sitting outside of rm..." At 1330, "Pt remains calm + cooperative..." At 2055, "Pt. calm + cooperative...Rt. ankle remains shackled to stretcher by HPD. Good PMS (pulse, motor, sensation). Pt remains IVC'd." At 2300, "Pt continues to watch TV..." At 1130 (11/04/2013), "...cooperative..." At 0810, "Remains cooperative..." At 0900, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1545, "...Remains Cooperative...No suicidal/homicidal gestures. ..." At 1800, "Remains cooperative..." At 2040, "...Pt. pleasant + cooperative..." At 0140 (11/05/2013), "Resting c eyes closed....Law enforcement present." At 0815, "...Remains cooperative." At 1400, "...Law enforcement remains present. No suicidal/homicidal gestures." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 11/05/2013 at 1745 revealed "Description of Findings" with "...Pt now stabilized, A+OX4, (No) HI, SI. D/W (discussed with) group home for disposition. Does not currently meet IVC criteria." Review of ED physician reassessment

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A 175	Continued From page 90 documentation at 1755 (11/05/2013) revealed the patient was re-examined and has improved, AOX4, Stable, No homicidal or suicidal ideation. Group home agrees to assume care. Review revealed a clinical impression of Psychosis, Schizophrenia, acute exacerbation. Review of nursing documentation revealed at 1858, "...Taken back to group home per law enforcement. ..." Record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED	A 175		

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A 175	Continued From page 91 Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #9 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 7. Closed medical record review revealed Patient #2, admitted on 09/11/2014 diagnosed with anemia and gastrointestinal bleeding. Record review revealed on 09/14/2015 at 0700 the Patient was placed in soft upper limb restraints	A 175		

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A 175	Continued From page 92 with all 4 side rails of the bed placed in the up position. Medical record review revealed on 09/14/2014 0930 the following components of restraint documentation; "Restraint adjustments made to promote comfort and decrease and potential for harm, Loosened/Rotated Restraints, Foley in Place, Lying Down". Medical record review revealed no components of restraint documentation from 1200-1600 (4 hours). No further restraint components were documented from 09/14/2015 2000 until 09/15/2015 0400(8 hours). Interview on 01/15/2015 1130 with Nursing Systems Analyst, revealed there was no further restraint documentation available for review. The interview revealed "All you see is here, there's nothing else there." The interview indicated the Nursing staff is expected to document restraint assessments every 2 hours.	A 175		
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: Based on hospital policy and procedure reviews,	A 178	A178 – Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to protect and promote each patient's rights. The following actions have been implemented in support of Tag A 178: • The Medical Director of the ED re-educated all ED physicians specifically for the need of a one hour face-to-face evaluation performed by a qualified practitioner.	1/22/2015

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A 178	Continued From page 93 medical record reviews and staff interviews, the hospital's Emergency Department (ED) staff failed to ensure a 1-hour face-to-face evaluation was performed by a qualified physician or other licensed independent practitioner (LIP) or trained Registered Nurse (RN) after the initiation of restraint for 2 of 2 patients restrained in the ED for management of violent or self-destructive behaviors (#12, #9). The findings include: Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. ...DEFINITIONS: ...Restraints for Violent or Self-Destructive Behavior: refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting. ...PROCEDURE FOR USE OF RESTRAINT: Initiation and Renewal of Orders ...When use of restraints is contemplated, a physician/LIP or RN who has been trained in restraint application must document a face-to-face assessment prior to applying restraints, and document the need for restraint within the 1 hour time frame. ...The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following: *an evaluation of the patient's immediate situation *the patient's reaction to the restraint *the	A 178	Continued from page 93 **Monitored** by Director of Quality and reported to Patient Safety and Clinical Quality Committee with minutes from this committee going to the Board of Trustees a minimum of ten times a year. • Physician documentation will include their initial assessment as well as reassessment of the appropriateness of continuing restraints using Mental Health Reassessment form (Attachment E). Reassessment is based on the patient's age; every four hours for adults 18 years or older, every two hours for children ages 9 – 17, every hour for children under 9. • Responsible Person – Nursing Director ED	

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A 178	Continued From page 94 patient's medical and behavioral condition *the need to continue or terminate the restraint or seclusion. ...For Violent/Self-Destructive Restraints [V/SD] A physician/LIP or trained RN must document a face-to-face assessment within 1 hour of implementation of restraint or seclusion. The 1-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior. During the face-to-face assessment, the qualified practitioner will evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion. ..." 1. Closed medical record review of Patient #12 revealed a 9 (nine) year old child presenting to the Emergency Department with mother on 12/12/2014 at 2001 with a chief complaint of "Pt (patient) with hx (history) of ADHD (Attention Deficient Hyperactivity Disorder) seen by daymark and referred to ER for psych eval. (evaluation). Mother sts (states) pt acting out when not getting 'his way'. Mother sts pt using foul language, and damaging property at home. Pt age appropriate, resp (respirations) even and	A 178	Continued from page 95 **Monitoring:** Quality Director or designee conducting Monday - Friday restraint rounds in the Emergency Department and Nursing Supervisors Saturday - Sunday. Quality Director will continue to audit 100% of restraint patient charts to assure appropriate time limited orders. Any deficiencies are immediately reported to the Nursing Director of the ED for resolution. Restraint audits will be reported to the Patient Safety & Clinical Quality Committee at a minimum of ten times a year with minutes of this committee going to the Board of Trustees.	

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A 178	Continued From page 95 unlabored, NAD (no acute distress)." Medical record review revealed documentation by nursing staff that triage was conducted at 2003 and the child was alert responded to voice and was oriented to person, time and place. Review of nursing documentation at 2002 revealed the "Pt ambulated to ER-1 - Pt very agitated and uncontrollable. Pt screaming, constantly in motion and tearing up thins at home. Pt using foul language". Medical record review revealed documentation of the physician's medical screening exam (MSE) on 12/12/2014 at 2010 in room 1. Review of the MSE revealed the parent was with the patient during the exam and the child was "angry, frustrated, agitated". Review of the MSE revealed the clinical impression by the physician was ADHD. Review of nursing documentation revealed at 2140 the patient was"very agitated - screaming, rolling around on floor, slapping at wall and not following instructions. Medical record review revealed the patient was administered per physician's order Ativan (medication for treatment of anxiety disorders) 1 mg IM at 2219 and Benadryl 25 (medication used for psychiatric symptoms) mg IM at 2213. Medical record review revealed documentation on the "Appropriateness/Justification for Acute Medical/Surgical Restraint" form of a physician's order for the patient to be physically restrained due to "Pt's (patient's) behavior uncontrollable - spitting, scratching- trying to bite, cursing- uncontrollable with meds." Further review of the physician's order for restraint revealed the restraint type was ordered "Soft limb holders...Four Side Rails". Review of the type order revealed no documentation of which limbs or how many limbs were to be restrained. Review of the order revealed the restraint was initiated on	A 178		

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A 178	Continued From page 96 12/12/ 2014 at 2248 and the order was signed by the physician at 2250. Review of the order did not reveal any documentation of the time limit for restraining the child. Record review did not reveal any documentation of an one hour face to face evaluation. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of a face-to-face within 1-hour after initiation of restraint for Patient #12 because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview confirmed the documentation of the physician's order for restraint signed by the ED physician on 12/12/2014 at 2250. Interview confirmed the ED staff did not follow the hospital's Restraint of Patient policy. 2. Closed medical record review on 01/14/2015 revealed Patient #9 presented to the hospital's ED on 11/01/2013 at 1106 via private transportation accompanied by group home staff. Review revealed the patient's chief complaint (cc) was Crisis Evaluation Referral. Review of triage nurse documentation at 1116 revealed "pt admitted to new group home Monday, staff reports pt made threats to 'kill himself and everybody else.' Stated pt attempted to run away." Review of initial nursing assessment documentation revealed the patient was alert,	A 178		

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A 178	Continued From page 97 awake, responsive to voice, oriented to person, time, and place. Review of a ED risk screen revealed the patient was assessed as "No" for risk for self harm/elopement. Review revealed the patient was evaluated by a ED physician at 1109. Review revealed a chief complaint of suicidal thoughts, expressing SI (suicidal ideation) and HI (homicidal ideation). Review revealed a past medical history of bipolar disorder, schizophrenia, and moderate mental retardation (MR). Review revealed the patient was assessed as no acute distress; awake and alert; oriented X4 (person, place, time, and situation); mood and affect normal. Extremities non-tender and no signs of injury. Review of a Affidavit and Petition For Involuntary Commitment form dated 11/01/2013 (note timed) revealed the Respondent was Patient #9 and the Petitioner was ED Physician A. Review revealed "The facts upon which this opinion is based are as follows....Patient is mentally challenged with history of Bipolar D/O (disorder) and Schizophrenia who is very unstable at this time. He is making threats that he will kill others at the group home and himself." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 11/01/2013 at 1258 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #9) is probably: [X] 1. mentally ill and dangerous to self or others...." Review revealed the respondent was taken into custody by ABC City Police Officer on 11/01/2013 at 1336 (Patient in ED when taken into custody). Review of a Computerized Physician's Order Entry (CPOE) report, Order # 26, CPOE #398912, revealed a physician's order entered by	A 178		

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A 178	Continued From page 98	A 178		

ED Physician A on 11/01/2013 at 1358 for "Restraints, Place in", Frequency: "ONCE", Priority: "Routine". Review of nursing documentation revealed on 11/01/2013 at 1106 "Pt cc HI. Pt @ (at) group home. MR high functioning w (with)/Psychosis + (and) Bipolar. Pt pretending to shoot staff + 'flipping off' other patients from room." At 1245, "Pt moved to isolation room, IVC in place, officer @ bedside. Pt acting iriatic [sic], cuffed (restraint) to bed, Pt had previously tried to hang self w/belt. Now threatening officer + trying to bite him, Pt trying to break free from cuffs, bed now broken, officer warning pt of violent behavior." At 1400, "Pt out of control, violent, calling everyone 'F**king Bi**hs.' Broke posey chest vest....threatening to kill officer. Pt sprayed w/pepper spray @ close range." At 1410, "Pt refusing flushing treatment. V/S (vital signs) WNL (within normal limits), resting in bed with eyes open, resp (respirations) nonlabored." Review of a Comprehensive Assessment Tool-Intake form dated 11/01/2013 at 1452 revealed "...presents to (Hospital A) - ED c (with) group staff. Staff from group home report clt (client) was trying to run away this am and threatened to kill self as well as staff. Upon admission clt was making a gun with his fingers and placing it to the head of staff, threatening to stab another staff c a plastic fork and being verbally abusive. ...Clt was restrained on admission c forensic restraints and required pepper spray p (after) refusing chemical restraint. ..." Review of nursing documentation revealed at 1600, "Pt starting to yell out again, HPD (ABC City Police Department) at bedside." At 1755, "Pt resp WNL..." Review of Crisis Assessment documentation by mobile crisis management staff for Patient #9 dated 11/01/2013 at 1800 revealed the reason for referral was physical aggression,

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A 178	Continued From page 99 property destruction, threats of physical aggression, running away, verbal aggression, hallucinations or delusions, homicidal and suicidal. Review revealed "Became aggressive at GH (group home). Threatened to stab + shoot self + others. Ran to neighbors. Upon entering ED he refused meds + put a belt around his neck. He had to be pepper sprayed + put in 4 point restraints. ..." Review of mental status examination revealed the patient was disheveled with poor hygiene, and in 4 point restraints. Review of nursing documentation revealed at 1900, "...Pt sleeping on bed in 4 point restraints. HPD c (with) patient." Record review failed to reveal documentation of a 1-hour face-to-face assessment of Patient #9, conducted by a qualified physician/LIP or trained RN within 1 hour (1246 to 1345) after implementation of restraint for violent or self-destructive behaviors on 11/01/2013 at 1245 and within 1 hour (1401-1500) after being sprayed with pepper spray (a weapon) while restrained at 1400; that included the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion per hospital policy. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of a face-to-face within 1-hour	A 178		

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A 178	Continued From page 100 after initiation of restraint for Patient #9 because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview confirmed the documentation of the CPOE order for restraint entered by ED Physician A on 11/01/2013 at 1358. Interview confirmed the ED staff did not follow the hospital's Restraint of Patient policy.	A 178		
A 179	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION [the patient must be seen face-to-face within 1 hour after the initiation of the intervention --] §482.13(e)(12)(ii) To evaluate - 1. The patient's immediate situation; 2. The patient's reaction to the intervention; 3. The patient's medical and behavioral condition; and 4. The need to continue or terminate the restraint or seclusion. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record reviews, and staff interviews the hospital's Emergency Department (ED) staff failed to ensure the physician or other licensed independent practitioner (LIP) or trained RN conducting the face-to-face evaluation within 1 hour after the initiation of restraint evaluated the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint for 2 of 2 patients (#12, #9) restrained for the management of violent or self-destructive behaviors. The findings include:	A 179	A179 – Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to protect and promote each patient's rights. The following actions have been implemented in support of Tag A 179: • The Medical Director of the ED re-educated all ED physicians specifically for the need of a one hour face-to-face evaluation performed by a qualified practitioner. **Monitored** by Director of Quality or and reported to Patient Safety and Clinical Quality Committee with minutes from this committee going to the Board of Trustees a minimum of ten times a year with the report going to the Board of Trustees. • Responsible person Chief Nursing Officer	1/22/2015

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A 179	Continued From page 101 Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. ...DEFINITIONS: ...Restraints for Violent or Self-Destructive Behavior: refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting. ...PROCEDURE FOR USE OF RESTRAINT: Initiation and Renewal of Orders ...When use of restraints is contemplated, a physician/LIP or RN who has been trained in restraint application must document a face-to-face assessment prior to applying restraints, and document the need for restraint within the 1 hour time frame. ...The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following: *an evaluation of the patient's immediate situation *the patient's reaction to the restraint *the patient's medical and behavioral condition *the need to continue or terminate the restraint or seclusion. ...For Violent/Self-Destructive Restraints [V/SD] A physician/LIP or trained RN must document a face-to-face assessment within 1 hour of implementation of restraint or seclusion. The 1-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition	A 179	Continued from page 102 • Physician documentation will include their initial assessment as well as reassessment of the appropriateness of continuing restraints. using the Mental Health Reassessment form (Attachment E). Reassessment is based on the patient's age; every four hours for adults 18 years or older, every two hours for children ages 9 – 17, every hour for children under 9. (Director, ED) **Monitoring:** Quality Director or designee conducting Monday - Friday restraint rounds in the Emergency Department and Nursing Supervisors Saturday - Sunday. Quality Director will continue to audit 100% of restraint patient charts to assure appropriate time limited orders. Any deficiencies are immediately reported to the Nursing Director of the ED for resolution. Restraint audits will be reported to the Patient Safety & Clinical Quality Committee at a minimum of ten times a year with minutes of this committee going to the Board of Trustees. • Responsible Person Chief Nursing Officer	

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A 179	Continued From page 102 would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior. During the face-to-face assessment, the qualified practitioner will evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion. ..." 1. Closed medical record review of Patient #12 revealed a 9 (nine) year old child presenting to the Emergency Department with mother on 12/12/2014 at 2001 with a chief complaint of "Pt (patient) with hx (history) of ADHD (Attention Deficient Hyperactivity Disorder) seen by daymark and referred to ER for psych eval. (evaluation). Mother sts (states) pt acting out when not getting 'his way'. Mother sts pt using foul language, and damaging property at home. Pt age appropriate, resp (respirations) even and unlabored, NAD (no acute distress)." Medical record review revealed documentation by nursing staff that triage was conducted at 2003 and the child was alert responded to voice and was oriented to person, time and place. Review of nursing documentation at 2002 revealed the "Pt ambulated to ER-1 - Pt very agitated and uncontrollable. Pt screaming, constantly in motion and tearing up thins at home. Pt using foul language". Medical record review revealed documentation of the physician's medical	A 179		

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A 179	Continued From page 103 screening exam (MSE) on 12/12/2014 at 2010 in room 1. Review of the MSE revealed the parent was with the patient during the exam and the child was "angry, frustrated, agitated". Review of the MSE revealed the clinical impression by the physician was ADHD. Review of nursing documentation revealed at 2140 the patient was"very agitated - screaming, rolling around on floor, slapping at wall and not following instructions. Medical record review revealed the patient was administered per physician's order Ativan (medication for treatment of anxiety disorders) 1 mg IM at 2219 and Benadryl 25 (medication used for psychiatric symptoms) mg IM at 2213. Medical record review revealed documentation on the "Appropriateness/Justification for Acute Medical/Surgical Restraint" form of a physician's order for the patient to be physically restrained due to "Pt's (patient's) behavior uncontrollable - spitting, scratching- trying to bite, cursing- uncontrollable with meds." Further review of the physician's order for restraint revealed the restraint type was ordered "Soft limb holders...Four Side Rails". Review of the type order revealed no documentation of which limbs or how many limbs were to be restrained. Review of the order revealed the restraint was initiated on 12/12/ 2014 at 2248 and the order was signed by the physician at 2250. Review of the order did not reveal any documentation of the time limit for restraining the child. Record review did not reveal any documentation of an one hour face to face evaluation. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic"	A 179		

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A 179	Continued From page 104	A 179		

restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of a face-to-face within 1-hour after initiation of restraint for Patient #12 because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview confirmed the documentation of the physician's order for restraint signed by the ED physician on 12/12/2014 at 2250. Interview confirmed the ED staff did not follow the hospital's Restraint of Patient policy.

2. Closed medical record review on 01/14/2015 revealed Patient #9 presented to the hospital's ED on 11/01/2013 at 1106 via private transportation accompanied by group home staff. Review revealed the patient's chief complaint (cc) was Crisis Evaluation Referral. Review of triage nurse documentation at 1116 revealed "pt admitted to new group home Monday, staff reports pt made threats to 'kill himself and everybody else.' Stated pt attempted to run away." Review of initial nursing assessment documentation revealed the patient was alert, awake, responsive to voice, oriented to person, time, and place. Review of a ED risk screen revealed the patient was assessed as "No" for risk for self harm/elopement. Review revealed the patient was evaluated by a ED physician at 1109. Review revealed a chief complaint of suicidal thoughts, expressing SI (suicidal ideation) and HI (homicidal ideation). Review revealed a past medical history of bipolar disorder, schizophrenia, and moderate mental retardation (MR). Review revealed the patient

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A 179	Continued From page 105	A 179		

was assessed as no acute distress; awake and alert; oriented X4 (person, place, time, and situation); mood and affect normal. Extremities non-tender and no signs of injury. Review of a Affidavit and Petition For Involuntary Commitment form dated 11/01/2013 (note timed) revealed the Respondent was Patient #9 and the Petitioner was ED Physician A. Review revealed "The facts upon which this opinion is based are as follows....Patient is mentally challenged with history of Bipolar D/O (disorder) and Schizophrenia who is very unstable at this time. He is making threats that he will kill others at the group home and himself." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 11/01/2013 at 1258 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #9) is probably: [X] 1. mentally ill and dangerous to self or others...." Review revealed the respondent was taken into custody by ABC City Police Officer on 11/01/2013 at 1336 (Patient in ED when taken into custody). Review of a Computerized Physician's Order Entry (CPOE) report, Order # 26, CPOE #398912, revealed a physician's order entered by ED Physician A on 11/01/2013 at 1358 for "Restraints, Place in", Frequency: "ONCE", Priority: "Routine". Review of nursing documentation revealed on 11/01/2013 at 1106 "Pt cc HI. Pt @ (at) group home. MR high functioning w (with)/Psychosis + (and) Bipolar. Pt pretending to shoot staff + 'flipping off' other patients from room." At 1245, "Pt moved to isolation room, IVC in place, officer @ bedside. Pt acting iriatic [sic], cuffed (restraint) to bed, Pt had previously tried to hang self w/belt. Now

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A 179	Continued From page 106	A 179		

threatening officer + trying to bite him, Pt trying to break free from cuffs, bed now broken, officer warning pt of violent behavior." At 1400, "Pt out of control, violent, calling everyone 'F**king Bi**hs.' Broke posey chest vest....threatening to kill officer. Pt sprayed w/pepper spray @ close range." At 1410, "Pt refusing flushing treatment. V/S (vital signs) WNL (within normal limits), resting in bed with eyes open, resp (respirations) nonlabored." Review of a Comprehensive Assessment Tool-Intake form dated 11/01/2013 at 1452 revealed "...presents to (Hospital A) - ED c (with) group staff. Staff from group home report clt (client) was trying to run away this am and threatened to kill self as well as staff. Upon admission clt was making a gun with his fingers and placing it to the head of staff, threatening to stab another staff c a plastic fork and being verbally abusive. ...Clt was restrained on admission c forensic restraints and required pepper spray p (after) refusing chemical restraint. ..." Review of nursing documentation revealed at 1600, "Pt starting to yell out again, HPD (ABC City Police Department) at bedside." At 1755, "Pt resp WNL..." Review of Crisis Assessment documentation by mobile crisis management staff for Patient #9 dated 11/01/2013 at 1800 revealed the reason for referral was physical aggression, property destruction, threats of physical aggression, running away, verbal aggression, hallucinations or delusions, homicidal and suicidal. Review revealed "Became aggressive at GH (group home). Threatened to stab + shoot self + others. Ran to neighbors. Upon entering ED he refused meds + put a belt around his neck. He had to be pepper sprayed + put in 4 point restraints. ..." Review of mental status examination revealed the patient was disheveled with poor hygiene, and in 4 point restraints.

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A 179	Continued From page 107 Review of nursing documentation revealed at 1900, "...Pt sleeping on bed in 4 point restraints. HPD c (with) patient." Record review failed to reveal documentation of a 1-hour face-to-face assessment of Patient #9, conducted by a qualified physician/LIP or trained RN within 1 hour (1246 to 1345) after implementation of restraint for violent or self-destructive behaviors on 11/01/2013 at 1245 and within 1 hour (1401-1500) after being sprayed with pepper spray (a weapon) while restrained at 1400; that included the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion per hospital policy. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of a face-to-face within 1-hour after initiation of restraint for Patient #9 because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview confirmed the documentation of the CPOE order for restraint entered by ED Physician A on 11/01/2013 at 1358. Interview confirmed the ED staff did not follow the hospital's Restraint of Patient policy.	A 179		
A 263	482.21 QAPI	A 263		

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A 263	Continued From page 108 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on restraint list/log documentation reviews, observations during tours, and staff interviews the hospital failed to maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement (QAPI) program for monitoring restraint in the ED. The findings include: 1. The hospital failed to have the Quality Assessment Performance Improvement (QAPI) program monitoring the effectiveness and safety of involuntary commitment (IVC) patients restrained by Law Enforcement Officers in the ED. ~Cross refer to 482.21 (b) Quality Assessment Performance Improvement, Standard Tag A0273.	A 263	A263 – Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to maintain an effective, ongoing, hospital-wide data-drive quality assessment and performance improvement program. The following actions have been implemented in support of A263: • Nursing Supervisors will include in their hand off a discussion of patients in restraints and are expected to review documentation of every patient in restraints and appropriateness of the restraints based on behavior. Care nurses will include in their hand off/shift huddle a review of the previous shift's documentation for completeness and continued need for restraints based on behavior. **Monitoring** will be through daily review of all patients in restraints for safety or behavioral by Director of Quality. Time frame for this monitor is three consecutive months of 100% compliance.	1/19/2015

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A 273	Continued From page 109	A 273	Continued from page 110	
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on restraint list/log documentation reviews, observations during tour, and staff interviews the hospital failed to have the Quality Assessment Performance Improvement (QAPI) program monitoring the effectiveness and safety of involuntary commitment (IVC) patients restrained by Law Enforcement Officers in the ED.	A 273	Responsible person: Chief Nursing Officer Restraint audits will be reported to the Patient Safety & Clinical Quality Trustees with a report to the Board of Trustees at a minimum of ten times each year.	

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A 273	Continued From page 110 The findings include: Interview on 01/14/2015 at 1420 during tour of the ED (1420-1500) with Charge Nurse #2 revealed the ED had three (3) patients currently under involuntary commitment (IVC) in exam rooms #1, #5, #17 and one (1) patient pending IVC in exam room #7. Observations during tour revealed all 4 patients (#13, #14, #17, #16) in the aforementioned exam rooms were observed in restraints (handcuffs/shackles) applied by Law Enforcement Officers. Review of a "Restraint List" dated 01/15/2015 at 1501 for the Hospital's nursing units and ED from 01/14/2015 at 0000 to 01/15/2015 at 1501 revealed no documentation of the names of Patients #13, #14, #17, and #16 observed in restraints during the ED tour on 01/14/2015 at 1420-1500. Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients placed into "forensic" restraints (handcuffs/shackles) by law enforcement officers are not placed on the restraint log and are not reported quarterly. Interview with the Director of Quality Management on 01/15/2015 at 1427 revealed she maintains the hospital's restraint log. Interview revealed she reviews inpatient restraints. Interview revealed "the hospital had not been looking at restraints from an ED perspective until December 2014." Interview revealed the hospital had revised the restraint policy to make the policy more compliant. Interview revealed the ED Director is responsible for reviewing restraints in the ED. Interview revealed the hospital is not	A 273		

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A 273	Continued From page 111 currently looking at "forensic" restraints applied by law enforcement officers. Interview revealed "We're not looking at patients in forensic restraints from a quality perspective." Interview revealed "I have no data for that population (patient's restrained by law enforcement)." Interview revealed the hospital staff failed to include ED patients placed in restraint by law enforcement officers in their restraint data.	A 273		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on Hospital policy/procedure review, Hospital administrative staff interview, medical record reviews, observations, staff/physician interviews and Law Enforcement Officer (LEO) interviews the hospital nursing staff failed to ensure nursing supervision of care per the hospital policy and procedure when the staff failed to provide ongoing assessment and monitoring of the condition of patients during restraint or seclusion in the emergency department (ED) who were under involuntary commitment (IVC) and of intensive care unit (ICU) patients not under IVC. The findings include: The hospital's nursing staff failed to provide ongoing assessment and monitoring of the condition of a patient during restraint or seclusion for 6 of 6 emergency department (ED) patients (#14, #16, #13, #17 #12, #9) under involuntary	A 385	See Tag A395	

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A 385	Continued From page 112 commitment (IVC) and 1 of 1 intensive care unit (ICU) patients not under IVC (#2). ~cross refer to 482.23(b)(3) Nursing Services Standard - Tag A0395.	A 385	A385 & A395 – Maria Parham Medical Center will meet and continue to meet the regulations that require a hospital to provide ongoing assessment and monitoring of a patient during restraint or seclusion.	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based upon hospital policy and procedure reviews, observations during tours, medical record reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews, the hospital's nursing staff failed to provide ongoing assessment and monitoring of the condition of a patient during restraint or seclusion for 6 of 6 emergency department (ED) patients (#14, #16, #13, #17 #12, #9) under involuntary commitment (IVC) and 1 of 1 intensive care unit (ICU) patients not under IVC (#2). The findings include: Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. The decision to use a restraint is driven by a comprehensive individual assessment. This document is used to provide consistent guidelines for the safe use of chemical and physical restraints and seclusion, if alternatives, as determined by an interdisciplinary team, have proven to be clinically ineffective to	A 395	The following actions have been implemented in support of Tags A385 & A395: • Nursing Supervisors will include in their hand off a discussion of patients in restraints and are expected to review documentation of every patient in restraints and appropriateness of the restraints based on behavior. Care nurses will include in their hand off/shift huddle a review of the previous shift's documentation for completeness and continued need for restraints based on behavior. **Monitoring** will be through daily review of all patients in restraints for safety or behavioral by Director of Quality. Time frame for this monitor is three consecutive months of 100% compliance. Reporting to Patient Safety Clinical Quality Committee with minutes to the Board of Trustees at a minimum of ten times each year. Responsible Person: Chief Nursing Officer	2/1/2015

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A 395	Continued From page 113 provide a safe environment for the patient. ...DEFINITIONS: Restraint - is the direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof. Physical Restraints - any manual method or physical/mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. ...Restraint to Promote Medical Recovery (non-violent): refers to the use of restraints in those patients who require various medically essential therapies while hospitalized and who demonstrate a state of confusion or altered cognition that puts those therapies at risk OR those patients who require management of non-psychiatric behaviors that put them at risk for injury. Restraints for Violent or Self-Destructive Behavior: refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting. ...Restrictive Devices Applied by Law Enforcement Officials - handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons and is not involved in the provision of health care; no considered restraints. ...Seclusion - seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. The following interventions are not considered	A 395		

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A 395	Continued From page 114 seclusion: 1. a patient physically restrained alone in an unlocked room. ...POLICY: It is the policy of (Hospital name) Medical Center to: 1. Prevent, reduce and eliminate the use of restraints by: a. preventing emergencies that have the potential to lead to the use of restraints, b. limiting the use of restraints to emergencies where there is a risk of the patient harming himself/herself or others. c. using the least restrictive method. 2. Protect the patient and preserve the patient's rights, dignity and well being during restraint use by: a. respecting the patient as an individual; b. maintaining a clean and safe environment; ...d. maintaining the patient's modesty, preventing visibility to others, and maintaining comfortable body temperature is maintained. 3. Provide for safe application and removal of the restraint by qualified staff. 4. Monitor and meet the patient's needs while in restraints. 5. Re-assess and encourage release of restraints as soon as possible. ...Restraints will be used only in situations where the patient is demonstrating observable behaviors that indicate he/she is at risk of injuring himself/herself or others. Restraints are not to be used for punishment, coercion, discipline, or retaliation of the patient or for staff convenience. This policy does not apply to devices....used by law enforcement officials although the standards of care stated within this document may be applicable. ...PROCEDURES: ASSESSMENT OF RISK FACTORS, INTERVENTIONS AND ALTERNATIVES TO RESTRAINT USE: A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it. ...Attempts should be made to evaluate and use the following interventions/alternatives when possible and in response to the patient's	A 395		

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assessed needs: *Monitoring: 1. Companionship; staff or family stay with patient 2. Room near or visible from nursing station 3. Close, frequent observation ...*Environmental Measures: ...5. Room/halls clear of obstacles such as excess equipment ...Regular toileting: 1. Establish consistent toileting schedule for patient. ...CLINICAL JUSTIFICATION FOR USE OF RESTRAINT AND/OR SECLUSION: When clinically indicated, the restraint procedure is implemented by the RN who is trained in restraint and/or seclusion techniques upon a physician's/LIP's order. Unless there is an immediate and overriding concern for safety, the restraint procedure is utilized only after all alternatives, less restrictive treatment interventions have been tried without success. Prior to implementation of any restraint, care team members will confer to determine that appropriate alternative measures have been attempted. Using the decision flowcharts for patient behaviors and alternatives for use of restraint, clinical assessment and utilization of restraint should be based on patient's behavior that may place the patient or others at risk for harm. Situations in which restraints are clinically justified include: *Threatens placement and/or patiency of necessary therapeutic lines/tubs, interfering with necessary medical treatment, and appropriate alternative measures have been attempted. ...*Unable to follow directions to avoid self-injury, and appropriate protective, alternative measures have been attempted. *Vulnerable patient populations, such as Pediatrics, who are cognitively or physically limited, are at a greater risk for injury Great caution should be utilized before initiating restraint use. LEAST RESTRICTIVE RESTRAINT/SAFE APPLICATION: Assessment and reassessment

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A 395	Continued From page 116 processes should include the appropriateness of the choice of restraint and/or seclusion. Physical restraints will be loosened periodically to evaluate skin integrity and circulation while the patient is in restraints. The types of restraint devices available within this facility and how to apply safely is as follows: ...2. Limb Restraints 1-->2-->3-->4-point ...5. Seclusion - Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member, or others. Seclusion is not a patient physically restrained alone in an unlocked room... ALTERNATIVE THERAPY: Prior to physically restraining a patient, restraint-free interventions such as (but not limited to) the following are attempted: *Provide safe environment, i.e., bed in low position, clutter free environment ...Enhanced observation ...*Sitter... PROCEDURE FOR USE OF RESTRAINT: Initiation and Renewal of Orders Standing orders, protocols, and/or PRN orders are not permitted. When initiating the use of a restraint, the appropriate restraint physician's order form (Nonviolent or Violent/Self Destructive) must be completed and placed on the chart within 30 minutes. This original order is time-limited based on type of restraint and age of patient. When use of restraints is contemplated, a physician/LIP or RN who has been trained in restraint application must document a face-to-face assessment prior to applying restraints, and document the need for restraint within the 1 hour time frame. The physician's/LIP's order must specify: *the restraint type *the justification for the restraint *date and time ordered *duration ...The in-person	A 395		

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A 395	Continued From page 117 evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following: *an evaluation of the patient's immediate situation *the patient's reaction to the restraint *the patient's medical and behavioral condition *the need to continue or terminate the restraint or seclusion ...The Nonviolent Restraint Physician's Orders: Orders for nonviolent restraints must be renewed each calendar day by the patient's attending physician or other designated LIP based on his or her examination of the patient. It is not necessary for the renewal to be completed within a 24-hour time-frame as the physician can re-evaluate the patient and need for non-violent/self-destructive restraints during routine rounds. If restraints for nonviolent behavior purposes are anticipated to be continued beyond the maximum time limit of the order, a restraint renewal sticker is placed on the physician order form and must be completed by the LIP before the original order expires. Its use is based on his or her face-to-face examination of the patient. For Violent/Self-Destructive Restraints [V/SD] A physician/LIP or trained RN must document a face-to-face assessment within 1 hour of implementation of restraint or seclusion. The 1-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a	A 395		

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A 395	Continued From page 118 comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior. During the face-to-face assessment, the qualified practitioner will evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion. The time limit for Violent/Self-Destructive Restraints is: *4 hours for adults (18 years of age or older) *2 hours for children (ages 9-17) *1 hour for children under age of 9 ...All patients who are in restraints must be continuously monitored and reassessed for the need to continue restraint by a qualified registered nurse (RN). ...When the order for restraints expires, a qualified, trained individual (who has been authorized by the organization to perform this function) will conduct an in-person assessment. If the patient is not ready for release from restraints, the authorized staff member will re-evaluate the efficacy of the patient's treatment plan and revise accordingly. the physician/LIP responsible for the patient's ongoing care will then be notified and a telephone order will be obtained and a new restraint physician order form will be placed on the chart for completion by the LIP. When the authorized, qualified staff member other than the physician/LIP continues restraints based on a new telephone order by the physician/LIP, the physician/LIP will re-evaluate the patient i.e. face-to-face assessment at least every 24 hours for adults, 2 hours for ages 9-17 and after 1 hour for children under age of 9 years for nonviolent restraints. If restraints are to be continued, a new time-limited order for restraints will be obtained	A 395		

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from the physician/LIP. For Violent/Self Destructive restraints, a face-to-face re-evaluation by the physician/LIP is required after 4 hours for adult patients, after 2 hours for children ages 9-17 and after 1 hour for children under age 9. Seclusion guidelines 1. Individuals placed in seclusion must have a protected, private observable environment that safe guards their dignity and well-being. 2. The decision to seclude may be made by a trained RN in an emergency situation in which the patient exhibits violent, self-destructive behavior, when the physician is not available, after conducting a face-to-face assessment of the individual to determine whether the behavior requires seclusion. A physician or other LIP must see and evaluate the need for seclusion within one hour after the intervention is initiated. ...4. The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient. 5. Staff must monitor an individual placed in seclusion and document findings at a minimum of every 15 minutes. 6. Articles that might be used to inflict self-injury must be removed prior to placing in seclusion. ...8. If an individual falls asleep in seclusion, the door must be unlocked and opened within the nearest fifteen minute period monitoring. If the door is not unlocked, clinical justification must be documented in the patient's clinical record. Upon awakening, the patient must be re-evaluated by a RN or the physician upon awakening for continued release without regard to how long the individual was asleep or whether the maximum length of time prescribed in the order has expired. ...Discontinuing Restraint Once restraint is applied or initiated, the patient should be

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A 395	Continued From page 120 monitored and evaluated for the continued need of the intervention and the continued appropriateness of the type of intervention. ...The restraint should be discontinued as soon as the patient meets the behavior criteria for its discontinuation. The assessment of the continued need for restraint to determine early release should be documented at a minimum of every two hours or more often as the patient's condition improves. ...MONITORING, ASSESSING, AND CARE OF THE PATIENT IN RESTRAINTS: When restraints are used there is an increased need for patient monitoring and assessment to assure patient safety, that the less restrictive methods are used when possible, and that restraint is discontinued as soon as possible. Immediately after restraints are applied an assessment should be made to ensure that the restraints were properly and safely applied so as to not cause the patient harm or pain. Documentation should include this assessment as well as the patient's response, any adjustments made. The frequency of monitoring the patient must be made on an individual basis, which includes a rationale that reflects consideration of the individual patient's medical needs and health status. The assessment includes, as appropriate to the type of restraint used: *signs of injury associated with the restraints *nutrition/hydration *circulation and range of motion in the extremities *vital signs *hygiene and elimination *physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being) *readiness for release from restraints *patient's understanding of the reasons for restraint and requirements for release ...PATIENT/FAMILY EDUCATION: Restraint	A 395		

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A 395	Continued From page 121 procedures should be performed in a manner that does not violate the patient's rights. ...For Non-Violent restraints, reassessment and documentation is required at least every 2 hours and for Violent/Self-Destructive restraints, it is required every 15 minutes. DOCUMENTATION: The medical record should document: *that the patient and/or family was informed of the organization's policy on the use of restraints; *any medical condition or any physical disability that would place the patient at greater risk during restraints/seclusion; *any history of sexual or physical abuse that would place the patient at grater psychological risk during restraint/seclusion. Documentation within the patient's record should indicate a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more restricted measure. When a restraint is initiated, the order must be documented immediately upon initiation. If the order for restraint is note initiated by the treating physician, the order must be followed by consultation with the patient's attending physician as soon as possible. ...Each episode of restraint/seclusion use is to be recorded in the medical record. Documentation will include: *date restraint applied *time restraint applied *type of Restraint (non-violent or violent/self destructive) *restraint device (soft, mitten, vest, geri-chair, etc.) *safe application verified *level of consciousness *safety/rights/dignity maintained verified *observed restraints appropriately intact *behavior during restraints *vital signs taken *free from injury associated with restraint *skin under/around restraint intact * range of motion done *circulation distal to restraint verified *offered nutrition/hydration *offered assistance with	A 395		

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A 395	Continued From page 122 toileting/hygiene *offered comfort measures *the circumstances that led to restraint or seclusion use *consideration or failure of non-physical interventions including alternatives attempted and successful *the rationale for the type of physical intervention selected *notification of the patient's family/significant other, when appropriate *patient's response and any changes made as a result of the restraints *each telephone order received from a physician/LIP * debriefing of the patient with staff *any injuries that are sustained and treatment received from these injuries *any deaths. DISCONTINUING RESTRAINT DOCUMENTATION GUIDELINES *Criteria for restraint release met *Date restraint discontinued *Time restraint discontinued *Restraint debriefing when applicable for behavior (violent/self-destructive) MODIFICATION TO PATIENT'S PLAN OF CARE: The plan of care should clearly reflect a loop of assessment, intervention, evaluation and re-intervention. Restraint use must be in accordance with a written modification to the patient's plan of care..." 1. Observation during ED tour on 01/14/2015 at 1427 of exam room #17, revealed the room was located across from the nursing station. Observation revealed the room had a sliding glass door. Observation revealed a male patient (Patient #14) wearing green disposable scrubs and sitting on the end of the stretcher leaning over a bedside table. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right leg/ankle was chained to the stretcher's frame with a metal shackle/cuff (restraint). Observation revealed the patient did not exhibit any violent or self-destructive	A 395		

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A 395	Continued From page 123 behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. At 1433, observation revealed Patient #14 stood up off the end of the stretcher and pivoted around to the side of the stretcher without difficulty or assistance. At 1434, observation revealed XYZ County Sheriff Deputy (CSD) #1 was sitting behind the nursing station in a cubical. Observation revealed the cubical was on the opposite side of the nursing station, away from exam room #17. Observation revealed CSD #1 stood up and exited the cubical and walked down the hallway on the opposite side of the nursing station, away from exam room #17 and exited the emergency department treatment area through a set of double doors. Observation revealed Patient #14 was alone in exam room #17 unsupervised by a LEO. At 1436, observation revealed CSD #1 returned to the cubical in the nursing station and sat down. Observations from 1427 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #14 while being restrained in exam room #17. Open medical record review on 01/14/2015 revealed Patient #14, a 60 year old male presented to the hospital's ED on 01/13/2015 at 1820 accompanied by Law Enforcement under IVC petition. Review revealed the patient's chief complaint was IVC-Crisis Evaluation Referral. Review of triage nurse documentation at 1827 revealed "IVC, per caregiver pt (patient) with bizarre behavior, pt walking around showing gentials [sic], pt endorses auditory hallucinations, pt with rambling thoughts in triage, pt states he will only hurt someone if they try to hurt him." Review of triage assessment documentation revealed the patient was alert, oriented x 3	A 395		

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(person, place, time) and anxious. Review revealed the patient was evaluated by a physician at 1908. Review revealed a chief complaint of being agitated and exposing genitals. Review revealed the patient was assessed as no acute distress, awake and alert, slightly agitated, pressured speech, and directable. Review revealed the patient was "cooperative." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 01/13/2015 at 1541 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #14) is probably: [X] 1. mentally ill and dangerous to self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness. ..." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 01/13/2015 at 2345 revealed "Description of Findings" with "...presenting for agitation, exposing himself inappropriately to others. On evaluation, pt is disorganized with pressured speech. Oriented to location but not situation. Is currently a danger to himself due to psychosis." Review of nursing documentation at 2235 revealed "Resting quietly in bed. No aggressive behaviors, no self-injurious behavior. ..." At 1215 (01/14/2015) "...Pt unshackled while bed was exchanged." At 1330 "Pt sitting at end of bed. No c/o voiced. No distress noted." At 1500 "Pt sitting on bed c (with) no distress noted." At 1845 "Pt transported to (hospital name)....ambulated to police care no distress noted." Review of "Suicide Precautions Flow sheet" documentation on 01/13/2015 from 1900 to 2300 and 01/14/2015 from 0715 to 1845

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revealed the patient's behavior was documented by staff as calm or cooperative. Review revealed no documentation the patient was violent or aggressive. Review revealed on 01/14/2015 at 1430, 1445, and 1500 (corresponding timeframe to Surveyor's observation [1427-1500] of the patient cuffed/shackled to the stretcher) as being cooperative. Record review failed to reveal any available documentation Patient #14 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 1820 through discharge on 01/14/2015 at 1845. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy.

Interview on 01/14/2015 at 1442 with CSD #1 revealed he was a Deputy Sheriff with the XYZ County Sheriff's Department. Interview revealed he was present in the ED for a "10-73" (mental subject). Interview revealed the patient (#14) in exam room #17 was under IVC. Interview revealed the patient was brought to the ED on 01/13/2015. Interview revealed he relieved the previous Deputy this morning (01/14/2015) at

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A 395	Continued From page 126 shift change. Interview revealed the previous Deputy placed the patient into "ankle shackles." Interview revealed the "officer makes the decision wither or not the patient needs to be handcuffed or shackled." Interview revealed Patient #14 was not going to jail and was not under arrest. Interview revealed he (CSD #1) was on standby until a mental health facility could be found for the patient. Interview revealed because the patient was in his custody, he was responsible for any of the patient's actions. Interview revealed when the patient complains the cuffs/shackles are too tight or hurting, he will use 2-3 fingers to check to see if the cuffs/shackles are too tight. Interview revealed there was no set schedule for periodically removing the cuffs/shackles or checking for tightness. Interview revealed the "patient lets me know if they are too tight." Interview revealed if the patient needed to go to the restroom, the cuffs/shackles are removed. Interview revealed he does not check pulses or skin for circulation. Interview revealed the nurse is responsible for taking care of the patient's medical needs. Interview revealed he does not document in the patients ED medical record. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED	A 395		

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A 395	Continued From page 127 Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #14 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 2. Observation during ED tour on 01/14/2015 at 1438 of exam room #5, revealed the room was located diagonally across from the nursing station. Observation revealed the room had a	A 395		

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A 395	Continued From page 128 wood door. Observation revealed a female patient (Patient #16) wearing green disposable scrubs and laying on her left side on the stretcher, watching television. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's left wrist was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. Observation revealed an ABC City Police Department officer was sitting behind the nursing station in a cubical, reading a magazine. Observations from 1438 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #5. Open medical record review on 01/15/2015 for Patient #16 revealed an 18 year old female presented to the Hospital's ED on 01/13/2015 at 1726 for "potential drug overdose." Review revealed the patient was triaged by a RN at 1732 and was assessed by a ED Physician at 1734. Review revealed the patient was assessed at 1912 by a mobile crisis worker. Review revealed on 01/14/2015 at 0050, the patient was IVC for being mentally ill and dangerous to self and others. Review revealed at 0200 and 0400, the patient's behavior was documented as asleep with parent and LEO at bedside. Review revealed from 0600 to 01/15/2015 at 0515, the patient's behavior was documented as asleep, tearful, and resting quietly in bed, resting in bed with eyes closed and laying in bed with eyes closed. Review revealed at 0536, the patient	A 395		

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requested the "shackle" (restraint) be loosened and the hospital staff informed the LEO. Review revealed at 0725, the patient behavior was documented as alert and oriented with right lower extremity "cuffed" (restraint) to bed frame. Review revealed at 0835, the patient was transferred to a Psychiatric hospital. Record review failed to reveal any available documentation Patient #16 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 1726 through discharge on 01/15/2015 at 0835.

Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles.

Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through

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A 395	Continued From page 130 this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #16 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 3. Observation during ED tour on 01/14/2015 at 1430 of exam room #1, revealed an ante room was located diagonally across from the nursing station. Observation revealed the room was an isolation room. Observation revealed to view a patient required walking into the ante room, turning right and proceeding approximately 4 feet to enter the isolation room proper. Observation revealed a male patient (Patient #13) wearing green disposable scrubs and laying supine on the stretcher with both hands across his abdomen. Observation revealed the stretcher's two side rails were up. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right ankle was chained to the stretcher's frame with a metal cuff/shackle	A 395		

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(restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the isolation room alone and without direct supervision of a LEO. Observation revealed an ABC City Police Department officer was sitting behind the nursing station in a cubical and due to location he could not observe the patient. Observation revealed from the LEO's location the ante room could be observed only. Observations from 1430 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #7.

Open medical record review on 01/14/2015 for Patient #13 revealed a 26 year old male presented to the hospital ED (Emergency Department) on 01/13/2015 at 0125 with thoughts of suicide and for substance abuse detoxification. Review revealed at 0127, the patient was triaged by a RN and at 0234, the patient was assessed by a ED Physician. Review revealed at 0840, the patient was assessed by a mobile crisis worker and was admitted for suicidal thoughts. Review revealed at 1600, the patient was IVC (Involuntary Commitment) due to mentally ill and dangerous to self and others. Further review revealed when the patient was IVC, LEO (Law Enforcement Officer) placed the patient in leg shackles. Review revealed at 1800 and 2000, the patient's behavior was documented as calm and resting with eyes closed with the right ankle in shackled (restraint). Review revealed on 01/14/2015 at 0000, 0200, 0430, 0600, 0735 and 0935, the patient behavior was documented as asleep and resting quietly with the right ankle shackled. Review revealed at 1645, the patient was transferred to a Psychiatric hospital for treatment. Review revealed no documentation

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A 395	Continued From page 132 the patient demonstrated violent or self-destructive behaviors. Record review failed to reveal any available documentation Patient #13 exhibited violent or self-destructive behaviors necessitating the need for restraint use while hospitalized from 01/13/2015 at 0125 through discharge on 01/14/2015 at 1645. Interview with ABC Police Officer #1 on 01/14/2015 at 1435 revealed he was responsible for 3 patients under IVC in the ED at this time. The interview revealed he stations himself at an area in the corner. The interview revealed he can observe the patient in the seclusion room and the patient in room #5. The interview revealed Officer # 1 was not allowed to answer any further questions. The interview revealed a phone number to two Lieutenant at the City Police Department if further questions needed to be asked. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police	A 395		

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A 395	Continued From page 133 officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #13 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 4. Observation during ED tour on 01/14/2015 at 1430 of the seclusion room #7 revealed a room with a solid wood door and window with blinds and the blinds were outside covering the window. Observation revealed on the left side of the room at the head of the stretcher a metal plate with two sharp pointed corners partially attached to the wall. Observation revealed the metal plate could be easily pulled further off of the wall. When	A 395		

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A 395	Continued From page 134 exiting the room a male patient (Patient #17) was observed standing calmly beside with door EMS personnel at his side. Observation revealed the patient was escorted into the seclusion room along with the Mental Health Nurse (MHRN). Approximately 10 minutes 2 City LEOs were observed entering the seclusion room and the MHRN standing out side of the room. The door and the blinds were closed. Interview with the MHRN during the observation revealed City LEO were in the room searching the patient, putting the patient in scrubs and cuffing the patient. The interview revealed the LEO cuffed the patient because the patient was IVC. The interview revealed that even if the patient is calm and cooperative the patient is always cuffed. The interview revealed the MHRN had training on the Hospital policy and procedure for restraining patients in October, 2014. The interview revealed she was also aware of the revision of the restraint and seclusion policy completed in December, 2014. Patient #17 was observed during the interview with both wrist cuffed with metal cuffs Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview with ABC Police Officer #1 on 01/14/2015 at 1435 revealed he was responsible for 3 patients under IVC in the ED at this time.	A 395		

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A 395	Continued From page 135 The interview revealed he stations himself at an area in the corner. The interview revealed he can observe the patient in the seclusion room and the patient in room #5. The interview revealed Officer # 1 was not allowed to answer any further questions. The interview revealed a phone number to two Lieutenant at the City Police Department if further questions needed to be asked. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles	A 395		

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were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring patients while restrained in the ED with metal cuffs/shackles placed by a law enforcement officer.

5. Closed medical record review of Patient #12 revealed a 9 (nine) year old child presenting to the Emergency Department with mother on 12/12/2014 at 2001 with a chief complaint of "Pt (patient) with hx (history) of ADHD (Attention Deficient Hyperactivity Disorder) seen by daymark and referred to ER for psych eval. (evaluation). Mother sts (states) pt acting out when not getting 'his way'. Mother sts pt using foul language, and damaging property at home. Pt age appropriate, resp (respirations) even and unlabored, NAD (no acute distress)." Medical record review revealed documentation by nursing staff that triage was conducted at 2003 and the child was alert responded to voice and was oriented to person, time and place. Review of nursing documentation at 2002 revealed the "Pt ambulated to ER-1 - Pt very agitated and uncontrollable. Pt screaming, constantly in motion and tearing up thins at home. Pt using foul language". Medical record review revealed documentation of the physician's medical screening exam (MSE) on 12/12/2014 at 2010 in room 1. Review of the MSE revealed the parent was with the patient during the exam and the child was "angry, frustrated, agitated". Review of the MSE revealed the clinical impression by the physician was ADHD. Review of nursing documentation revealed at 2140 the patient was"very agitated - screaming, rolling around on floor, slapping at wall and not following instructions. Medical record review revealed the

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patient was administered per physician's order Ativan (medication for treatment of anxiety disorders) 1 mg IM at 2219 and Benadryl 25 (medication used for psychiatric symptoms) mg IM at 2213. Medical record review revealed documentation on the "Appropriateness/Justification for Acute Medical/Surgical Restraint" form of a physician's order for the patient to be physically restrained due to "Pt's (patient's) behavior uncontrollable - spitting, scratching- trying to bite, cursing- uncontrollable with meds." Further review of the physician's order for restraint revealed the restraint type was ordered "Soft limb holders...Four Side Rails". Review of the type order revealed no documentation of which limbs or how many limbs were to be restrained. Review of the order revealed the restraint was initiated on 12/12/ 2014 at 2248 and the order was signed by the physician at 2250. Review of the order did not reveal any documentation of the time limit for restraining the child. Medical record review revealed documentation at 2254 the restraint was discontinued. Medical record review did not reveal any documentation of a one hour face to face examination after the child was placed in restraints. Review of nursing documentation revealed at 2230 "mental health case worker in to evaluate pt". Review of the mental health staff documentation at 2300 revealed "client was being placed in a four point restrain by hospital staff. Client was displaying aggressive behaviors to his mother and medical staff...Client damaged hospital property...Client had to be move to the seclusion room where all items were removed including bed...Client continued his aggressive behavior for about two hours which led to the doctor giving client 25 mg Benedryl IM at 10:10 pm and 1 mg ativan IM at 10:30 pm due to client

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continue disruptive behavior client was given 2 mg of Haldol IM at 11:10 pm...continue disruptive behavior for about thirty minutes before calming down at that time XXX County Officer arrived and placed patient into custody. Medical staff place bed back into seclusion room at that time...Client had to be place in four point restraints by medical staff." Record review revealed documentation of "Petition for involuntary commitment" dated 12/12/2014 and completed by the physician stating the patient was agitation and a danger to self and others and requested inpatient treatment and stabilization. Nursing documentation at 2254 revealed "Pt got himself out of restrains, still out of control. Nursing documentation revealed at 2306 the patient was moved to room 7 for seclusion and at 2314 the patient was hitting the door. Nursing documentation at 2309 revealed the patient was kicking scratching and spitting and trying to "break down door, Haldol (antipsychotic medication) 2 mg IM" was given. Further review of nursing documentation revealed the patient calmed down at 2340, "resting on floor...placed on cardiac monitor" and was placed in bed. Documentation by nursing staff revealed at 2345 the patient was "IVC'd and restrained by law enforcement with ankle cuff to left ankle and bed. Pt sleeping without distress". Nursing documentation revealed on 12/13/2014 at 0100, 0200, 0300, 0400 and 0600 the patient was sleeping without distress. Documentation revealed the patient was offered water at 0300, refused and took sips of water at 0600. Review of nursing documentation revealed no documentation of assessment at 0500. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/12/2014 from 2350 until 12/13/2014 at 0720 revealed the patient was " A-resting in bed". Review of nursing

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A 395	Continued From page 139 documentation on 12/13/2014 at 0730 revealed law enforcement was present and the child's "left ankle cuffed to bed rail per law enforcement protocol." Nursing documentation revealed at 0810 the patient was yelling "I'm hungry" and the staff "encouraged to relax breakfast will be coming soon." Documentation at 0835 revealed the child continued yell for the nurse and the child was given orange juice and peanut butter crackers. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/13/2014 from 0900 until 12/14/2014 at 0716 revealed the patient was " A-resting in bed". Documentation at 0900 revealed the breakfast tray was made available to the child and at 0940 he was asleep. Nursing documentation at 1100 revealed the child told nursing staff that heard and sees the devil telling him to do it". Review of nursing documentation at 1300 revealed the patient was released from forensic restraints by the LEO and the patient ran. Documentation revealed "the officer captured pt and brought back to room pt began banging forensic restraints PRN (as needed) given at 1322". Nursing documentation at 1400 revealed the patient was medicated due to the patient not taking redirection. Nursing documentation revealed the patient slept until 1905 when he awoke and asked for dinner. Nursing documentation at 1951 revealed the patient was placed in "4 pt (point) forensic restraints after "slamming upon bed and jumping up and down, cursing and threatening staff." Nursing documentation revealed at 2000 "remains in 4 pt restraints...Ativan was given, at 2012 "remains in 4 pt restraint, at 2033 "Forensic arm restraint removed. Leg shackles remain...Pt being monitored by nurses and officer." Documentation at 2045 revealed the patient was placed back in 4	A 395		

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point restraints due to cursing and yelling. documentation at 2118 revealed the patient remained in 4 point restraints and "Haldol given as ordered". Documentation at 2215 revealed the patient remained in 4 point restraints. review of nursing documentation on 12/14/2014 at 0615 revealed the patient slept since being medicated at "midnight" and "remains in restraints". Documentation by nursing staff at 0820 revealed the "pt yelling out 'I'm wet' In room to assess pt. pt voided self and floor. Officer in room to uncuff pt...pt c/o (complained of) 'my moms gonna be so mad I pissed myself'." Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/14/2014 from 0830 until 12/16/2014 at 0630 revealed the patient was " A-resting in bed". Documentation revealed the patient was cleaned and rested quietly until 1345. Documentation at 1345 revealed an attempt was made to remove one restraint "Pt climbing over bed. Forensic restraint had to be reapplied "Pt cursing, yelling, urinated on self". Record review revealed the patient was administered Haldol IM at 1415 and was documented resting at 1455 (40 minutes after medication), 1548 (53 minutes after previous assessment), 1639 (1 hour later) and at 1730 (51 minutes later). Nursing documentation revealed the patient rested quietly from 12/15/2014 at 2400 through 1319 (13 hours) with law enforcement. Nursing documentation revealed the patient cried at intervals for his mother. Nursing documentation at 1500 revealed the patient was up to the bathroom "for BM (bowel movement) x1. Shackles on." Review of nursing documentation did not reveal any documentation of the patient having disruptive or aggressive behaviors prior to or after going to the bathroom. Nursing documentation revealed no documentation of aggressive, agitated or self

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destructive behavior from 1600 on 12/15/2014 through 12/16/2014 at 0710. Documentation at 0710 revealed the LEO was at the bedside. Nursing documentation on 12/16/2014 at 1100 revealed "Patient kept yelling out 'Nurse, Nurse'...mental health,charge nurse and writer in room to talk to patient that if he stops yelling out loud he could be able to talk to his mother and will be moved to a room with tv". Documentation at 1140 revealed the patient vomited yellowish emesis on the floor and told the nurse he "does not feel good". Documentation revealed the nurse notified the physician and at 1315 the patient continued to yell out for the Nurse. Documentation at 1500 revealed the patient vomited a second time and the physician was made aware. Documentation revealed Zofran (antiseptic) IV was administered at 1830 and Normal Saline infused at a "bolus rate". Record reviewed revealed nursing documentation at 2030 (2 hours after medication) that the patient was resting. Record review revealed on 12/17/2014 at 1045 the patient was administered Ativan 1 mg IM, Zofran by mouth and the patient had pulled out his IV. Record review revealed at 1055 the patient was placed in 4 point restraints by LEO for yelling, not following directions and "pulling the stretcher to the door." Review of documentation by mental health staff on 12/17/2014 at 1120 revealed "Client pulled out his IV in his hand and made himself vomit. Client has escalated to where he is yelling constantly and has had both hands and one leg put in restraints." Nursing documentation revealed at 1357 the patient remained in "2 pt forensic restraints" (3 hours since last documentation). Review of nursing documentation on 12/18/2014 at 1110 revealed the patient remained in 2 point forensic restraints. Nursing documentation

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A 395	Continued From page 142 revealed at 1230 the patient complained of urinating on self. Review of documentation by mental health staff at 1400 revealed "Reassessment completed. Client continues to yell and have outburst. Staff not able to redirect. Client has been medicated and is still in restrains. Client now has a one on one staff member sitting with him. Client has been calmer when staff person is sitting with him." Documentation by nursing at 1445"staff member sitting with pt 1:1". Nursing documentation at 1645 and 1755 revealed a staff member sat with the patient 1:1 and the patient was "pleasant & cooperative." Documentation by nursing on 12/18/2014 revealed the "officer" was at the bedside and the patient "remains cooperative.' Review of nursing documentation on 12/19/2014 at 0730 revealed "Pt unshackled by officer so RN could assist pt with bath...Pt states 'these cuffs make my feet hurt'. " Record review did not reveal any documentation of an assessment of the patient's feet after he complained of hurting due to the "cuffs". Review of documentation by mental health staff at 1010 revealed "Reassessment completed. Client continues to yell out and not follow directions. Client is still in restraint." Review of nursing documentation at 1845 revealed LEO was at the hospital to transport the patient to an acute psychiatric hospital. Medical record review revealed documentation on 12/20/2014 at 1200, a written physician certification order for the transfer of the child to a psychiatric acute hospital for psychiatric services not available at the hospital. Review of the certification revealed the patient remained under IVC and was transported by law enforcement officer. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15	A 395		

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A 395	Continued From page 143 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview	A 395		

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A 395	Continued From page 144 revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #12 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 6. Closed medical record review on 01/14/2015 revealed Patient #9 presented to the hospital's ED on 11/01/2013 at 1106 via private transportation accompanied by group home staff. Review revealed the patient's chief complaint was Crisis Evaluation Referral. Review of triage nurse documentation at 1116 revealed "pt admitted to new group home Monday, staff reports pt made threats to 'kill himself and everybody else.' Stated pt attempted to run away." Review of initial nursing assessment documentation revealed the patient was alert, awake, responsive to voice, oriented to person, time, and place. Review of a ED risk screen revealed the patient was assessed as "No" for risk for self	A 395		

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A 395	Continued From page 145 harm/elopement. Record review revealed the patient was initially placed in exam room #20. Review revealed the patient was evaluated by a ED physician at 1109. Review revealed a chief complaint of suicidal thoughts, expressing SI (suicidal ideation) and HI (homicidal ideation). Review revealed a past medical history of bipolar disorder, schizophrenia, and moderate mental retardation (MR). Review revealed the patient was assessed as no acute distress; awake and alert; oriented X4 (person, place, time, and situation); mood and affect normal. Extremities non-tender and no signs of injury. Review of a Affidavit and Petition For Involuntary Commitment form dated 11/01/2013 (note timed) revealed the Respondent was Patient #9 and the Petitioner was ED Physician A. Review revealed "The facts upon which this opinion is based are as follows....Patient is mentally challenged with history of Bipolar D/O (disorder) and Schizophrenia who is very unstable at this time. He is making threats that he will kill others at the group home and himself." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 11/01/2013 at 1200 revealed "Description of Findings" with "...Patient is mentally challenged with history of Bipolar and Schizophrenia who is very unstable at this time. He is making threats to kill himself and others - needs in-patient stabilization." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 11/01/2013 at 1258 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #9) is probably: [X] 1. mentally ill and dangerous to self or others...."	A 395		

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Review revealed the respondent was taken into custody by ABC City Police Officer on 11/01/2013 at 1336 (Patient in ED when taken into custody). Review of a Computerized Physician's Order Entry (CPOE) report, Order # 26, CPOE #398912, revealed a physician's order entered by ED Physician A on 11/01/2013 at 1358 for "Restraints, Place in", Frequency: "ONCE", Priority: "Routine". Review of a Comprehensive Assessment Tool-Intake form dated 11/01/2013 at 1452 revealed "...presents to (Hospital A) - ED c group staff. Staff from group home report clt (client) was trying to run away this am and threatened to kill self as well as staff. Upon admission clt was making a gun with his fingers and placing it to the head of staff, threatening to stab another staff c a plastic fork and being verbally abusive. ...Clt was restrained on admission c forensic restraints and required pepper spray p (after) refusing chemical restraint. ..." Review of nursing documentation revealed on 11/01/2013 at 1106 "Pt cc HI. Pt @ (at) group home. MR high functioning w (with)/Psychosis + (and) Bipolar. Pt pretending to shoot staff + 'flipping off' other patients from room." At 1245, "Pt moved to isolation room (Exam Room #1), IVC in place, officer @ bedside. Pt acting iriatic [sic], cuffed (restraint) to bed, Pt had previously tried to hang self w/belt. Now threatening officer + trying to bite him, Pt trying to break free from cuffs, bed now broken, officer warning pt of violent behavior." At 1400, "Pt out of control, violent, calling everyone 'F**king Bi**hs.' Broke posey chest vest....threatening to kill officer. Pt sprayed w/pepper spray @ close range." At 1410, "Pt refusing flushing treatment. V/S (vital signs) WNL (within normal limits), resting in bed with eyes open, resp (respirations) nonlabored." At 1600, "Pt starting to yell out again, HPD (ABC

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A 395	Continued From page 147 City Police Department) at bedside." At 1755, "Pt resp WNL..." Review of Crisis Assessment documentation by mobile crisis management staff for Patient #9 dated 11/01/2013 at 1800 revealed the reason for referral was physical aggression, property destruction, threats of physical aggression, running away, verbal aggression, hallucinations or delusions, homicidal and suicidal. Review revealed "Became aggressive at GH (group home). Threatened to stab + shoot self + others. Ran to neighbors. Upon entering ED he refused meds + put a belt around his neck. He had to be pepper sprayed + put in 4 point restraints. ..." Review of mental status examination revealed the patient was disheveled with poor hygiene, and in 4 point restraints. Review revealed the patient had good eye contact, was calm, and had no impairment with communication and appropriate speech. Review revealed the patient's mood was depressed, slightly withdrawn, and cooperative. Review of nursing documentation revealed at 1900, "...Pt sleeping on bed in 4 point restraints. HPD c (with) patient." At 2230, "Sleeping. Quiet and cooperative." At 0100 (11/02/2013), Pt continues to sleep soundly." At 0300, "Pt. continues to sleep with restraints to wrist." At 0730, "Observed asleep. Law enforcement present. ..." At 0930, "Mental Health Services cont. (continue) to evaluate for mental health facility placement." At 1050, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1330, "...Remains cooperative. No suicidal or homicidal gestures." At 1440, "...Remains cooperative..." At 1555, "Law enforcement remains present. ...No suicidal or homicidal gestures." At 1900, "Pt moved to room 7 (Seclusion Room). Police officer remains @ bedside..." At 2000 to 0200 (11/03/2013) continued observation by police	A 395		

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officer. At 0327, "...Pt calm + cooperative...." At, 0600 "...Calm Cooperative....Officer outside of rm (room)." At 0705, "...Pt calm + cooperative..." At 0930, "...HPD officer sitting outside of rm..." At 1330, "Pt remains calm + cooperative..." At 2055, "Pt. calm + cooperative...Rt. ankle remains shackled to stretcher by HPD. Good PMS (pulse, motor, sensation). Pt remains IVC'd." At 2300, "Pt continues to watch TV..." At 1130 (11/04/2013), "...cooperative..." At 0810, "Remains cooperative..." At 0900, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1545, "...Remains Cooperative...No suicidal/homicidal gestures. ..." At 1800, "Remains cooperative..." At 2040, "...Pt. pleasant + cooperative..." At 0140 (11/05/2013), "Resting c eyes closed....Law enforcement present." At 0815, "...Remains cooperative." At 1400, "...Law enforcement remains present. No suicidal/homicidal gestures." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 11/05/2013 at 1745 revealed "Description of Findings" with "...Pt now stabilized, A+OX4, (No) HI, SI. D/W (discussed with) group home for disposition. Does not currently meet IVC criteria." Review of ED physician reassessment documentation at 1755 (11/05/2013) revealed the patient was re-examined and has improved, AOX4, Stable, No homicidal or suicidal ideation. Group home agrees to assume care. Review revealed a clinical impression of Psychosis, Schizophrenia, acute exacerbation. Review of nursing documentation revealed at 1858, "...Taken back to group home per law enforcement. ..." Record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or

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A 395	Continued From page 149	A 395		

every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy.

Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles.

Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through

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A 395	Continued From page 150 this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #9 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer.	A 395		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on hospital policy reviews, observations during Emergency Department (ED) tour, and staff interviews the hospital's ED staff failed to maintain the facilities, supplies, and equipment in an manner to ensure an acceptable level of safety and quality for 1 of 1 ED toured. The findings include:	A 724	A724 – Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to maintain facilities, supplies and equipment to ensure an acceptable level of safety and quality. The following actions have been implemented in support of Tag A724: • End of month checks to remove any expired supplies in the ED. Responsible Person: Nursing ED Director	2/2/2015

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A 724	Continued From page 151 Review of current hospital policy "Compressed Gas and Oxygen Use, EOC-69" revised 10/2014, revealed "PROCEDURE: *General Standards ...*Cylinders must be secured at all times so they cannot fall. ...*Oxygen Use: *Oxygen and other gases are potentially dangerous. Special safety precautions shall be followed at all times while using or storing oxygen. *Ensure cylinders are secure on rack and never hand anything on cylinder. ...*Store oxygen cylinders upright and secured. *Ensure oxygen cylinders are secured in a dedicated carrier..." Review of current hospital policy "Refrigerators and Freezers: Care of, PC 19" revised 02/2012, revealed "PURPOSE: To insure that refrigerators and freezers are clean, contents properly stored, and the temperature monitored. POLICY: 1. Patient care refrigerators/freezers should be cleaned regularly and as necessary for spills by the nursing staff. ...GUIDELINES CONTENTS: 1. Patient food refrigerators should contain only food that has been properly wrapped. Food items designated for a specific patient should be dated and labeled with that patient's name. ..." Review of current hospital policy "Emergency Department Infection Prevention Guidelines, IC-103" revised 12/2011, revealed "...Refrigerators All refrigerators will be cleaned when soiled. ...Any food stored for patients should be in containers and labeled with the name of the patient and discarded in 24 hours. ...Housekeeping All work surfaces and equipment should be cleaned with a disinfectant solution daily and when visibly soiled. Routine daily cleaning of floors is required and walls routinely or when visibly soiled. ...The medication preparation area should be freeze of clutter and	A 724	Continued from page 152 **Monitoring** - End of month checks to be sent to Risk Manager. • Emergency Department staff have been re-educated that oxygen tanks are to be stored upright and secured and/or secured in a dedicated carrier. • Cleaning of refrigerator/freezers has been added to the daily cleaning schedule. • Patient microwave has been added to daily cleaning schedule. • Medication Room has been added to daily cleaning schedule. • Linen cart has been covered. Responsible Person: Nursing Director ED **Monitoring**: Random checks (for the above) three times a week by the Director of ED or her designee.	

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A 724	Continued From page 152 the countertop wiped with disinfectant cleaner once each shift. ..." Review of current hospital policy "...Infection Prevention Guidelines, IC-113" revised 01/2014, revealed "...ENVIRONMENT, EQUIPMENT AND CLEANING: ...Medical Supplies Staff should check supplies before using and routinely for expiration dates. Return out of date supplies to Materials Management for replacements. ..." Observations during tour of the ED on 01/13/2015 from 1107 to 1230 revealed the following: 1. In Exam (Trauma) Room #2 - Observed one (1) 8.5 French Percutaneous Sheath Introducer Kit with an expiration date of 10/2014 (expired) and one (1) pneumothorax kit with an expiration date of 06/2014 (expired), stored in cabinet. Observed a portable oxygen cylinder containing approximately 900 Liters of oxygen, standing upright on the floor without being secured in a manner to prevent fall. 2. In Clean Supply/Storage Room - Observed bulk linen stored on multiple shelves, uncovered. Observation revealed the room was not a dedicated linen storage room. Observation revealed other clean medical supplies and equipment stored on track shelves. 3. Patient Refrigerator/Freezer - Observed four (4) salads and three (3) fruit cobblers stored in refrigerator compartment, not dated or labeled. Observed dried liquid spills on the inside refrigerator surfaces. Observed brown food particles spilled on the inside surfaces of the freezer compartment. 4. Patient Microwave - Observed food particles and dried liquids spilled on inside surfaces of the microwave. 5. In Medication Room - Observed heavy dust	A 724		

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A 724	Continued From page 153 accumulation on outer surfaces of the automated medication dispensing system (Pyxis). Observed dried liquid splatter on the countertop surfaces, outer cabinet doors surfaces, outer medication refrigerator door surface, and the floor. Interview during ED tour with ED Nursing Director #1 and ED Charge Nurse #1 revealed the above observations. Interview revealed nursing staff check the trauma room two times per day (morning and evening) to ensure supplies are present. Interview revealed nursing staff should be checking supplies for expiration dates and expired supplies should be removed and not available for patient care. Interview revealed the oxygen cylinder should not be stored standing upright and unsecured, the cylinder should be stored in a rack. Interview revealed the clean supply/storage room is used to store medical supplies and linens. Interview revealed the linen is kept uncovered. Interview revealed food items should not be placed into the refrigerator without being dated and labeled. Interview revealed it is unknown how long the salads and fruit cobblers had been in the refrigerator. Interview revealed dietary staff are responsible for cleaning the inside of the refrigerator/freezer. Interview revealed it is unknown when the refrigerator/freezer was last cleaned. Interview revealed there is not a set schedule for cleaning the microwave. Interview revealed nursing staff are responsible for cleaning the microwave when they find it dirty. Interview revealed it is unknown when the microwave was last cleaned. Interview revealed nursing staff are responsible for cleaning the counter surfaces in the medication room and house keeping is responsible for dusting and mopping the floor. Interview revealed there is not a set schedule for cleaning	A 724		

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A 724	Continued From page 154 the medication room. Interview revealed it is unknown when the medication room surfaces and floors were last cleaned. Interview revealed the ED staff failed to follow hospital policies.	A 724		
A1100	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based upon hospital policy and procedure reviews, observations during tours, medical record reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews, the hospital failed to meet the emergency needs of behavioral health patients in accordance with the hospital's policy and procedures. The findings include: 1. The hospital's Emergency nursing staff failed to provide ongoing assessment and monitoring of the condition of a patient during restraint or seclusion for 6 of 6 emergency department (ED) patients (#14, #16, #13, #17 #12, #9) under involuntary commitment (IVC). ~cross refer to 482.55(a)(3) Standard - Tag A1104.	A1100	A1100 & A 1104 – Maria Parham Medical Center meets and will continue to meet the regulations that require a hospital to meet the emergency needs of patients. The following actions have been implemented in support of A1100 & A 1104: Continued on page 157	
A1104	482.55(a)(3) EMERGENCY SERVICES POLICIES [If emergency services are provided at the hospital --] (3) The policies and procedures governing medical care provided in the emergency service	A1104		

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A1104	Continued From page 155 or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based upon hospital policy and procedure reviews, observations during tours, medical record reviews, Law Enforcement Officer (LEO) interviews, staff and physician interviews, the hospital's Emergency nursing staff failed to provide ongoing assessment and monitoring of the condition of a patient during restraint or seclusion for 6 of 6 emergency department (ED) patients (#14, #16, #13, #17 #12, #9) under involuntary commitment (IVC). The findings include: Review of current hospital policy "Restraint of Patients, PC 17", revised 12/2014, revealed "PURPOSE: The use of restraints is a therapeutic intervention implemented to prevent the patient from injuring himself/herself or from injuring others. The decision to use a restraint is driven by a comprehensive individual assessment. This document is used to provide consistent guidelines for the safe use of chemical and physical restraints and seclusion, if alternatives, as determined by an interdisciplinary team, have proven to be clinically ineffective to provide a safe environment for the patient. ...DEFINITIONS: Restraint - is the direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof. Physical Restraints - any manual method or physical/mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her	A1104	Continued from page 156 A100 and A 1104 – Maria Parham Medical Center does and will continue to protect and promote each patient's rights during restraint or seclusion. This is evidenced by our practice of not applying metal shackles in the treatment of any of our patients. It is only the Law Enforcement Officers (LEOs) who apply forensic restraints which include handcuffs, other chain-type restraint devices and other restrictive devices which are used for custody, detention and public safety and are not involved in the provision of health care. (Attachment B) PC 17 – Restraint of Patients policy. Maria Parham Medical Center has had numerous discussions with LEO regarding their practice of applying forensic restraints. Forensic Standard Policy EOC 66 (Attachment F) Corrective Action: On January 28, 2015 the Emergency Department implemented the "Behavioral Management/Forensic Restraint Flow Record" (Attachment C) to monitor and observe patients in restraints. Language includes forensic restraints and defines violent and non-violent behaviors to guide care as stated in Patient Care Policy #17 -"Restraint of Patients (Attachment B) Responsible Person: Nursing Director of ED.	1/28/2015

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A1104	Continued From page 156 arms, legs, body, or head freely. ...Restraint to Promote Medical Recovery (non-violent): refers to the use of restraints in those patients who require various medically essential therapies while hospitalized and who demonstrate a state of confusion or altered cognition that puts those therapies at risk OR those patients who require management of non-psychiatric behaviors that put them at risk for injury. Restraints for Violent or Self-Destructive Behavior: refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting. ...Restrictive Devices Applied by Law Enforcement Officials - handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons and is not involved in the provision of health care; no considered restraints. ...Seclusion - seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. The following interventions are not considered seclusion: 1. a patient physically restrained alone in an unlocked room. ...POLICY: It is the policy of (Hospital name) Medical Center to: 1. Prevent, reduce and eliminate the use of restraints by: a. preventing emergencies that have the potential to lead to the use of restraints, b. limiting the use of restraints to emergencies where there is a risk of the patient harming himself/herself or others. c. using the least restrictive method. 2. Protect the patient and	A1104	Continued from page 157 Corrective Action: Nursing Supervisors will include in their hand off a discussion of patients in restraints and are expected to review documentation of every patient in restraints and appropriateness of the restraints based on behavior. Care nurses will include in their hand off/shift huddle a review of the previous shift's documentation for completeness and continued need for restraints based on behavior. Monitoring will be through daily review of all patients in restraints for safety or behavioral by Director of Quality. Time frame for this monitor is three consecutive months of 100% compliance. Further monitoring will be based in the results of the 3 months review and the recommendations from Patient Safety Clinical Quality Committee, that reports director to the Board of Trustees. Responsible Person Chief Nursing Officer	2/1/2015

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A1104	Continued From page 157 preserve the patient's rights, dignity and well being during restraint use by: a. respecting the patient as an individual; b. maintaining a clean and safe environment; ...d. maintaining the patient's modesty, preventing visibility to others, and maintaining comfortable body temperature is maintained. 3. Provide for safe application and removal of the restraint by qualified staff. 4. Monitor and meet the patient's needs while in restraints. 5. Re-assess and encourage release of restraints as soon as possible. ...Restraints will be used only in situations where the patient is demonstrating observable behaviors that indicate he/she is at risk of injuring himself/herself or others. Restraints are not to be used for punishment, coercion, discipline, or retaliation of the patient or for staff convenience. This policy does not apply to devices....used by law enforcement officials although the standards of care stated within this document may be applicable. ...PROCEDURES: ASSESSMENT OF RISK FACTORS, INTERVENTIONS AND ALTERNATIVES TO RESTRAINT USE: A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it. ...Attempts should be made to evaluate and use the following interventions/alternatives when possible and in response to the patient's assessed needs: *Monitoring: 1. Companionship; staff or family stay with patient 2. Room near or visible from nursing station 3. Close, frequent observation ...*Environmental Measures: ...5. Room/halls clear of obstacles such as excess equipment ...Regular toileting: 1. Establish consistent toileting schedule for patient. ...CLINICAL JUSTIFICATION FOR USE OF RESTRAINT AND/OR SECLUSION: When clinically indicated, the restraint procedure is	A1104	Continued from page 158 The following actions have been implemented in support of Tag A175: • The ED staff, including physicians were re-educated on restraint usage and the Restraint of Patients policy PC 17 (Attachment B). Surgical, Medical, Progressive Care (PCU) and ICU staffs received re-education on restraint usage and the restraint policy. • Responsible Person: Nursing Director ED	

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A1104	Continued From page 158 implemented by the RN who is trained in restraint and/or seclusion techniques upon a physician's/LIP's order. Unless there is an immediate and overriding concern for safety, the restraint procedure is utilized only after all alternatives, less restrictive treatment interventions have been tried without success. Prior to implementation of any restraint, care team members will confer to determine that appropriate alternative measures have been attempted. Using the decision flowcharts for patient behaviors and alternatives for use of restraint, clinical assessment and utilization of restraint should be based on patient's behavior that may place the patient or others at risk for harm. Situations in which restraints are clinically justified include: *Threatens placement and/or patiency of necessary therapeutic lines/tubs, interfering with necessary medical treatment, and appropriate alternative measures have been attempted. ...*Unable to follow directions to avoid self-injury, and appropriate protective, alternative measures have been attempted. *Vulnerable patient populations, such as Pediatrics, who are cognitively or physically limited, are at a greater risk for injury Great caution should be utilized before initiating restraint use. LEAST RESTRICTIVE RESTRAINT/SAFE APPLICATION: Assessment and reassessment processes should include the appropriateness of the choice of restraint and/or seclusion. Physical restraints will be loosened periodically to evaluate skin integrity and circulation while the patient is in restraints. The types of restraint devices available within this facility and how to apply safely is as follows: ...2. Limb Restraints 1-->2-->3-->4-point ...5. Seclusion - Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically	A1104	Continued from page 159 **Monitoring:** Quality Director or designee conducting Monday - Friday restraint rounds in the Emergency Department and Nursing Supervisors Saturday - Sunday. Any deficiencies are immediately reported to the Nursing Director of the ED for resolution. Quality Director will continue to audit 100% of restraint patient charts to assure ongoing assessment and monitoring of the patient's condition meets standards specified in PC 17. A restraint report will be reported to Patient Safety & Clinical Quality at a minimum of ten times each year with minutes of this committee going to the Board of Trustees. • When restrictive devices have been applied by LEO, these patients must be observed 100% of the time by the law enforcement official. Responsible person: Chief Operating Officer **Monitoring**: Any deviation in Law enforcement practice would be reported to the Nursing Supervisor who would contact the Administrator on Call with report to the Chief Operating Officer. • Metal plate with two sharp pointed corners has been secured to the wall thus assuring no danger to patient. Responsible person: Nursing Director Emergency Department	1/15/2015

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prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member, or others. Seclusion is not a patient physically restrained alone in an unlocked room... ALTERNATIVE THERAPY: Prior to physically restraining a patient, restraint-free interventions such as (but not limited to) the following are attempted: *Provide safe environment, i.e., bed in low position, clutter free environment ...Enhanced observation ...*Sitter... PROCEDURE FOR USE OF RESTRAINT: Initiation and Renewal of Orders Standing orders, protocols, and/or PRN orders are not permitted. When initiating the use of a restraint, the appropriate restraint physician's order form (Nonviolent or Violent/Self Destructive) must be completed and placed on the chart within 30 minutes. This original order is time-limited based on type of restraint and age of patient. When use of restraints is contemplated, a physician/LIP or RN who has been trained in restraint application must document a face-to-face assessment prior to applying restraints, and document the need for restraint within the 1 hour time frame. The physician's/LIP's order must specify: *the restraint type *the justification for the restraint *date and time ordered *duration ...The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following: *an evaluation of the patient's immediate situation *the patient's reaction to the restraint *the patient's medical and behavioral condition *the need to continue or terminate the restraint or seclusion ...The Nonviolent Restraint Physician's

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A1104	Continued From page 160 Orders: Orders for nonviolent restraints must be renewed each calendar day by the patient's attending physician or other designated LIP based on his or her examination of the patient. It is not necessary for the renewal to be completed within a 24-hour time-frame as the physician can re-evaluate the patient and need for non-violent/self-destructive restraints during routine rounds. If restraints for nonviolent behavior purposes are anticipated to be continued beyond the maximum time limit of the order, a restraint renewal sticker is placed on the physician order form and must be completed by the LIP before the original order expires. Its use is based on his or her face-to-face examination of the patient. For Violent/Self-Destructive Restraints [V/SD] A physician/LIP or trained RN must document a face-to-face assessment within 1 hour of implementation of restraint or seclusion. The 1-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior. During the face-to-face assessment, the qualified practitioner will evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition; and the need to continue or terminate the	A1104		

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restraint or seclusion. The time limit for Violent/Self-Destructive Restraints is: *4 hours for adults (18 years of age or older) *2 hours for children (ages 9-17) *1 hour for children under age of 9 ...All patients who are in restraints must be continuously monitored and reassessed for the need to continue restraint by a qualified registered nurse (RN). ...When the order for restraints expires, a qualified, trained individual (who has been authorized by the organization to perform this function) will conduct an in-person assessment. If the patient is not ready for release from restraints, the authorized staff member will re-evaluate the efficacy of the patient's treatment plan and revise accordingly. the physician/LIP responsible for the patient's ongoing care will then be notified and a telephone order will be obtained and a new restraint physician order form will be placed on the chart for completion by the LIP. When the authorized, qualified staff member other than the physician/LIP continues restraints based on a new telephone order by the physician/LIP, the physician/LIP will re-evaluate the patient i.e. face-to-face assessment at least every 24 hours for adults, 2 hours for ages 9-17 and after 1 hour for children under age of 9 years for nonviolent restraints. If restraints are to be continued, a new time-limited order for restraints will be obtained from the physician/LIP. For Violent/Self Destructive restraints, a face-to-face re-evaluation by the physician/LIP is required after 4 hours for adult patients, after 2 hours for children ages 9-17 and after 1 hour for children under age 9. Seclusion guidelines 1. Individuals placed in seclusion must have a protected, private observable environment that safe guards their dignity and well-being. 2. The decision to seclude may be made by a trained RN in an

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A1104	Continued From page 162 emergency situation in which the patient exhibits violent, self-destructive behavior, when the physician is not available, after conducting a face-to-face assessment of the individual to determine whether the behavior requires seclusion. A physician or other LIP must see and evaluate the need for seclusion within one hour after the intervention is initiated. ...4. The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient. 5. Staff must monitor an individual placed in seclusion and document findings at a minimum of every 15 minutes. 6. Articles that might be used to inflict self-injury must be removed prior to placing in seclusion. ...8. If an individual falls asleep in seclusion, the door must be unlocked and opened within the nearest fifteen minute period monitoring. If the door is not unlocked, clinical justification must be documented in the patient's clinical record. Upon awakening, the patient must be re-evaluated by a RN or the physician upon awakening for continued release without regard to how long the individual was asleep or whether the maximum length of time prescribed in the order has expired. ...Discontinuing Restraint Once restraint is applied or initiated, the patient should be monitored and evaluated for the continued need of the intervention and the continued appropriateness of the type of intervention. ...The restraint should be discontinued as soon as the patient meets the behavior criteria for its discontinuation. The assessment of the continued need for restraint to determine early release should be documented at a minimum of every two hours or more often as the patient's condition improves. ...MONITORING,	A1104		

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A1104	Continued From page 163 ASSESSING, AND CARE OF THE PATIENT IN RESTRAINTS: When restraints are used there is an increased need for patient monitoring and assessment to assure patient safety, that the less restrictive methods are used when possible, and that restraint is discontinued as soon as possible. Immediately after restraints are applied an assessment should be made to ensure that the restraints were properly and safely applied so as to not cause the patient harm or pain. Documentation should include this assessment as well as the patient's response, any adjustments made. The frequency of monitoring the patient must be made on an individual basis, which includes a rationale that reflects consideration of the individual patient's medical needs and health status. The assessment includes, as appropriate to the type of restraint used: *signs of injury associated with the restraints *nutrition/hydration *circulation and range of motion in the extremities *vital signs *hygiene and elimination *physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being) *readiness for release from restraints *patient's understanding of the reasons for restraint and requirements for release ...PATIENT/FAMILY EDUCATION: Restraint procedures should be performed in a manner that does not violate the patient's rights. ...For Non-Violent restraints, reassessment and documentation is required at least every 2 hours and for Violent/Self-Destructive restraints, it is required every 15 minutes. DOCUMENTATION: The medical record should document: *that the patient and/or family was informed of the organization's policy on the use of restraints; *any medical condition or any physical disability that	A1104		

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would place the patient at greater risk during restraints/seclusion; *any history of sexual or physical abuse that would place the patient at grater psychological risk during restraint/seclusion. Documentation within the patient's record should indicate a clear progression in how techniques were implemented with the less intrusive restrictive intervention attempted or considered prior to the introduction of more restricted measure. When a restraint is initiated, the order must be documented immediately upon initiation. If the order for restraint is not initiated by the treating physician, the order must be followed by consultation with the patient's attending physician as soon as possible. ...Each episode of restraint/seclusion use is to be recorded in the medical record. Documentation will include: *date restraint applied *time restraint applied *type of Restraint (non-violent or violent/self destructive) *restraint device (soft, mitten, vest, geri-chair, etc.) *safe application verified *level of consciousness *safety/rights/dignity maintained verified *observed restraints appropriately intact *behavior during restraints *vital signs taken *free from injury associated with restraint *skin under/around restraint intact * range of motion done *circulation distal to restraint verified *offered nutrition/hydration *offered assistance with toileting/hygiene *offered comfort measures *the circumstances that led to restraint or seclusion use *consideration or failure of non-physical interventions including alternatives attempted and successful *the rationale for the type of physical intervention selected *notification of the patient's family/significant other, when appropriate *patient's response and any changes made as a result of the restraints *each telephone order received from a physician/LIP * debriefing of the

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A1104	Continued From page 165 patient with staff *any injuries that are sustained and treatment received from these injuries *any deaths. DISCONTINUING RESTRAINT DOCUMENTATION GUIDELINES *Criteria for restraint release met *Date restraint discontinued *Time restraint discontinued *Restraint debriefing when applicable for behavior (violent/self-destructive) MODIFICATION TO PATIENT'S PLAN OF CARE: The plan of care should clearly reflect a loop of assessment, intervention, evaluation and re-intervention. Restraint use must be in accordance with a written modification to the patient's plan of care..." 1. Observation during ED tour on 01/14/2015 at 1427 of exam room #17, revealed the room was located across from the nursing station. Observation revealed the room had a sliding glass door. Observation revealed a male patient (Patient #14) wearing green disposable scrubs and sitting on the end of the stretcher leaning over a bedside table. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right leg/ankle was chained to the stretcher's frame with a metal shackle/cuff (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. At 1433, observation revealed Patient #14 stood up off the end of the stretcher and pivoted around to the side of the stretcher without difficulty or assistance. At 1434, observation revealed XYZ County Sheriff Deputy (CSD) #1 was sitting behind the nursing station in a cubical. Observation revealed the cubical was on the opposite side of the nursing station, away	A1104		

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A1104	Continued From page 166 from exam room #17. Observation revealed CSD #1 stood up and exited the cubical and walked down the hallway on the opposite side of the nursing station, away from exam room #17 and exited the emergency department treatment area through a set of double doors. Observation revealed Patient #14 was alone in exam room #17 unsupervised by a LEO. At 1436, observation revealed CSD #1 returned to the cubical in the nursing station and sat down. Observations from 1427 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #14 while being restrained in exam room #17. Open medical record review on 01/14/2015 revealed Patient #14, a 60 year old male presented to the hospital's ED on 01/13/2015 at 1820 accompanied by Law Enforcement under IVC petition. Review revealed the patient's chief complaint was IVC-Crisis Evaluation Referral. Review of triage nurse documentation at 1827 revealed "IVC, per caregiver pt (patient) with bizarre behavior, pt walking around showing gentials [sic], pt endorses auditory hallucinations, pt with rambling thoughts in triage, pt states he will only hurt someone if they try to hurt him." Review of triage assessment documentation revealed the patient was alert, oriented x 3 (person, place, time) and anxious. Review revealed the patient was evaluated by a physician at 1908. Review revealed a chief complaint of being agitated and exposing genitals. Review revealed the patient was assessed as no acute distress, awake and alert, slightly agitated, pressured speech, and directable. Review revealed the patient was "cooperative." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on	A1104		

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A1104	Continued From page 167 01/13/2015 at 1541 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #14) is probably: [X] 1. mentally ill and dangerous to self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness. ..." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 01/13/2015 at 2345 revealed "Description of Findings" with "...presenting for agitation, exposing himself inappropriately to others. On evaluation, pt is disorganized with pressured speech. Oriented to location but not situation. Is currently a danger to himself due to psychosis." Review of nursing documentation at 2235 revealed "Resting quietly in bed. No aggressive behaviors, no self-injurious behavior. ..." At 1215 (01/14/2015) "...Pt unshackled while bed was exchanged." At 1330 "Pt sitting at end of bed. No c/o voiced. No distress noted." At 1500 "Pt sitting on bed c (with) no distress noted." At 1845 "Pt transported to (hospital name)....ambulated to police care no distress noted." Review of "Suicide Precautions Flow sheet" documentation on 01/13/2015 from 1900 to 2300 and 01/14/2015 from 0715 to 1845 revealed the patient's behavior was documented by staff as calm or cooperative. Review revealed no documentation the patient was violent or aggressive. Review revealed on 01/14/2015 at 1430, 1445, and 1500 (corresponding timeframe to Surveyor's observation [1427-1500] of the patient cuffed/shackled to the stretcher) as being cooperative. Record review failed to reveal any available documentation Patient #14 exhibited violent or self-destructive behaviors necessitating	A1104		

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the need for restraint use while hospitalized from 01/13/2015 at 1820 through discharge on 01/14/2015 at 1845. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy.

Interview on 01/14/2015 at 1442 with CSD #1 revealed he was a Deputy Sheriff with the XYZ County Sheriff's Department. Interview revealed he was present in the ED for a "10-73" (mental subject). Interview revealed the patient (#14) in exam room #17 was under IVC. Interview revealed the patient was brought to the ED on 01/13/2015. Interview revealed he relieved the previous Deputy this morning (01/14/2015) at shift change. Interview revealed the previous Deputy placed the patient into "ankle shackles." Interview revealed the "officer makes the decision wither or not the patient needs to be handcuffed or shackled." Interview revealed Patient #14 was not going to jail and was not under arrest. Interview revealed he (CSD #1) was on standby until a mental health facility could be found for the patient. Interview revealed because the patient was in his custody, he was responsible for any of

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the patient's actions. Interview revealed when the patient complains the cuffs/shackles are too tight or hurting, he will use 2-3 fingers to check to see if the cuffs/shackles are too tight. Interview revealed there was no set schedule for periodically removing the cuffs/shackles or checking for tightness. Interview revealed the "patient lets me know if they are too tight." Interview revealed if the patient needed to go to the restroom, the cuffs/shackles are removed. Interview revealed he does not check pulses or skin for circulation. Interview revealed the nurse is responsible for taking care of the patient's medical needs. Interview revealed he does not document in the patients ED medical record.

Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles.

Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the

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A1104	Continued From page 170 monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #14 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 2. Observation during ED tour on 01/14/2015 at 1438 of exam room #5, revealed the room was located diagonally across from the nursing station. Observation revealed the room had a wood door. Observation revealed a female patient (Patient #16) wearing green disposable scrubs and laying on her left side on the stretcher, watching television. Observation revealed the stretcher's two side rails were up and in the locked position. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's left wrist was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the	A1104		

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A1104	Continued From page 171 patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the exam room alone and without direct supervision of a LEO. Observation revealed an ABC City Police Department officer was sitting behind the nursing station in a cubical, reading a magazine. Observations from 1438 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #5. Open medical record review on 01/15/2015 for Patient #16 revealed an 18 year old female presented to the Hospital's ED on 01/13/2015 at 1726 for "potential drug overdose." Review revealed the patient was triaged by a RN at 1732 and was assessed by a ED Physician at 1734. Review revealed the patient was assessed at 1912 by a mobile crisis worker. Review revealed on 01/14/2015 at 0050, the patient was IVC for being mentally ill and dangerous to self and others. Review revealed at 0200 and 0400, the patient's behavior was documented as asleep with parent and LEO at bedside. Review revealed from 0600 to 01/15/2015 at 0515, the patient's behavior was documented as asleep, tearful, and resting quietly in bed, resting in bed with eyes closed and laying in bed with eyes closed. Review revealed at 0536, the patient requested the "shackle" (restraint) be loosened and the hospital staff informed the LEO. Review revealed at 0725, the patient behavior was documented as alert and oriented with right lower extremity "cuffed" (restraint) to bed frame. Review revealed at 0835, the patient was transferred to a Psychiatric hospital. Record review failed to reveal any available documentation Patient #16 exhibited violent or self-destructive behaviors necessitating the need	A1104		

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A1104	Continued From page 172 for restraint use while hospitalized from 01/13/2015 at 1726 through discharge on 01/15/2015 at 0835. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used). Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC	A1104		

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A1104	Continued From page 173 while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #16 while he was restrained in the ED with metal cuffs/shackles placedby a law enforcement officer. 3. Observation during ED tour on 01/14/2015 at 1430 of exam room #1, revealed an ante room was located diagonally across from the nursing station. Observation revealed the room was an isolation room. Observation revealed to view a patient required walking into the ante room, turning right and proceeding approximately 4 feet to enter the isolation room proper. Observation revealed a male patient (Patient #13) wearing green disposable scrubs and laying supine on the stretcher with both hands across his abdomen. Observation revealed the stretcher's two side rails were up. Observation revealed the patient was alert, calm, and cooperative. Observation revealed the patient's right ankle was chained to the stretcher's frame with a metal cuff/shackle (restraint). Observation revealed the patient did not exhibit any violent or self-destructive behaviors. Observation revealed the patient was in the isolation room alone and without direct supervision of a LEO. Observation revealed an	A1104		

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A1104	Continued From page 174 ABC City Police Department officer was sitting behind the nursing station in a cubical and due to location he could not observe the patient. Observation revealed from the LEO's location the ante room could be observed only. Observations from 1430 to 1500 failed to observe any violent or self-destructive behaviors exhibited by Patient #16 while being restrained in exam room #7. Open medical record review on 01/14/2015 for Patient #13 revealed a 26 year old male presented to the hospital ED (Emergency Department) on 01/13/2015 at 0125 with thoughts of suicide and for substance abuse detoxification. Review revealed at 0127, the patient was triaged by a RN and at 0234, the patient was assessed by a ED Physician. Review revealed at 0840, the patient was assessed by a mobile crisis worker and was admitted for suicidal thoughts. Review revealed at 1600, the patient was IVC (Involuntary Commitment) due to mentally ill and dangerous to self and others. Further review revealed when the patient was IVC, LEO (Law Enforcement Officer) placed the patient in leg shackles. Review revealed at 1800 and 2000, the patient's behavior was documented as calm and resting with eyes closed with the right ankle in shackled (restraint). Review revealed on 01/14/2015 at 0000, 0200, 0430, 0600, 0735 and 0935, the patient behavior was documented as asleep and resting quietly with the right ankle shackled. Review revealed at 1645, the patient was transferred to a Psychiatric hospital for treatment. Review revealed no documentation the patient demonstrated violent or self-destructive behaviors. Record review failed to reveal any available documentation Patient #13 exhibited violent or self-destructive behaviors necessitating the need for restraint use while	A1104		

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A1104	Continued From page 175 hospitalized from 01/13/2015 at 0125 through discharge on 01/14/2015 at 1645. Interview with ABC Police Officer #1 on 01/14/2015 at 1435 revealed he was responsible for 3 patients under IVC in the ED at this time. The interview revealed he stations himself at an area in the corner. The interview revealed he can observe the patient in the seclusion room and the patient in room #5. The interview revealed Officer # 1 was not allowed to answer any further questions. The interview revealed a phone number to two Lieutenant at the City Police Department if further questions needed to be asked. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the	A1104		

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A1104	Continued From page 176 monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #13 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 4. Observation during ED tour on 01/14/2015 at 1430 of the seclusion room #7 revealed a room with a solid wood door and window with blinds and the blinds were outside covering the window. Observation revealed on the left side of the room at the head of the stretcher a metal plate with two sharp pointed corners partially attached to the wall. Observation revealed the metal plate could be easily pulled further off of the wall. When exiting the room a male patient (Patient #17) was observed standing calmly beside with door EMS personnel at his side. Observation revealed the patient was escorted into the seclusion room along with the Mental Health Nurse (MHRN).	A1104		

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A1104	Continued From page 177 Approximately 10 minutes 2 City LEOs were observed entering the seclusion room and the MHRN standing out side of the room. The door and the blinds were closed. Interview with the MHRN during the observation revealed City LEO were in the room searching the patient, putting the patient in scrubs and cuffing the patient. The interview revealed the LEO cuffed the patient because the patient was IVC. The interview revealed that even if the patient is calm and cooperative the patient is always cuffed. The interview revealed the MHRN had training on the Hospital policy and procedure for restraining patients in October, 2014. The interview revealed she was also aware of the revision of the restraint and seclusion policy completed in December, 2014. Patient #17 was observed during the interview with both wrist cuffed with metal cuffs Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview with ABC Police Officer #1 on 01/14/2015 at 1435 revealed he was responsible for 3 patients under IVC in the ED at this time. The interview revealed he stations himself at an area in the corner. The interview revealed he can observe the patient in the seclusion room and the patient in room #5. The interview revealed Officer # 1 was not allowed to answer any further	A1104		

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A1104	Continued From page 178 questions. The interview revealed a phone number to two Lieutenant at the City Police Department if further questions needed to be asked. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring patients while restrained in the ED with metal cuffs/shackles placed by a law	A1104		

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A1104	Continued From page 179 enforcement officer. 5. Closed medical record review of Patient #12 revealed a 9 (nine) year old child presenting to the Emergency Department with mother on 12/12/2014 at 2001 with a chief complaint of "Pt (patient) with hx (history) of ADHD (Attention Deficient Hyperactivity Disorder) seen by daymark and referred to ER for psych eval. (evaluation). Mother sts (states) pt acting out when not getting 'his way'. Mother sts pt using foul language, and damaging property at home. Pt age appropriate, resp (respirations) even and unlabored, NAD (no acute distress)." Medical record review revealed documentation by nursing staff that triage was conducted at 2003 and the child was alert responded to voice and was oriented to person, time and place. Review of nursing documentation at 2002 revealed the "Pt ambulated to ER-1 - Pt very agitated and uncontrollable. Pt screaming, constantly in motion and tearing up thins at home. Pt using foul language". Medical record review revealed documentation of the physician's medical screening exam (MSE) on 12/12/2014 at 2010 in room 1. Review of the MSE revealed the parent was with the patient during the exam and the child was "angry, frustrated, agitated". Review of the MSE revealed the clinical impression by the physician was ADHD. Review of nursing documentation revealed at 2140 the patient was"very agitated - screaming, rolling around on floor, slapping at wall and not following instructions. Medical record review revealed the patient was administered per physician's order Ativan (medication for treatment of anxiety disorders) 1 mg IM at 2219 and Benadryl 25 (medication used for psychiatric symptoms) mg IM at 2213. Medical record review revealed	A1104		

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A1104	Continued From page 180 documentation on the "Appropriateness/Justification for Acute Medical/Surgical Restraint" form of a physician's order for the patient to be physically restrained due to "Pt's (patient's) behavior uncontrollable - spitting, scratching- trying to bite, cursing- uncontrollable with meds." Further review of the physician's order for restraint revealed the restraint type was ordered "Soft limb holders...Four Side Rails". Review of the type order revealed no documentation of which limbs or how many limbs were to be restrained. Review of the order revealed the restraint was initiated on 12/12/ 2014 at 2248 and the order was signed by the physician at 2250. Review of the order did not reveal any documentation of the time limit for restraining the child. Medical record review revealed documentation at 2254 the restraint was discontinued. Medical record review did not reveal any documentation of a one hour face to face examination after the child was placed in restraints. Review of nursing documentation revealed at 2230 "mental health case worker in to evaluate pt". Review of the mental health staff documentation at 2300 revealed "client was being placed in a four point restrain by hospital staff. Client was displaying aggressive behaviors to his mother and medical staff...Client damaged hospital property...Client had to be move to the seclusion room where all items were removed including bed...Client continued his aggressive behavior for about two hours which led to the doctor giving client 25 mg Benedryl IM at 10:10 pm and 1 mg ativan IM at 10:30 pm due to client continue disruptive behavior client was given 2 mg of Haldol IM at 11:10 pm...continue disruptive behavior for about thirty minutes before calming down at that time XXX County Officer arrived and placed patient into custody. Medical staff place	A1104		

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A1104	Continued From page 181 bed back into seclusion room at that time...Client had to be place in four point restraints by medical staff." Record review revealed documentation of "Petition for involuntary commitment" dated 12/12/2014 and completed by the physician stating the patient was agitation and a danger to self and others and requested inpatient treatment and stabilization. Nursing documentation at 2254 revealed "Pt got himself out of restrains, still out of control. Nursing documentation revealed at 2306 the patient was moved to room 7 for seclusion and at 2314 the patient was hitting the door. Nursing documentation at 2309 revealed the patient was kicking scratching and spitting and trying to "break down door, Haldol (antipsychotic medication) 2 mg IM" was given. Further review of nursing documentation revealed the patient calmed down at 2340, "resting on floor...placed on cardiac monitor" and was placed in bed. Documentation by nursing staff revealed at 2345 the patient was "IVC'd and restrained by law enforcement with ankle cuff to left ankle and bed. Pt sleeping without distress". Nursing documentation revealed on 12/13/2014 at 0100, 0200, 0300, 0400 and 0600 the patient was sleeping without distress. Documentation revealed the patient was offered water at 0300, refused and took sips of water at 0600. Review of nursing documentation revealed no documentation of assessment at 0500. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/12/2014 from 2350 until 12/13/2014 at 0720 revealed the patient was " A-resting in bed". Review of nursing documentation on 12/13/2014 at 0730 revealed law enforcement was present and the child's "left ankle cuffed to bed rail per law enforcement protocol." Nursing documentation revealed at 0810 the patient was yelling "I'm hungry" and the	A1104		

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A1104	Continued From page 182	A1104		

staff "encouraged to relax breakfast will be coming soon." Documentation at 0835 revealed the child continued yell for the nurse and the child was given orange juice and peanut butter crackers. Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/13/2014 from 0900 until 12/14/2014 at 0716 revealed the patient was " A-resting in bed". Documentation at 0900 revealed the breakfast tray was made available to the child and at 0940 he was asleep. Nursing documentation at 1100 revealed the child told nursing staff that heard and sees the devil telling him to do it". Review of nursing documentation at 1300 revealed the patient was released from forensic restraints by the LEO and the patient ran. Documentation revealed "the officer captured pt and brought back to room pt began banging forensic restraints PRN (as needed) given at 1322". Nursing documentation at 1400 revealed the patient was medicated due to the patient not taking redirection. Nursing documentation revealed the patient slept until 1905 when he awoke and asked for dinner. Nursing documentation at 1951 revealed the patient was placed in "4 pt (point) forensic restraints after "slamming upon bed and jumping up and down, cursing and threatening staff." Nursing documentation revealed at 2000 "remains in 4 pt restraints...Ativan was given, at 2012 "remains in 4 pt restraint, at 2033 "Forensic arm restraint removed. Leg shackles remain...Pt being monitored by nurses and officer." Documentation at 2045 revealed the patient was placed back in 4 point restraints due to cursing and yelling. documentation at 2118 revealed the patient remained in 4 point restraints and "Haldol given as ordered". Documentation at 2215 revealed the patient remained in 4 point restraints. review of

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A1104	Continued From page 183 nursing documentation on 12/14/2014 at 0615 revealed the patient slept since being medicated at "midnight" and "remains in restraints". Documentation by nursing staff at 0820 revealed the "pt yelling out 'I'm wet' In room to assess pt. pt voided self and floor. Officer in room to uncuff pt...pt c/o (complained of) 'my moms gonna be so mad I pissed myself'." Review of documentation on the "Suicide precautions flow sheet"by Security Officer on 12/14/2014 from 0830 until 12/16/2014 at 0630 revealed the patient was " A-resting in bed". Documentation revealed the patient was cleaned and rested quietly until 1345. Documentation at 1345 revealed an attempt was made to remove one restraint "Pt climbing over bed. Forensic restraint had to be reapplied "Pt cursing, yelling, urinated on self". Record review revealed the patient was administered Haldol IM at 1415 and was documented resting at 1455 (40 minutes after medication), 1548 (53 minutes after previous assessment), 1639 (1 hour later) and at 1730 (51 minutes later). Nursing documentation revealed the patient rested quietly from 12/15/2014 at 2400 through 1319 (13 hours) with law enforcement. Nursing documentation revealed the patient cried at intervals for his mother. Nursing documentation at 1500 revealed the patient was up to the bathroom "for BM (bowel movement) x1. Shackles on." Review of nursing documentation did not reveal any documentation of the patient having disruptive or aggressive behaviors prior to or after going to the bathroom. Nursing documentation revealed no documentation of aggressive, agitated or self destructive behavior from 1600 on 12/15/2014 through 12/16/2014 at 0710. Documentation at 0710 revealed the LEO was at the bedside. Nursing documentation on 12/16/2014 at 1100 revealed "Patient kept yelling out 'Nurse,	A1104		

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A1104	Continued From page 184	A1104		

Nurse'...mental health,charge nurse and writer in room to talk to patient that if he stops yelling out loud he could be able to talk to his mother and will be moved to a room with tv". Documentation at 1140 revealed the patient vomited yellowish emesis on the floor and told the nurse he "does not feel good". Documentation revealed the nurse notified the physician and at 1315 the patient continued to yell out for the Nurse. Documentation at 1500 revealed the patient vomited a second time and the physician was made aware. Documentation revealed Zofran (antiseptic) IV was administered at 1830 and Normal Saline infused at a "bolus rate". Record reviewed revealed nursing documentation at 2030 (2 hours after medication) that the patient was resting. Record review revealed on 12/17/2014 at 1045 the patient was administered Ativan 1 mg IM, Zofran by mouth and the patient had pulled out his IV. Record review revealed at 1055 the patient was placed in 4 point restraints by LEO for yelling, not following directions and "pulling the stretcher to the door." Review of documentation by mental health staff on 12/17/2014 at 1120 revealed "Client pulled out his IV in his hand and made himself vomit. Client has escalated to where he is yelling constantly and has had both hands and one leg put in restraints." Nursing documentation revealed at 1357 the patient remained in "2 pt forensic restraints" (3 hours since last documentation). Review of nursing documentation on 12/18/2014 at 1110 revealed the patient remained in 2 point forensic restraints. Nursing documentation revealed at 1230 the patient complained of urinating on self. Review of documentation by mental health staff at 1400 revealed "Reassessment completed. Client continues to yell and have outburst. Staff not able to redirect.

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Client has been medicated and is still in restrains. Client now has a one on one staff member sitting with him. Client has been calmer when staff person is sitting with him." Documentation by nursing at 1445"staff member sitting with pt 1:1". Nursing documentation at 1645 and 1755 revealed a staff member sat with the patient 1:1 and the patient was "pleasant & cooperative." Documentation by nursing on 12/18/2014 revealed the "officer" was at the bedside and the patient "remains cooperative.' Review of nursing documentation on 12/19/2014 at 0730 revealed "Pt unshackled by officer so RN could assist pt with bath...Pt states 'these cuffs make my feet hurt'. " Record review did not reveal any documentation of an assessment of the patient's feet after he complained of hurting due to the "cuffs". Review of documentation by mental health staff at 1010 revealed "Reassessment completed. Client continues to yell out and not follow directions. Client is still in restraint." Review of nursing documentation at 1845 revealed LEO was at the hospital to transport the patient to an acute psychiatric hospital. Medical record review revealed documentation on 12/20/2014 at 1200, a written physician certification order for the transfer of the child to a psychiatric acute hospital for psychiatric services not available at the hospital. Review of the certification revealed the patient remained under IVC and was transported by law enforcement officer. Further record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration,

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A1104	Continued From page 186 circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into	A1104		

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A1104	Continued From page 187 the ED under IVC or who are placed under IVC while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #12 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. 6. Closed medical record review on 01/14/2015 revealed Patient #9 presented to the hospital's ED on 11/01/2013 at 1106 via private transportation accompanied by group home staff. Review revealed the patient's chief complaint was Crisis Evaluation Referral. Review of triage nurse documentation at 1116 revealed "pt admitted to new group home Monday, staff reports pt made threats to 'kill himself and everybody else.' Stated pt attempted to run away." Review of initial nursing assessment documentation revealed the patient was alert, awake, responsive to voice, oriented to person, time, and place. Review of a ED risk screen revealed the patient was assessed as "No" for risk for self harm/elopement. Record review revealed the patient was initially placed in exam room #20. Review revealed the patient was evaluated by a ED physician at 1109. Review revealed a chief complaint of suicidal thoughts, expressing SI	A1104		

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(suicidal ideation) and HI (homicidal ideation). Review revealed a past medical history of bipolar disorder, schizophrenia, and moderate mental retardation (MR). Review revealed the patient was assessed as no acute distress; awake and alert; oriented X4 (person, place, time, and situation); mood and affect normal. Extremities non-tender and no signs of injury. Review of a Affidavit and Petition For Involuntary Commitment form dated 11/01/2013 (not timed) revealed the Respondent was Patient #9 and the Petitioner was ED Physician A. Review revealed "The facts upon which this opinion is based are as follows....Patient is mentally challenged with history of Bipolar D/O (disorder) and Schizophrenia who is very unstable at this time. He is making threats that he will kill others at the group home and himself." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 11/01/2013 at 1200 revealed "Description of Findings" with "...Patient is mentally challenged with history of Bipolar and Schizophrenia who is very unstable at this time. He is making threats to kill himself and others - needs in-patient stabilization." Review of a "Findings and Custody Order Involuntary Commitment" revealed the order was signed on 11/01/2013 at 1258 by a Magistrate. Review revealed "The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent (Patient #9) is probably: [X] 1. mentally ill and dangerous to self or others...." Review revealed the respondent was taken into custody by ABC City Police Officer on 11/01/2013 at 1336 (Patient in ED when taken into custody). Review of a Computerized Physician's Order Entry (CPOE) report, Order # 26, CPOE

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#398912, revealed a physician's order entered by ED Physician A on 11/01/2013 at 1358 for "Restraints, Place in", Frequency: "ONCE", Priority: "Routine". Review of a Comprehensive Assessment Tool-Intake form dated 11/01/2013 at 1452 revealed "...presents to (Hospital A) - ED c group staff. Staff from group home report clt (client) was trying to run away this am and threatened to kill self as well as staff. Upon admission clt was making a gun with his fingers and placing it to the head of staff, threatening to stab another staff c a plastic fork and being verbally abusive. ...Clt was restrained on admission c forensic restraints and required pepper spray p (after) refusing chemical restraint. ..." Review of nursing documentation revealed on 11/01/2013 at 1106 "Pt cc HI. Pt @ (at) group home. MR high functioning w (with)/Psychosis + (and) Bipolar. Pt pretending to shoot staff + 'flipping off' other patients from room." At 1245, "Pt moved to isolation room (Exam Room #1), IVC in place, officer @ bedside. Pt acting iriatic [sic], cuffed (restraint) to bed, Pt had previously tried to hang self w/belt. Now threatening officer + trying to bite him, Pt trying to break free from cuffs, bed now broken, officer warning pt of violent behavior." At 1400, "Pt out of control, violent, calling everyone 'F**king Bi**hs.' Broke posey chest vest....threatening to kill officer. Pt sprayed w/pepper spray @ close range." At 1410, "Pt refusing flushing treatment. V/S (vital signs) WNL (within normal limits), resting in bed with eyes open, resp (respirations) nonlabored." At 1600, "Pt starting to yell out again, HPD (ABC City Police Department) at bedside." At 1755, "Pt resp WNL..." Review of Crisis Assessment documentation by mobile crisis management staff for Patient #9 dated 11/01/2013 at 1800 revealed the reason for referral was physical aggression,

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property destruction, threats of physical aggression, running away, verbal aggression, hallucinations or delusions, homicidal and suicidal. Review revealed "Became aggressive at GH (group home). Threatened to stab + shoot self + others. Ran to neighbors. Upon entering ED he refused meds + put a belt around his neck. He had to be pepper sprayed + put in 4 point restraints. ..." Review of mental status examination revealed the patient was disheveled with poor hygiene, and in 4 point restraints. Review revealed the patient had good eye contact, was calm, and had no impairment with communication and appropriate speech. Review revealed the patient's mood was depressed, slightly withdrawn, and cooperative. Review of nursing documentation revealed at 1900, "...Pt sleeping on bed in 4 point restraints. HPD c (with) patient." At 2230, "Sleeping. Quiet and cooperative." At 0100 (11/02/2013), Pt continues to sleep soundly." At 0300, "Pt. continues to sleep with restraints to wrist." At 0730, "Observed asleep. Law enforcement present. ..." At 0930, "Mental Health Services cont. (continue) to evaluate for mental health facility placement." At 1050, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1330, "...Remains cooperative. No suicidal or homicidal gestures." At 1440, "...Remains cooperative..." At 1555, "Law enforcement remains present. ...No suicidal or homicidal gestures." At 1900, "Pt moved to room 7 (Seclusion Room). Police officer remains @ bedside..." At 2000 to 0200 (11/03/2013) continued observation by police officer. At 0327, "...Pt calm + cooperative...." At, 0600 "...Calm Cooperative....Officer outside of rm (room)." At 0705, "...Pt calm + cooperative..." At 0930, "...HPD officer sitting outside of rm..." At 1330, "Pt remains calm + cooperative..." At 2055,

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"Pt. calm + cooperative...Rt. ankle remains shackled to stretcher by HPD. Good PMS (pulse, motor, sensation). Pt remains IVC'd." At 2300, "Pt continues to watch TV..." At 1130 (11/04/2013), "...cooperative..." At 0810, "Remains cooperative..." At 0900, "...Remains cooperative." At 1200, "Law enforcement remains present..." At 1545, "...Remains Cooperative...No suicidal/homicidal gestures. ..." At 1800, "Remains cooperative..." At 2040, "...Pt. pleasant + cooperative..." At 0140 (11/05/2013), "Resting c eyes closed....Law enforcement present." At 0815, "...Remains cooperative." At 1400, "...Law enforcement remains present. No suicidal/homicidal gestures." Review of an "Examination and Recommendation to Determine Necessity for Involuntary Commitment" form dated 11/05/2013 at 1745 revealed "Description of Findings" with "...Pt now stabilized, A+OX4, (No) HI, SI. D/W (discussed with) group home for disposition. Does not currently meet IVC criteria." Review of ED physician reassessment documentation at 1755 (11/05/2013) revealed the patient was re-examined and has improved, AOX4, Stable, No homicidal or suicidal ideation. Group home agrees to assume care. Review revealed a clinical impression of Psychosis, Schizophrenia, acute exacerbation. Review of nursing documentation revealed at 1858, "...Taken back to group home per law enforcement. ..." Record review failed to reveal documentation of ongoing monitoring and assessment of the patient at least every 15 minutes for violent/self-destructive restraint or every two hours for non-violent restraint (as appropriate to the type of restraint used) for one or more of the following: signs of injury associated with the restraints, nutrition/hydration, circulation and range of motion in the extremities,

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A1104	Continued From page 192 vital signs, hygiene and elimination, physical and psychological status and comfort (i.e. skin integrity, comfortable body temperature, the patient's dignity, mental status, and emotional well being), readiness for release from restraints, patient's understanding of the reasons for restraint and requirements for release, per hospital policy. Interview on 01/13/2015 at 1107 during ED tour with Charge Nurse #1 revealed the only approved restraints used in the ED by nursing staff are "soft limb restraints." Interview revealed "only the Sheriff and Police Departments use handcuffs and shackles with IVC patients." Interview revealed the nurse is responsible for monitoring and assessing the patient when in handcuffs or shackles. Interview revealed the nursing staff is not responsible for applying the handcuffs or shackles. Interview on 01/15/2015 at 1015 with the ED Medical Director revealed he spoke with a police officer with the ABC City Police Department while in the ED. Interview revealed the police officer stated the Chief of Police had determined that the IVC patients were in the custody of the police officer and that it was Departmental policy for all IVC patients to be placed into handcuffs or shackles while in the ED. Interview revealed "we can't control the police putting the patients in custody." Interview revealed "we can control the monitoring of the patients." The interview revealed " we have been trying to work through this for the past 9 months with Chief of Police." Interview on 01/15/2015 at 1235 with the ED Nursing Director revealed patients brought into the ED under IVC or who are placed under IVC	A1104		

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A1104	Continued From page 193 while in the ED were placed into "forensic" restraints (handcuffs or shackles) by the law enforcement officers. Interview revealed the ED staff did not view the placement of IVC patients in handcuffs or shackles as a restraint, because they were in the custody of law enforcement. Interview revealed there would not be any documentation of monitoring and assessment every 15 minutes (for violent self-destructive behavior) and/or 2 hours (for non-violent behavior), because the handcuffs and shackles were not considered a restrictive intervention by ED staff. Interview revealed the ED staff did not follow the hospital's Restraint of Patient policy for monitoring Patient #9 while he was restrained in the ED with metal cuffs/shackles placed by a law enforcement officer. NC00100584 NC00093865 NC00093275 NC00092645 NC00096103 NC00103051	A1104		