

Bureau of Health Care Quality & Compliance

hospital. Prohace, HFS III 4/8/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN632HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING <i>Not all of the directed POC items were addressed in updated POC received from</i> B. WING	(X3) DATE SURVEY COMPLETED C 03/09/2009
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NAME OF PROVIDER OR SUPPLIER BHC WEST HILLS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1240 E NINTH ST RENO, NV 89515
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S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a State Licensure complaint survey initiated on 2/3/09 and finalized on 3/9/09.</p> <p>The survey was conducted using the authority of NAC 449 Hospitals.</p> <p>Complaint #NV00020789 was a self reported incident. It was substantiated with deficiencies cited. See Tag S-055, S-060, S-291, S-298, S-300, S-311</p> <p>Complaint # NV0021065 was a self reported incident. It was substantiated with deficiencies cited. See Tag S-291, S-298, S-300, S-311.</p> <p>Complaint #NV00020763 was a complaint. It was unsubstantiated.</p> <p>Complaint # NV00020788 was a self reported incident. No deficiencies were cited.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	S 000		
S 055	<p>NAC 449.314 Quality of Care/Staffing</p> <p>4 A hospital shall ensure that it is staffed by a sufficient number of personnel, whose qualifications are consistent with their job responsibilities, to provide care to the patients of the hospital.</p> <p>This Regulation is not met as evidenced by. Based on record review, staff interviews and observation, the facility failed to provide adequate staffing to meet patient needs for 2 of 10 patients (#1, #2) and failed to provide agency staff with the training needed to provide safe patient care.</p>	S 055	<p>449.314 QUALITY OF CARE/STAFFING</p> <p>West Hills Hospital now ensures adequate staffing to meet patient needs and proper training of agency staff to provide safe patient care.</p> <p>Corrective Action:</p> <p>Patients #1 and #2 were discharged following the event, however, the facility took immediate steps to ameliorate safety concerns and keep all other patients safe by:</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *CEO* (x6) DATE *4/8/09*

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S 055	<p>Continued From page 1</p> <p>for 4 of 4 agency staff (#9, #8, #7, #11)</p> <p>Findings include:</p> <p>Patient #1 was admitted to the facility on 12/08/08, with diagnoses including major depressive disorder and psychosis. She was placed on the Youth Services Unit.</p> <p>Patient #1's record review revealed she had a history of suicidal ideation. On 12/9/08, she was placed on suicidal precautions due to having a plan to ingest cleaning agents. Her physician ordered that she be observed by staff every 15 minutes. On 12/12/08, she was also restricted to the unit due to active suicidal ideation. The unit restrictions were in effect until 12/17/08. She was again placed on unit restrictions due to active suicidal thoughts on 12/23/08. The patient was on suicidal precautions with unit restrictions on 12/25/08.</p> <p>Patient #2 was admitted to the facility on 12/1/08, with diagnoses including major depressive disorder, possible bipolar disorder and severe asthma. She was placed on the Youth Services Unit.</p> <p>Review of Patient #2's records revealed that increasing active suicidality was a reason for admission. On 12/16/08, her physician ordered that she be placed on 1:1 supervision due to a suicide attempt at the facility. She had tied a sweat shirt tightly around her neck and tied the other end to the door. On 12/21/08, the physician discontinued 1:1 supervision and placed her on line of sight supervision meaning staff were to maintain constant visual observation of the patient. The patient was on line of sight supervision on 12/25/08.</p>	S 055	<ol style="list-style-type: none"> Staffing patterns were thoroughly reviewed and revised for all units to include a minimum of two licensed personnel 24/7 so that there is adequate staff to meet the needs of all patients on all shifts on an ongoing basis. A supervisor was added to the night shift and weekend shifts to provide supervision of nursing staff, ongoing training and orientation of new nursing staff. Relief times for meals and breaks are scheduled for each shift to assure adequate staffing by licensed nurses for patient needs consistently throughout each shift. Additional staffing patterns were reviewed and revised to make sure sufficient staff are scheduled to meet patient needs ensuring that the revised staffing patterns are based on: <ol style="list-style-type: none"> Census Patient acuity Levels of observation and special precautions including line-of-sight and 1:1 staffing 	<p>3/6/09</p> <p>3/8/09</p> <p>3/6/09</p>

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S 055	<p>Continued From page 2</p> <p>Record review revealed that on 12/25/08 at 10:45 PM. Patient #1 and Patient #2 were found with nooses around their necks made from a sheet. The sheet was hung over the bathroom door. They used each other's weight to put tension on each noose.</p> <p>Patient #1 was found still conscious and her face was described as red. She later complained of a sore neck. The Mental Health Technician (MHT), who found the patient, wrote a statement describing the incident. The statement read "I went into the room and tried to untie the sheet from _____'s neck first. It was so tight I couldn't even get my fingers in it. I have to lift _____ off the floor to loosen the tightness."</p> <p>Patient #2's acuity/progress notes revealed her face was red and she complained of neck pain following the suicide attempt. She reported to the physician that she tried to claw at the noose as soon as it tightened and she panicked. She reported that she began to feel dizzy and numb.</p> <p>In an interview with the Director of Nurses (DON) on 2/4/09, he revealed that he was not aware of the attempted suicides until 12/29/08, when he received the incident reports and began an investigation of the incident. He stated that he reviewed the video recordings of the common areas of the Youth Services unit and found that MHT #1 and Registered Nurse (RN) #1 did not monitor the patients as required by the physician's orders and by facility policy.</p> <p>The DON provided a form entitled "Daily Nursing Schedule" which showed that one registered nurse (RN), RN #1, and one MHT (MHT #1) were assigned to the Youth Services unit on the 3</p>	S 055	<p>d. Volume of admissions and discharges, and</p> <p>e. Special needs.</p> <p>4. Responsibilities of the Nursing Supervisors include, but not limited to:</p> <p>a. Assist with training and orientation of nursing staff,</p> <p>b. oversee the utilization of agency staff by direct observation and provide oversight via rounds conducted every shift.</p> <p>c. Provide meal breaks for unit RNs;</p> <p>d. Assist with admission process as needed,</p> <p>e. Complete random audits of chart documentation.</p> <p>5. The Interim Director of Nursing and/or designee have provided all first time agency staff with orientation, training and post testing to ensure their competence to perform staff assignments.</p> <p>This ongoing orientation and training includes:</p> <ul style="list-style-type: none"> • Seclusion and restraint • Patient's Rights • Location of emergency equipment • Patient identification procedures 	<p>3/8/09</p> <p>3/6/09</p>

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S 055	<p>Continued From page 4</p> <p>attending physician. He called the attending physician as part of his investigation of the event and confirmed that the physician had not received a phone call regarding the suicide attempts until 12/26/08. The report revealed that the physician stated she would have come to the hospital to assess her patients if she were called. The DON also confirmed that the RN did not assess Patient #1 and Patient #2 following the attempted suicides.</p> <p>Review of the facility's policy and procedure entitled "Levels of Observation" revealed that all patients would be routinely observed in compliance with physician orders and prescribed protocols. The policy and procedure revealed that all patients were to be checked every 15 minutes without a physician's order. Line of sight observation required that staff maintain constant visual observation through direct observation or through the use of audio/visual monitoring.</p> <p>Facility policy and procedure entitled "Suicide Emergency Care" revealed that all suicide attempts were to be reported to the attending physician and the patient's needs were to be immediately tended to. A RN assessment was to be conducted and a call for emergency help was to be made as needed, based on the RN assessment and physician order. An incident report was to be completed.</p> <p>On 3/5/09, Employee #13 was interviewed. The employee reported that nurses do leave the unit and leave the MHT's alone on the locked units without supervision of a RN. Employee #13 stated that the nurses usually go to the dining room, which was outside of the locked patient units. He reported nurses can leave the building on lunch or dinner. The employee expressed</p>	S 055	<p>8. Only a West Hills Hospital RN will complete a face to face assessment of any patient requiring seclusion and/or restraint. If such RN is not available, the MD will be notified to complete the face to face assessment.</p> <p>9. Agency staff now receive extensive training on seclusion and restraint including:</p> <ul style="list-style-type: none"> • WHH seclusion and restraint philosophy • WHH seclusion and restraint policy • Proper orders for seclusion and restraints • Physician role in seclusion and restraints • Safe care of patients during seclusion and restraint • Seclusion and restraint documentation requirements • Debriefing requirements following seclusion and restraint • Treatment planning modifications following seclusion and restraints • Internal reporting requirements for seclusion and restraints • State patients rights reporting requirements <p>Responsible Person:</p> <p>Interim Director of Nursing CEO</p>	3/16/09

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S 055	<p>Continued From page 6</p> <p>Services Unit. Agency Staff #9, a Registered Nurse (RN), Agency Staff #8 and #11 both Certified Nurse Assistants (CNA's) all reported they were contracted agency staff personnel and not hospital employees. They reported that there were no hospital employees working on the unit during their shift which began at 11:00 PM on 3/5/09.</p> <p>Agency Staff #8 reported that it was her first night working at the hospital. She stated that Agency Staff #11, who was also a contracted agency worker, was showing her what she needed to do. Agency Staff #8 was asked if she received any training by hospital staff in fire/emergency procedures or hospital policies and procedures, including restraint and seclusion, when she reported for work. She reported that she never received training.</p> <p>Agency Staff #11, began to work as an agency worker at the hospital on 2/12/09. She confirmed she had no training in the hospital's fire safety, emergencies or other policies and procedures.</p> <p>Agency Staff #9, a RN, also reported that she had no training by the hospital in fire and emergency procedures. She reported that she had no training on restraint, seclusion or other hospital policies and procedures. She stated that she did follow a hospital nurse for awhile on her first night of work and was shown how to take off orders and how to do 15 minute checks. She stated she had some experience on restraints since she worked at a developmentally disabled group home.</p> <p>On 3/6/09, the hospital was asked to provide the agency workers files. Licensed Practical Nurse (LPN) #5 provided three files which contained</p>	S 055		

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S 055	Continued From page 7 orientation check lists of procedures she claimed she had given to the agency workers. The policy and procedures were signed off by LPN #5 as being given but there were no signatures or initials of agency workers. Agency Staff #9, #8 and #11 were contacted via phone on 3/6/09 and all three denied receiving training in fire safety, emergency procedures or hospital policies and procedures. On 3/6/09, Agency Staff #7, a RN, was interviewed. She reported that she was an agency nurse and that she started working at the hospital approximately one month ago. She was asked if she had received training in the facility's policies and procedures including fire and evacuation, emergency procedures and restraint and seclusion. She stated that she had not received training other than being paired with another worker on her first night. On 3/6/09, LPN #5 was asked for Agency Staff #7's file. No evidence of hospital orientation was found within the file. LPN #5 confirmed that Agency Staff #7 had not received hospital orientation. Severity.4 Scope 3	S 055		
S 060	NAC 449.3152 Quality Improvement 1. The governing body of a hospital shall ensure that the hospital has an effective, comprehensive quality improvement program to evaluate the provision of care to its patients. This Regulation is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure thorough analysis of two adverse patient events by not considering lack of	S 060	449.3152 QUALITY IMPROVEMENT West Hills Hospital now ensures thorough analysis of all adverse patient events with a significant risk of patient harm by conducting Root Cause Analysis (RCA) for each significant adverse patient event.	

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S 060	<p>Continued From page 8</p> <p>nursing staff and supervision as a contributing factor in the incident and failing to do a root cause analysis of the incident for 2 of 10 patients (#1, #2).</p> <p>Findings include:</p> <p>Patient #1 was admitted to the facility on 12/08/08, with diagnoses including major depressive disorder and psychosis. She was placed on the Youth Services unit. The patient was on suicidal precautions with unit restrictions on 12/25/08.</p> <p>Patient #2 was admitted to the facility on 12/1/08, with diagnoses including major depressive disorder, possible bipolar disorder and severe asthma. She was placed on the Youth Services Unit. The patient was on line of sight supervision on 12/25/08.</p> <p>Record review revealed that on 12/25/08 at 10:45 PM, Patient #1 and Patient #2 were found with nooses around their necks made from a sheet. The sheet was hung over the bathroom door. They used each other's weight to put tension on each noose.</p> <p>Patient #1 was found still conscious and her face was described as red. She later complained of a sore neck. The Mental Health Technician (MHT), who found the patient, wrote a statement describing the incident. The statement read "I went into the room and tried to untie the sheet from _____'s neck first. It was so tight I couldn't even get my fingers in it. I have to lift _____ off the floor to loosen the tightness."</p> <p>In an interview with the Director of Nurses (DON) on 2/4/09, he stated that he reviewed the video</p>	S 060	<p>Corrective Action:</p> <p>Patients #1 and #2 were discharged following the event, however, the facility clinical leadership took immediate steps to initiate aggressive daily risk management surveillance to identify actual or near miss events. Intensive analysis procedures were implemented to identify root causes in order to prevent recurrence.</p> <ol style="list-style-type: none"> 1. The "Never 27" list of serious adverse events from the National Quality Forum was incorporated into hospital policy and now requires an RCA to be completed on events listed per policy. 2. The hospital's 2009 Performance Improvement Plan and Critical Event Review policy was amended to reflect that a Root Cause Analyses will be performed in the event of a significant suicide attempt including any event that does not result in a major loss of permanent function. 3. Root Cause Analyses will follow The Joint Commissions RCA Matrix format that includes consideration of the effects of staffing levels and competencies as contributing factors in all adverse events. 	<p>3/28/09</p> <p>3/28/09</p> <p>3/28/09</p>

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S 060	<p>Continued From page 9</p> <p>recordings of the common areas of the adolescent unit and found that MHT #1 and RN #1 did not monitor the patients as required by the physician's orders and by facility policy.</p> <p>The DON provided a form entitled "Daily Nursing Schedule" which showed that one RN (RN #1) and one MHT (MHT #1) were assigned to the Youth Services unit on the 3 PM to 11 PM shift when the incident occurred. Seven patients were on the unit during the shift. Patient # 2 was on line of sight supervision requiring constant observation by a staff member at all times. Six other patients required observation (checks) by staff every 15 minutes.</p> <p>The schedule revealed that there was no RN available to relieve RN #1 during her meal time or break times. The schedule revealed that four RN's were assigned to cover four units on the 3 PM to 11 PM shift on 12/25/08. There was no nursing supervisor on duty for the 3 PM to 11 PM shift.</p> <p>Review of the DON's investigative report dated 1/5/09, revealed that RN #1 left the unit for her break and left MHT #1 alone on the locked unit for the duration of her break. There was no RN or staff member, other than MHT #1, on the locked unit when Patient #1 and Patient #2 were found hanging from the bathroom door.</p> <p>Review of the DON's investigative report revealed that the MHT was at the nurses' station for more than 30 minutes prior to the incident and did not conduct Patient #1's 15 minute checks or keep Patient #2 within line of sight. The report revealed that RN #1 allowed the MHT "to sit for more than 30 minutes in the nurses station and not complete face-to-face fifteen minute checks</p>	S 060	<p>4. The clinical leadership Participated in a Root Cause Analysis completed on suicide attempts and gestures, including consideration of staffing levels and staff competency as variables</p> <p>5. Staff training was provided on suicide prevention utilizing the suicide prevention video.</p> <p>6. Disciplinary actions and counseling commensurate with accountability for risk management activities were implemented.</p> <p>7. Governing Board members were re-educated by the CEO on their duties and responsibilities in accordance with the Governing Board Bylaws and reviewed CMS Conditions of Participation.</p> <p>Responsible Person: Director of Performance Improvement/Risk Management CEO</p>	<p>4/1/09</p> <p>3/29/09</p> <p>3/28/09</p> <p>4/2/09</p>

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S 060	<p>Continued From page 10</p> <p>on the patients". The report revealed that RN #1 was at the nurses' station with the MHT until the RN left the unit for a break. The report revealed RN #1 returned to the unit as the MHT "was addressing the activity of the two female patients".</p> <p>On 3/5/09, the Hospital Administrator, Risk Manager and the DON were interviewed. The Administrator reported he believed the termination of RN #1 and MHT #1 and planned staff training were sufficient to deal with the incident. On 3/9/09, the Risk Manager was interviewed for a second time. She reported that she investigated the attempted hangings with the DON. She reported that she did not consider staffing as a safety issue when the investigation was done. She reported that a root cause analysis of the incident was not done.</p> <p>Review of the hospital's Performance Improvement Plan 2009, revealed that "Undesirable patterns or trends in performance are intensively analyzed per policy if comparisons show that: 1. Important single events, levels of performance, patterns or trends vary significantly from those expected. In addition, the plan revealed "Intense analysis (Root Cause Analysis) will be performed when, but not limited to when the following events occur: 1. The event has resulted in the unanticipated death or major loss of function not related to the natural course of the patient's illness or underlying condition 2. Suicide of an inpatient 3. Rape</p> <p>On 3/9/09 at 11:50 AM, Employee #21 was interviewed. She reported that the 2/26/09 Governing Body minutes were not typed yet. She reviewed her hand written notes with two members of the survey team. She reported that</p>	S 060	<p>How Monitored to Prevent Recurrence:</p> <p>The Director of Performance Improvement/Risk Management and/or designee now reports all adverse patient events and near misses to the Chief Executive Officer daily as part of the standing agenda of the morning leadership meeting.</p> <p>All Root Cause Analysis are reviewed by the MEC and Gov board including the action plans and recommendations.</p> <p>The Director of PI and/or designee will continue to monitor the implementation and efficacy of appropriate compliance with the RCA policy and protocol.</p> <p>Findings and RCA recommendations are reported to the Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly.</p>	

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S 060	Continued From page 11 the incident of the two patients attempting suicide was discussed but the board decided to wait for the state citation before making any recommendations. Following the 12/25/08 attempted hangings where staff did not conduct line of sight observation and fifteen minute checks of patients, another incident occurred. On 2/6/09, Patient #3 was not observed every 15 minutes by staff as required by facility policy. See tag S-0291. Severity: 3 Scope: 1	S 060		
S 090	NAC 449.316 Emergency Preparedness 3. A hospital shall ensure that the hospital staff and patients are adequately protected from fire and other disasters. To ensure that it has adequate fire protection, a hospital shall provide for the installation of extinguishers, sprinkling devices, fire barriers and the elimination of fire hazards. This Regulation is not met as evidenced by: Based on observation, interview and policy review, the facility failed to provide agency staff with emergency exit keys and staff training to maintain patient safety in the event of a fire or other emergency situation for 18 of 18 patients on the Youth Services Unit. Findings include: On 3/6/09 at 5:45 AM a self guided tour of the facility was conducted by two surveyors. It was observed that certain staff did not have keys to enter or exit the doors on the locked units. An interview was conducted with three contracted agency employees on the Youth Services Unit	S 090	449.316 EMERGENCY PREPAREDNESS West Hills Hospital now diligently ensures all agency staff are provided with emergency hospital keys and provided staff training to maintain patient safety in the event of a fire or other emergency situation. Corrective Action: 1. The hospital took immediate actions by giving all agency staff hospital keys. All agency staff were trained on proper use of emergency keys. All agency staff are now assigned hospital keys by the nursing supervisors and/or designee prior to reporting to their assigned unit. Hospital keys are returned to the nursing supervisor at the end of each shift.	3/06/09

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S 090	<p>Continued From page 12</p> <p>Agency Staff #11 stated that agency staff were not issued keys to the doors on the unit. She stated " I had to demand keys", " I don't want to cause trouble but I felt panicky that I could not get out if I needed to."</p> <p>Agency Staff #9 and Agency Staff #8 both stated they had never been issued keys. They reported that typically a hospital employee would work with them and the employee had keys, but this time they were all agency staff. No one on the unit had keys to leave the locked unit through hallway doors or emergency exit doors.</p> <p>The three agency employees were asked what they would do in the event of a fire or other emergency? They all agreed it would have been very dangerous since keys were required to exit the unit and also the emergency exit doors. They would have to rely on staff from another unit with keys to let them and the patients out of the unit to a safe area.</p> <p>It was observed that two doors were left open to enter and exit the nurses' station on the Youth Services Unit. One door was on the adolescent side of the unit and the other on the pediatric side. The three agency staff members all stated that at the beginning of the shift they had to keep the doors open because there were no keys to get in and out. They were only given one set of keys later in the shift. They reported that they were without keys to the unit for two to three hours.</p> <p>Agency Staff #8 stated it was her first night working in this facility and she was being oriented by Agency Staff #11 who had worked at the facility as an agency Certified Nurse Assistant (CNA) for three weeks. Both agency workers</p>	S 090	<ol style="list-style-type: none"> 2. The Interim Director of Nursing and/or designee and Shift Nursing supervisors are responsible for assuring that all agency staff have keys prior to reporting to their designated unit. An agency tracking log with signatures is maintained to track appropriate utilization of hospital keys. 3. All first time agency staff reporting for duty are <i>now</i> provided with a walk through orientation and return demonstration using the Orientation Checklist by the Nursing Supervisor. This process ensures all agency staff are aware of the location and use of fire extinguishers, patient safety protocol and exits in case of an emergency. 4. Agency staff receives a "Hot Sheet" with environmental safety talking points each time they return to work. This "Hot Sheet" is provided to the staff with hospital keys. 5. Fire drills are performed weekly (rotating shifts) to ensure staff's awareness of protocols and procedures involving emergency preparedness and patient safety. 	

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S 090	<p>Continued From page 13</p> <p>stated they had not had any orientation training on restraints and seclusion, emergency training such as fire, evacuation, or physical threat training.</p> <p>The patient census on the Youth Services unit on the night of 3/5/09 was 18.</p> <p>An interview was conducted with Agency Staff #10 on 3/6/09. She was the agency registered nurse working on the chemical dependency (CD) unit. She stated she had worked at the facility full time for one month. She said she had never been issued keys and thought it was the facility's policy to not issue keys to agency staff. The Mental Health Technician (MHT), Employee #15, worked the 11 PM to 7 AM shift with Agency Staff #10 and had a set of keys. The census on the CD unit was 11 patients.</p> <p>An interview with the DON was conducted on 3/6/09 in the morning. He stated it was the facility's practice since 2006 not to issue agency staff facility keys because they had experienced numerous incidents of keys being lost or not returned. He said there was always a regular staff member who could assist with the agency staff to enter or exit the units.</p> <p>On 3/6/09 at approximately 10:00 AM, a tour of the Youth Services unit was done with the Maintenance Supervisor and the Corporate Vice President. The Maintenance Supervisor stated a key was required to go in and out of all the units and to exit an emergency door. He confirmed that the emergency exit doors did not open automatically under any condition.</p> <p>A telephone interview was conducted with Agency Staff #8 on 3/6/09 at 1:00 PM. She</p>	S 090	<p>How Monitored to Prevent Recurrence:</p> <p>The Interim Director of Nursing or designee will report compliance with agency key policy weekly as a clinical indicator during the morning meeting to address any issues with missing hospital keys immediately.</p> <p>The Interim Director of Nursing and/or designee will continue to report findings to oversee compliance with hospital keys policy and protocol.</p> <p>Appropriate control of hospital keys issued and return is monitored by the Director of Nursing and/or designee.</p> <p>Findings will be reported by the Interim Director of Nursing Services to Performance Improvement Committee, Medical Executive Committee monthly and to the Governing Board quarterly.</p> <p>The Executive Director of Plant Operations will report the fire drill results to the Risk/Safety Committee monthly.</p> <p>Responsible Party:</p> <p>Interim Director of Nursing Director of Performance Improvement/Risk Management Executive Director of Plant Operations</p>	

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S 090	<p>Continued From page 14</p> <p>stated the 3/5/09, 11 PM to 7 AM shift was the first shift she had worked at the facility. She stated she came to work and went directly to the area she was assigned. She stated she was paired up with Agency Staff #11, a contracted agency employee, for orientation and never received any other type of orientation by the facility.</p> <p>A telephone interview was conducted with Agency Staff #9 on 3/6/09 at 1:20 PM. She stated she was never given an orientation to the facility and had never been issued keys. She stated this was her second shift worked at the facility.</p> <p>A telephone interview was conducted with Agency Staff #11 on 3/6/09 at 5:30 PM. She stated she had worked at the facility full time for three weeks and had never gotten an orientation other than following another aide and had never been issued keys.</p> <p>An interview was conducted with Employee #5 on 3/6/09, in the morning. She stated she was the scheduling coordinator and responsible for orientations of new staff members. She presented the surveyors with personnel files of Agency Staff #8, #9, and #11. She provided a document named Orientation Checklist for Contract/Registry/Student/Intern Personnel and told the two surveyors that the three employees had been oriented to the facility by her.</p> <p>An interview was conducted with the DON on 3/6/09 later in the morning and he was asked if Agency Staff #8 had been oriented. He stated that he had seen Agency Staff #8 in Employee # 5's office earlier in the morning and thought maybe they were going over orientation</p>	S 090		

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S 090	Continued From page 15 information. When Agency Staff #8 was asked if Employee #5 had gone over any information on facility policies she stated that Employee #5 had just told her of the orientation class that was scheduled for the following week for contract employees. Review of the facility's policy and procedure entitled "Fire Evacuation" revealed that "In case of needed evacuation due to fire, flood, bomb threat, earthquake or tornado: b. Begin evacuation immediately. Patients should evacuate in an orderly manner. Staff should direct patients to line up by the nearest exit." Severity: 4 Scope: 3	S 090		
S 291	NAC 449.361 Nursing Services 2. The governing body and the hospital shall ensure that the nursing services provided at the hospital are provided in accordance with all applicable federal and state laws and regulations. This Regulation is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that nursing services were provided in accordance with all applicable federal and state laws and regulations for 3 of 10 patients. (#1, #2, #3) Findings include Patient #1 was admitted to the facility on 12/08/08, with diagnoses including major depressive disorder and psychosis. She was placed on the Youth Services Unit. Patient #1's record review revealed she had a	S 291	449.361 NURSING SERVICES West Hills Hospital now ensures that nursing services are provided in accordance with all applicable federal and state laws and regulations. Corrective Action: Patients #1, #2 and #3 were discharged following the event, however, the facility took immediate and aggressive steps to ensure that nursing services are provided according physician orders and applicable laws and regulations:	

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S 291	<p>Continued From page 16</p> <p>history of suicidal ideation. On 12/9/08, she was placed on suicidal precautions due to having a plan to ingest cleaning agents. Her physician ordered that she be observed by staff every 15 minutes. On 12/12/08, she was also restricted to the unit due to active suicidal ideation. The unit restrictions were in effect until 12/17/08. She was again placed on unit restrictions due to active suicidal thoughts on 12/23/08. The patient was on suicidal precautions with unit restrictions on 12/25/08.</p> <p>Patient #2 was admitted to the facility on 12/1/08, with diagnoses including major depressive disorder, possible bipolar disorder and severe asthma. She was placed on the Youth Services unit.</p> <p>Review of Patient #2's records revealed that increasing active suicidality was a reason for admission. On 12/16/08, her physician ordered that she be placed on 1:1 supervision due to a suicide attempt at the facility. She had tied a sweat shirt tightly around her neck and tied the other end to the door. On 12/21/08, the physician discontinued 1:1 supervision and placed her on line of sight supervision meaning staff were to maintain constant visual observation of the patient. The patient was on line of sight supervision on 12/25/08.</p> <p>Record review revealed that on 12/25/08 at 10 45 PM, Patient #1 and Patient #2 were found with nooses around their necks made from a sheet. The sheet was hung over the bathroom door. They used each other's weight to put tension on each noose.</p> <p>Patient #1 was found still conscious and her face was described as red. She later complained of a</p>	S 291	<ol style="list-style-type: none"> All staff received remedial training on the provision of services of patient care in accordance with physician's orders. All regular staff and agency staff received remedial training on protocol for monitoring patient's on special precautions. Hereafter, all first time agency staff are now required to receive training, orientation and testing prior to receiving their assignment using the Orientation Checklist in accordance with the revised orientation policy. Training and orientation is provided by the Interim Director of Nursing Services and/or designee. Orientation <u>is</u> documented and filed in each agency staff competency file maintained in the nursing office. Only agency staff that have completed training and demonstrates competency may be assigned to the following roles: <ul style="list-style-type: none"> Charge Nurse (RN) Medication Nurse (RN, LVN, LPN) MHT's 	<p>3/25/09</p> <p>3/25/09</p> <p>3/25/09</p> <p>4/10/09</p>

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S 291	<p>Continued From page 17</p> <p>sore neck. The Mental Health Technician (MHT) who found the patient, wrote a statement describing the incident. The statement read "I went into the room and tried to untie the sheet from _____'s neck first. It was so tight I couldn't even get my fingers in it. I have to lift _____ off the floor to loosen the tightness."</p> <p>Patient #2's acuity/progress notes revealed her face was red and she complained of neck pain following the suicide attempt. She reported to the physician that she tried to claw at the noose as soon as it tightened and she panicked. She reported that she began to feel dizzy and numb</p> <p>In an interview with the Director of Nurses (DON) on 2/4/09, he revealed that he was not aware of the attempted suicides until 12/29/08, when he received the incident reports and began an investigation of the incident. He stated that he reviewed the video recordings of the common areas of the adolescent unit and found that MHT #1 and RN #1 did not monitor the patients as required by the physician's orders and by facility policy</p> <p>The DON provided the daily nursing schedule which showed that one registered nurse (RN #1) and one MHT (MHT #1) were assigned to the Youth Services unit on the 3 PM to 11 PM shift when the incident occurred. Seven patients were on the unit during the shift. Patient #2 was on line of sight supervision requiring constant observation by a staff member at all times. Six other patients required observation (checks) by staff every 15 minutes.</p> <p>The nursing daily schedule revealed that there were four RN's assigned to the 3 PM to 11 PM shift on 12/25/08. The hospital had four nursing</p>	S 291	<p>5. Agency staff will not be assigned a supervisory role.</p> <p>6. Agency staff without CPI certification will not be permitted to participate in seclusion or restraint of patients. Non-CPI certified agency staff will be assigned only with CPI certified staff on the same unit.</p> <p>7. The Nurse Managers, and/or Nursing Supervisors now conduct a thorough evaluation of licensed agency staff by completing an evaluation their job performance on first assignment and at least annually. Agency MHTs are evaluated by an RN on the unit or the Nursing Supervisor.</p> <p>8. Staff are evaluated in the following areas:</p> <ul style="list-style-type: none"> • Completes assignment within shift • Adheres to patient safety hospital procedures including suicide precautions and seclusion and restraint protocols. • Demonstrates appropriate interactions with patients/families • Performs all assigned tasks timely 	<p>3/6/09</p> <p>3/6/09</p> <p>3/23/09</p> <p>3/23/09</p>

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S 291	<p>Continued From page 18</p> <p>units. The schedule revealed that there was no nursing supervisor available in the hospital to relieve the RN's during their meal time or break time for the 3 PM to 11 PM and the 11 PM to 7 AM shifts. There was a note on the schedule that read "_____ - RN for both Adult and CD Leave Doors open" for the 11 PM to 7 AM shift. The chemical dependency unit was referred to as the CD unit.</p> <p>Review of the DON's investigative report dated 1/5/09 revealed that RN #1 left the unit for her break and left MHT #1 alone on the locked unit with the seven patients for the duration of her break. There was no RN on the locked unit when Patient #1 and Patient #2 were found hanging from the bathroom door.</p> <p>Review of the DON's investigative report revealed that the MHT was at the nurses' station for more than 30 minutes prior to the incident and did not conduct Patient #1's 15 minute checks or keep Patient #2 within line of sight. The report revealed that RN #1 allowed the MHT "to sit for more than 30 minutes in the nurses station and not complete face-to-face fifteen minute checks on the patients". The report revealed that RN #1 was at the nurses' station with the MHT until the RN left the unit for a break. The report revealed RN #1 returned to the unit as the MHT "was addressing the activity of the two female patients".</p> <p>The DON confirmed that RN #1 did not call the attending physician to report the attempted suicides. He called the attending physician as part of his investigation of the event and confirmed that the physician had not received a phone call regarding the suicide attempts until 12/26/08. The report revealed that the physician</p>	S 291	<ul style="list-style-type: none"> • Demonstrates respect for the dignity of patients and co-workers • Demonstrates expected phone protocol • Documents appropriately and legibly in the medical record • Seeks help/direction when needed • For licensed staff: Administers medications independently and with no significant variances • Overall performance is at an acceptable level <p>Responsible Person:</p> <p>Interim Director of Nursing CEO PI Director</p> <p>How Monitored to Prevent Recurrence:</p> <p>The Interim Director of Nursing or designee now reports compliance with orientation and training. Data is tracked, trended and reported to the Chief Executive Officer as part of the standing agenda of the morning leadership meeting.</p> <p>Compliance data is tracked and trended for completion of orientation, training and performance evaluations of all registry staff by the Interim Director of Nursing Services.</p>	

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S 291	<p>Continued From page 19</p> <p>stated she would have come to the hospital to assess her patients if she were called. The DON also confirmed that the RN did not assess Patient #1 and Patient #2 following the attempted suicides</p> <p>Review of the facility's policy and procedure entitled "Levels of Observation" revealed that all patients would be routinely observed in compliance with physician orders and prescribed protocols. The policy and procedure revealed that all patients were to be checked every 15 minutes without a physician's order. Line of sight observation required that staff maintain constant visual observation through direct observation or through the use of audio/visual monitoring.</p> <p>Patient #3 was admitted to the facility on 2/4/09, with the diagnosis of substance abuse of prescription drugs, opiates. The chief complaint was "I have a lot of problems getting off OxyContin."</p> <p>Patient #3 admitted himself to the facility voluntarily.</p> <p>Review of the nurse's notes dated 2/6/09 revealed Patient #3 was showing severe signs of detoxing with increase in vital signs, diaphoresis, agitation, and anxiety. A note was written by Employee #19 in the nurse's notes at 5:30 AM "Pt (patient) visible in room appeared asleep. Pt was awake most of the night and received medication." Nurse's notes dated 2/6/09 at 6:00 AM revealed, "Pt was anxious, restless, agitated for the first part of the night. Tossing and turning and up walking halls, required 1:1 supervision."</p> <p>The physician's progress note dated 2/6/09 revealed "severe withdrawals", "had horrible nite."</p>	S 291	Data is reported by the Interim Director of Nursing to the Performance Improvement Committee monthly, and to Medical Executive Committee and to the Governing Board quarterly.	

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S 291	<p>Continued From page 20</p> <p>The nursing notes and 15 minute Patient Observation Records revealed that Patient #3 was monitored continuously through out the night, by Employees #17 and #18 but the video tape surveillance revealed a time gap of 30 to 60 minutes where Employees #17 and #18 were sitting at the nurse's station and the every 15 minute observation checks were not completed</p> <p>An Incident Report dated 2/6/09, written by Employee #20 was reviewed. The RN stated "I came onto the unit this AM. Multiple patients started telling me about caring for _____ last night who was detoxing hard "</p> <p>An interview on 3/4/09 at 2:30 PM, was conducted with the DON. He stated the staff were terminated for not doing the every 15 minute patient checks as seen on the video surveillance tape, but documented the checks were done. He stated the tape showed four patients going in and out of Patient #3's room during the night, but the every 15 minute time checks revealed that those patients were in their rooms sleeping.</p> <p>An interview on 3/5/09 in the morning, was conducted with the Director of Risk Management (RM). She stated the films were reviewed and the every 15 minute checks were not done and stated that the every 15 minute time check reports were falsified. She stated the films showed patients walking with Patient #3 in the halls and in Patient #3's room. The patients who assisted Patient #3 were to be checked every 15 minutes themselves. As a result the RN and two MHT's on the unit the night of the incident were terminated.</p> <p>Severity 4 Scope 2</p>	S 291		

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S 298	<p>NAC 449.361 Nursing Service</p> <p>9 A hospital shall ensure that its patients receive proper treatment and care provided by its nursing services in accordance with nationally recognized standards of practice and physicians' orders</p> <p>This Regulation is not met as evidenced by: Based on record review, staff interviews and observation, the facility failed to assess and observe (check) patients as required by physician orders and facility policy for 3 of 10 patients (#1, #2, #3), and failed to train and equip non-employee contracted agency personnel with the equipment and training needed to provide a safe patient environment for 4 of 4 agency staff (#11, #9, #8, #10)</p> <p>Findings include</p> <p>Patient #1 was admitted to the facility on 12/08/08, with diagnoses including major depressive disorder and psychosis. She was placed on the Youth Services Unit.</p> <p>Patient #1's record review revealed she had a history of suicidal ideation. On 12/9/08, she was placed on suicidal precautions due to having a plan to ingest cleaning agents. Her physician ordered that she be observed by staff every 15 minutes. On 12/12/08, she was also restricted to the unit due to active suicidal ideation. The unit restrictions were in effect until 12/17/08. She was again placed on unit restrictions due to active suicidal thoughts on 12/23/08. The patient was on suicidal precautions with unit restrictions on 12/25/08</p> <p>Patient #2 was admitted to the facility on 12/1/08 with diagnoses including major depressive</p>	S 298	<p>449.361 NURSING SERVICES</p> <p>West Hills Hospital now ensures that all patients are assessed and observed as required by physician orders and facility policy.</p> <p>West Hills Hospital now ensures all non employed contracted agency personnel are trained and equipped to provide a safe patient environment.</p> <p>Corrective Action:</p> <p>Patients #1, #2 and #3 were discharged following the event, however, the facility took aggressive action to ensure assessment and reassessment as required by physician orders and/or change in patient condition. The hospital took immediate action by providing training to all nursing staff on patient safety, location of AED equipment, fire, disaster evacuation and emergency procedures.</p> <p>A monitoring tool was instituted that directs the Nurse Managers to randomly check appropriate monitoring of q15 minute checks, proper assessment of patient's needs. All nursing staff were trained on suicide precautions and showed suicide prevention video. Reviewed assessment and reassessment policy, reviewed indication for patient's need for reassessment and immediately reinforced q15 minutes protocols.</p>	<p>3/6/09</p> <p>3/17/09</p>

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S 298	<p>Continued From page 23</p> <p>In an interview with the Director of Nurses (DON) on 2/4/09, he revealed that he was not aware of the attempted suicides until 12/29/08, when he received the incident reports and began an investigation of the incident. He stated that he reviewed the video recordings of the common areas of the Youth Services unit and found that MHT #1 and Registered Nurse (RN) #1 did not monitor the patients as required by the physician's orders and by facility policy</p> <p>The DON provided a form entitled "Daily Nursing Schedule" which showed that one registered nurse (RN) , RN #1, and one MHT (MHT #1) were assigned to the Youth Services unit on the 3 PM to 11 PM shift when the incident occurred. Seven patients were on the unit during the shift. Patient # 2 was on line of sight supervision requiring constant observation by a staff member at all times. Six other patients required observation (checks) by staff every 15 minutes</p> <p>The nursing daily schedule revealed that there were four RN's assigned to the 3 PM to 11 PM shift on 12/25/08. The hospital had four nursing units. The schedule revealed that there was no nursing supervisor physically present in the building to relieve the RN's during their meal time or break time.</p> <p>Review of the DON's investigative report dated 1/5/09 revealed that RN #1 left the unit for her break and left MHT #1 alone on the locked unit with the seven patients for the duration of her break. There was no RN or staff member other than MHT #1 on the locked unit when Patient #1 and Patient #2 were found hanging from the bathroom door.</p>	S 298	<ul style="list-style-type: none"> • Notification of Interim Director of Nursing in adverse patient care incidents • Notification of administration in adverse patient care incidents • Suicide precautions <p>Incident findings were reviewed at leadership meeting and CEO advised the former Director of Nursing to reinforce the q15 minute check. The facility CEO directed the Director of Nursing to terminate the staff involved.</p> <p>Responsible Person:</p> <p>Unit Nurse Managers Interim Director of Nursing PI Director</p> <p>How Monitored to Prevent Recurrence:</p> <p>Effectiveness of education is now evaluated by testing competencies.</p> <p>Documentation of all staff trainings are now kept in the staff's personnel file.</p> <p>The Unit Nurse managers and/or Nursing Supervisor will conduct random audits by comparing physician order to observe compliance with written orders a minimum of once per shift. Additionally, the compliance is checked for timeliness of notification</p> <p>Findings are submitted to the Interim Director of Nursing for immediate response, review and analysis.</p>	3/17/09

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S 298	<p>Continued From page 24</p> <p>Review of the DON's investigative report revealed that the MHT was at the nurses' station for more than 30 minutes prior to the incident and did not conduct Patient #1's 15 minute checks or keep Patient #2 within line of sight. The report revealed that RN #1 allowed the MHT "to sit for more than 30 minutes in the nurses station and not complete face-to-face fifteen minute checks on the patients". The report revealed that RN #1 was at the nurses' station with the MHT until the RN left the unit for a break. The report revealed RN #1 returned to the unit as the MHT "was addressing the activity of the two female patients".</p> <p>The DON confirmed that RN #1 did not call the attending physician. He called the attending physician as part of his investigation of the event and confirmed that the physician had not received a phone call regarding the suicide attempts until 12/26/08. The report revealed that the physician stated she would have come to the hospital to assess her patients if she were called. The DON also confirmed that the RN did not assess Patient #1 and Patient #2 following the attempted suicides.</p> <p>Review of the facility's policy and procedure entitled "Levels of Observation" revealed that all patients would be routinely observed in compliance with physician orders and prescribed protocols. The policy and procedure revealed that all patients were to be checked every 15 minutes without a physician's order. Line of sight observation required that staff maintain constant visual observation through direct observation or through the use of audio/visual monitoring.</p> <p>Facility policy and procedure entitled "Suicide Emergency Care" revealed that all suicide</p>	S 298	<p>These findings are reported by the Interim Director of Nursing to the Performance Improvement Committee and the Medical Executive Committee monthly as a clinical indicator and to the Governing Board quarterly.</p>	

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S 298	<p>Continued From page 25</p> <p>attempts were to be reported to the attending physician and the patient's needs were to be immediately tended to. A RN assessment was to be conducted and a call for emergency help was to be made as needed, based on the RN assessment and physician order. An incident report was to be completed.</p> <p>On 3/5/09, Employee #13 was interviewed. The employee reported that nurses do leave the unit and leave the MHT's alone on the locked units without supervision of a RN. Employee #13 stated that the nurses usually go to the dining room, which was outside of the locked patient units. He reported nurses can leave the building on lunch or dinner. The employee expressed concern for the safety of staff when a single person was left on a unit. He reported that he has seen units staffed during meal times and breaks by one person on both the 3 PM to 11 PM shift and 11 PM to 7 AM shift.</p> <p>On 3/6/09, RN #14 was interviewed. She reported that she usually worked the 11 PM to 7 AM shift. The employee confirmed that nurses do leave the locked units for meals and will leave one staff member on the unit. She stated she made sure the unit was stable before she left. She reported she would stay on the unit or arrange for relief, if possible, if the unit was unstable. She reported that the nurses were encouraged to take their meal times and breaks off the unit. She reported that there was no night shift supervisor on site. She confirmed that one unit was sometimes combined with another unit by opening the doors between the units and closing down a nurses' station.</p> <p>Review of the Daily Nursing Schedules dated 12/25/08 through 3/4/09, revealed that there was</p>	S 298		

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S 298	<p>Continued From page 26</p> <p>no nursing supervisor scheduled to be physically present in the hospital beyond 12 midnight</p> <p>Patient #3 was admitted to the facility on 2/4/09, with the diagnosis of substance abuse of prescription drugs, opiates. The chief complaint was "I have a lot of problems getting off OxyContin"</p> <p>Patient #3 admitted himself to the facility voluntarily</p> <p>Review of the nurse's notes dated 2/6/09 revealed Patient #3 was showing severe signs of detoxing with increase in vital signs, diaphoresis, agitation, and anxiety. A note was written by Employee #19 in the nurse's notes at 5:30 AM "Pt (patient) visible in room appeared asleep. Pt was awake most of the night and received medication." Nurse's notes dated on 2/6/09 at 6:00 AM revealed, "Pt was anxious, restless, agitated for the first part of the night. Tossing and turning and up walking halls, required 1:1 supervision."</p> <p>The physician's progress note dated 2/6/09, revealed "severe withdrawals", "had horrible nite"</p> <p>The nursing notes and 15 minute Patient Observation Records revealed that Patient #3 was monitored continuously through out the night by Employees #17 and #18 but the video tape surveillance revealed a time gap of 30 to 60 minutes where Employee #17 and #18 were sitting at the nurse's station and the every 15 minute observation checks were not completed</p> <p>An Incident Report dated 2/6/09, written by Employee #20 was reviewed. The RN stated "I came onto the unit this AM. Multiple patients</p>	S 298		

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S 298	<p>Continued From page 27</p> <p>started telling me about caring for _____ last night who was detoxing hard "</p> <p>An interview on 3/4/09 at 2:30 PM, was conducted with the DON. He stated the staff were terminated for not doing the every 15 minute patient checks as seen on the video surveillance tape, but documented the checks were done. He stated the tape showed four patients going in and out of Patient #3's room during the night, but the every 15 minute checks revealed that those patients were in their rooms sleeping</p> <p>An interview on 3/5/09 in the morning, was conducted with the Director of Risk Management (RM). She stated the films were reviewed and the every 15 minute checks were not done and stated the every 15 minute time check reports were falsified. She said the films showed patients walking with Patient #3 in the halls and in Patient #3's room. The patients who assisted Patient #3 were to be checked by staff every 15 minutes themselves. As a result the RN and two MHT's on the unit the night of the incident were terminated.</p> <p>On 3/6/09 at 5 45 AM, a self guided tour of the facility was conducted by two surveyors. It was observed that certain staff did not have keys to enter or exit the doors on the locked unit.</p> <p>An interview was conducted with three contracted agency employees on the Youth Services Unit. Agency Staff #11 stated that agency staff were not issued keys to the doors on the unit. She stated " I had to demand keys". " I don't want to cause trouble but I felt panicky that I could not get out if I needed to "</p> <p>Agency Staff #9 and Agency Staff #8 both stated</p>	S 298		

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S 298	<p>Continued From page 28</p> <p>they had never been issued keys. They reported that typically a hospital employee would work with them and the employee had keys, but this time they were all agency staff. No one on the unit had keys to leave the locked unit through hallway doors or emergency exit doors.</p> <p>The three agency staff were asked what they would do in the event of a fire or other emergency? They all agreed it would have been very dangerous since keys were required to exit the unit and also the emergency exit doors. They would have to rely on staff from another unit with keys to let them and the patients out of the unit to a safe area.</p> <p>It was observed that two doors were left open to enter and exit the nurses' station on the Youth Services Unit. One door was on the adolescent side of the unit and the other on the pediatric side. The agency staff all stated that at the beginning of the shift they had to keep the doors open because there were no keys to get in and out. They were only given one set of keys later in the shift. They reported that they were without keys to the unit for two to three hours.</p> <p>Agency Staff #8 stated it was her first night working in this facility and she was being oriented by Agency Staff # 11. Agency Staff #11 had worked as a Certified Nurses Assistant (CNA) at the hospital for three weeks. Both agency staff stated they had not had any orientation training on restraints and seclusion, emergency training such as fire, evacuation, or physical threat training.</p> <p>The patient census on the Youth Services unit on the night of 3/5/09 was 18.</p>	S 298		

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S 298	<p>Continued From page 29</p> <p>An interview was conducted with Agency Staff #10 on 3/6/09. She was the agency RN working on the chemical dependency (CD) unit. She stated she had worked at the facility full time for one month. She said she had never been issued keys and thought it was the facility's policy to not issue keys to agency staff. The Mental Health Technician (MHT), Employee #15 worked the 11 PM-7 AM shift with Agency Staff #10 and had a set of keys. The census on the CD unit was 11 patients.</p> <p>An interview with the DON was conducted on 3/6/09 in the morning. He stated it was the facility's practice since 2006 not to issue agency employees facility keys because they had experienced numerous incidents of keys being lost or not returned. He stated there was always a regular staff member who could assist the agency staff to enter or exit the units.</p> <p>On 3/6/09 at approximately 10:00 AM, a tour of the Youth Services unit was done with the Maintenance Supervisor and the Corporate Vice President. The Maintenance Supervisor stated a key was required to go in and out of all the units and to exit an emergency door. He confirmed that the emergency exit doors did not open automatically under any condition.</p> <p>A telephone interview was conducted with Agency Staff #8 on 3/6/09 at 1:00 PM. She stated the 3/5/09, 11 PM to 7 AM shift was the first shift she had worked at the facility. She stated she came to work and went directly to the area she was assigned. She stated she was paired up with Agency Staff #11 for orientation and never received any other type of orientation by the facility.</p>	S 298		

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S 298	<p>Continued From page 30</p> <p>A telephone interview was conducted with Agency Staff #9 on 3/6/09 at 1:20 PM. She stated she was never given an orientation to the facility and had never been issued keys. She stated this was her second shift worked at the facility.</p> <p>A telephone interview was conducted with Agency Staff #11 on 3/6/09 at 5:30 PM. She stated she had worked at the facility full time for three weeks and had never gotten an orientation other than following another aide, and had never been issued keys.</p> <p>An interview was conducted with Employee #5 on 3/6/09, in the morning. She stated she was the scheduling coordinator and responsible for orientations of new staff members. She presented the surveyors with personnel files of Agency Staff #8, #9, and #11. She provided a document named Orientation Checklist for Contract/Registry/Student/Intern Personnel and told the two surveyors that the three employees had been oriented to the facility by her.</p> <p>An interview was conducted with the DON on 3/6/09 later in the morning and he was asked if Agency Staff #8 had been oriented. He stated that he had seen her in Employee #5's office earlier in the morning and thought maybe they were going over orientation information.</p> <p>When Agency Staff #8 was asked if Employee #5 had gone over any information on facility policies she stated that Employee #5 had just told her of the orientation class that was scheduled for the following week for contracted employees.</p> <p>Review of the facility's policy and procedure entitled "Fire Evacuation" revealed that "In case</p>	S 298		

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S 298	Continued From page 31 of needed evacuation due to fire, flood, bomb threat, earthquake or tornado. b. Begin evacuation immediately. Patients should evacuate in an orderly manner. Staff should direct patients to line up by the nearest exit." On 3/6/09, in the morning, an interview was conducted with the DON. He stated agency staff had never been issued keys to the facility because of problems losing them. He stated facility staff were responsible for letting the agency staff in and out of the units and nursing stations. No evidence was found to indicate the Governing Body addressed the safety issue regarding contracted nursing personnel not having the ability to unlock doors in an emergency. In an interview on 3/6/09, the DON reported that since 2006 it was the facility's practice not to issue keys to contracted agency personnel. Severity: 4 Scope: 3	S 298		
S 300	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by. Based on record review and staff interview, the facility failed to ensure that staff provided appropriate, individualized care and treatment based on patient assessment and in accordance with hospital policy for 3 of 10 patients (#1, #2, #3)	S 300	449.3622 APPROPRIATE CARE OF PATIENT West Hills Hospital now ensures that staff provides appropriate, individualized care and treatment based on patient assessments in accordance with hospital policy. Corrective Action: 1. All clinical staff received comprehensive remedial direction from the Interim Director of Nursing in core clinical processes including the assessment and reassessment of patients:	3/12/09

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S 300	<p>Continued From page 32</p> <p>Findings include:</p> <p>Patient #1 was admitted to the facility on 12/08/08, with diagnoses including major depressive disorder and psychosis. She was placed on the Youth Services unit. The patient was on suicidal precautions with unit restrictions on 12/25/08.</p> <p>Patient #2 was admitted to the facility on 12/1/08, with diagnoses including major depressive disorder, possible bipolar disorder and severe asthma. She was placed on the Youth Services Unit. The patient was on line of sight supervision on 12/25/08.</p> <p>Record review revealed that on 12/25/08 at 10:45 PM, Patient #1 and Patient #2 were found with nooses around their necks made from a sheet. The sheet was hung over the bathroom door. They used each other's weight to put tension on each noose.</p> <p>Patient #1 was found still conscious and her face was described as red. She later complained of a sore neck. The Mental Health Technician (MHT), who found the patient, wrote a statement describing the incident. The statement read "I went into the room and tried to untie the sheet from _____'s neck first. It was so tight I couldn't even get my fingers in it. I have to lift _____ off the floor to loosen the tightness."</p> <p>In an interview with the Director of Nurses (DON) on 2/4/09, he stated that he reviewed the video recordings of the common areas of the adolescent unit and found that MHT #1 and RN #1 did not monitor the patients as required by the physician's orders and by facility policy.</p>	S 300	<ol style="list-style-type: none"> a. Based on those assessments, individualized treatment interventions are developed that are reasonable and necessary to improve the patient's condition. b. These multidisciplinary and individualized interventions are implemented and documented. c. The critical importance of planning and delivering active treatment based on assessment and driven by the treatment plan in accordance with policies was stressed. <ol style="list-style-type: none"> 2. Staff are required to demonstrate competency by participation, observation, interviews and review of documentation. 3. Staff and nonemployee agency personnel were directed to comply with assignment and provision of special levels appropriate to assess patient needs and consistent with physician's orders. 4. Staff and nonemployee agency personnel received additional direction from the Interim 	<p>4/3/09</p> <p>4/2/09</p> <p>3/12/09</p>

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S 300	<p>Continued From page 33</p> <p>The DON provided a form entitled "Daily Nursing Schedule" which showed that one RN (RN #1) and one MHT (MHT #1) were assigned to the Youth Services unit on the 3 PM to 11 PM shift when the incident occurred. Seven patients were on the unit during the shift. Patient # 2 was on line of sight supervision requiring constant observation by a staff member at all times. Six other patients required observation (checks) by staff every 15 minutes.</p> <p>The schedule revealed that there was no RN available to relieve RN #1 during her meal time or break times. The schedule revealed that four RN's were assigned to cover four units on the 3 PM to 11 PM shift on 12/25/08. There was no nursing supervisor physically present in the hospital for the 3 PM to 11 PM shift.</p> <p>Review of the DON's investigative report dated 1/5/09, revealed that RN #1 left the unit for her break and and left MHT #1 alone on the locked unit for the duration of her break. There was no RN or staff member, other than MHT #1, on the locked unit when Patient #1 and Patient #2 were found hanging from the bathroom door.</p> <p>Review of the DON's investigative report revealed that the MHT was at the nurses' station for more than 30 minutes prior to the incident and did not conduct Patient #1's 15 minute checks or keep Patient #2 within line of sight. The report revealed that RN #1 allowed the MHT "to sit for more than 30 minutes in the nurses station and not complete face-to-face fifteen minute checks on the patients" The report revealed that RN #1 was at the nurses' station with the MHT until the RN left the unit for a break. The report revealed RN #1 returned to the unit as the MHT "was</p>	S 300	<p>Director of Nursing to:</p> <ul style="list-style-type: none"> • >make observations of patients behaviors; • >report observations of patient behaviors; • >and to institute precautions appropriate with level of risk assessed. <p>5 Written patient assignments include prompts for the delivery of individualized care.</p> <p>Responsible Person:</p> <p>Interim Director of Nursing Director of PI CEO</p> <p>How Monitored to Prevent Recurrence:</p> <p>Audits of documentation in medical records are performed on a monthly basis for compliance with assessment, reassessment and treatment planning. Findings are tracked and trended for identification of deficiencies and corrective action by the Director of Nursing. Oversight of the compliance data is obtained through quarterly reports to the Performance Improvement Committee and MEC monthly and to the Governing Board quarterly.</p>	3/12/09

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S 300	<p>Continued From page 34</p> <p>addressing the activity of the two female patients"</p> <p>Patient #3 was admitted to the facility on 2/4/09, with the diagnosis of substance abuse of prescription drugs, opiates. The chief complaint was "I have a lot of problems getting off OxyContin."</p> <p>Patient #3 admitted himself to the facility voluntarily.</p> <p>Review of the nurse's notes dated 2/6/09 revealed Patient #3 was showing severe signs of detoxing with increase in vital signs, diaphoresis, agitation, and anxiety. A note was written by Employee #19 in the nurse's notes at 5:30 AM: "Pt (patient) visible in room appeared asleep. Pt was awake most of the night and received medication." Nurse's notes dated 2/6/09 at 6:00 AM revealed, "Pt was anxious, restless, agitated for the first part of the night. Tossing and turning and up walking halls, required 1:1 supervision."</p> <p>The physician's progress note dated 2/6/09, revealed "severe withdrawals", "had horrible nite."</p> <p>The nursing notes and 15 minute Patient Observation Records revealed that Patient #3 was monitored continuously through out the night, by Employees #17 and #18 but the video tape surveillance revealed a time gap of 30 to 60 minutes where Employees #17 and #18 were sitting at the nurse's station and the every 15 minute observation checks were not completed</p> <p>An Incident Report dated 2/6/09, written by Employee #20 was reviewed. The RN stated "I came onto the unit this AM. Multiple patients started telling me about caring for _____ last</p>	S 300		

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S 300	<p>Continued From page 35</p> <p>night who was detoxing hard "</p> <p>An interview on 3/4/09 at 2 30 PM, was conducted with the DON. He stated the staff were terminated for not doing the every 15 minute patient checks as seen on the video surveillance tape but documented the checks were done. He stated the tape showed four patients going in and out of Patient #3's room during the night, but the every 15 minute time checks revealed that those patients were in their rooms sleeping</p> <p>An interview on 3/5/09 in the morning, was conducted with the Director of Risk Management (RM). She stated the films were reviewed and the every 15 minute checks were not done and stated that the every 15 minute time check reports were falsified. She stated the films showed patients walking with Patient #3 in the halls and in Patient #3's room. The patients assisting Patient #3 were to be checked every 15 minutes themselves. As a result the RN and two MHT's on the unit the night of the incident were terminated</p> <p>On 3/5/09, the Hospital Administrator, Risk Manager and the DON were interviewed. The Administrator reported he believed the termination of RN #1 and MHT #1 and planned staff training were sufficient to deal with the incident. On 3/9/09, the Risk Manager was interviewed for a second time. She reported that she investigated the attempted hangings with the DON. She reported that she did not consider staffing as a safety issue when the investigation was done. She reported that a root cause analysis of the incident was not done</p> <p>Review of the hospital's Performance Improvement Plan 2009, revealed that</p>	S 300		

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S 300	Continued From page 36 "Undesirable patterns or trends in performance are intensively analyzed per policy if comparisons show that: 1. Important single events, levels of performance, patterns or trends vary significantly from those expected In addition, the plan revealed "Intense analysis (Root Cause Analysis) will be performed when, but not limited to when the following events occur: 1. The event has resulted in the unanticipated death or major loss of function not related to the natural course of the patient's illness or underlying condition 2. Suicide of an inpatient 3. Rape On 3/9/09 at 11:50 AM, Employee #21 was interviewed. She reported that the 2/26/09 Governing Body minutes were not typed yet. She reviewed her hand written notes with two members of the survey team. She reported that the incident of the two patients attempting suicide was discussed but the board decided to wait for the state citation before making any recommendations. Following the 12/25/08 attempted hangings where staff did not conduct line of sight observation and fifteen minute checks of patients another incident occurred. On 2/6/09, Patient #3 was not observed every 15 minutes by staff as required by facility policy Severity 4 Scope 2	S 300		
S 311	NAC 449.3624 Assessment of Patients 2 Each patient must be reassessed according to hospital policy (a) When there is a significant change in his condition This Regulation is not met as evidenced by Based on record review and staff interview, the facility failed to assess patients when a significant	S 311	449.3624 ASSESSMENT OF PATIENTS West Hills Hospital now ensures all patients are re-assessed by a Registered Nurse when a significant change in condition is noted.	

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		<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. The Interim Director of Nursing provided remedial education and direction to nursing staff and to nonemployee agency staff regarding patient observation and assessment obligations. Nursing staff and nonemployee agency staff on each unit were directed to implement physician orders for levels of observation. Nurse managers were directed to provide ongoing concurrent monitoring and observation of compliance. The Interim Director of Nursing makes routine rounds for direct observation of staff, agency personnel, and manager compliance. Immediate action is taken to correct noncompliance. 2. All staff received direction and training on the identification of changes in the patient's behavior and condition. A variety of scenarios, including high risk, problem prone changes in behaviors, signs and symptoms were discussed. 3. Written patient assignments include information about particular triggers for each patient, and other integral information that might lead to the need for further assessment/reassessment. 4. Included in the shift summary, all RNs now perform an RN assessment of all patients each shift and provide interventions for proper treatment of the patient. Treatment plans will be adjusted accordingly and staff and nonemployee agency personnel now perform a comprehensive assessment when a change in patient's condition is noted. 5. MHT training on signs and symptoms to report to the RN when a change in patient's condition is noted was completed by the Interim 	<p>3/12/09</p> <p>3/17/09</p> <p>3/12/09</p> <p>4/10/09</p> <p>4/10/09</p>
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			<p>Director of Nursing Services and/or designee.</p> <p>Responsible Person:</p> <p>Interim Director of Nursing Unit Nurse Managers PI Director</p> <p>How Monitored to Prevent Recurrence:</p> <p>The Unit Nurse managers and/or Nursing Supervisor now conduct random audits on the proper completion of the RN reassessment when a significant change is noted in a patient's condition a minimum of once per shift per unit. The Interim Director of Nursing makes routine rounds for direct observation of staff, agency personnel, and manager compliance. Immediate action is taken to correct noncompliance.</p> <p>Findings of Nurse Manager observations and audits are submitted to the Interim Director of Nursing for analysis.</p> <p>These findings are reported by the Interim Director of Nursing to the Performance Improvement Committee and Medical Executive Committee monthly and the Governing Board quarterly.</p>	
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S 311	<p>Continued From page 37</p> <p>change in condition occurred for 3 of 10 patients (#1, #2, #3)</p> <p>Findings include:</p> <p>Patient #1 was admitted to the facility on 12/08/08 with diagnoses including major depressive disorder and psychosis. She was placed on the Youth Services Unit.</p> <p>Patient #1's record review revealed she had a history of suicidal ideation. On 12/9/08, she was placed on suicidal precautions due to having a plan to ingest cleaning agents. Her physician ordered that she be observed by staff every 15 minutes. On 12/12/08, she was also restricted to the unit due to active suicidal ideation. The unit restrictions were in effect until 12/17/08. She was again placed on unit restrictions due to active suicidal thoughts on 12/23/08. The patient was on suicidal precautions with unit restrictions on 12/25/08.</p> <p>Patient #2 was admitted to the facility on 12/1/08 with diagnoses including major depressive disorder, possible bipolar disorder and severe asthma. She was placed on the Youth Services unit.</p> <p>Review of Patient #2's records revealed that increasing active suicidality was a reason for admission. On 12/16/08, her physician ordered that she be placed on 1:1 supervision due to a suicide attempt at the facility. She had tied a sweat shirt tightly around her neck and tied the other end to the door. On 12/21/08, the physician discontinued 1:1 supervision and placed her on line of sight supervision meaning staff were to maintain constant visual observation of the patient. The patient was on line of sight</p>	S 311		

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S 311	<p>Continued From page 38 supervision on 12/25/08.</p> <p>Record review revealed that on 12/25/08 at 10 45 PM. Patient #1 and Patient #2 were found with nooses around their necks made from a sheet The sheet was hung over the bathroom door. They used each other's weight to put tension on each noose</p> <p>Patient #1 was found still conscious and her face was described as red. She later complained of a sore neck. The Mental Health Technician (MHT), who found the patient, wrote a statement describing the incident. The statement read "I went into the room and tried to untie the sheet from _____'s neck first. It was so tight I couldn't even get my fingers in it. I have to lift _____ off the floor to loosen the tightness "</p> <p>Patient #2's acuity/progress notes revealed her face was red and she complained of neck pain following the suicide attempt. She reported to the physician that she tried to claw at the noose as soon as it tightened and she panicked. She reported that she began to feel dizzy and numb</p> <p>In an interview with the Director of Nurses (DON) on 2/4/09, he revealed that he was not aware of the attempted suicides until 12/29/08, when he received the incident reports and began an investigation of the incident. He stated that he reviewed the video recordings of the common areas of the adolescent unit and found that MHT #1 and RN #1 did not monitor the patients as required by the physician's orders and by facility policy</p> <p>The DON provided the daily nursing schedule which showed that one registered nurse (RN #1) and one MHT (MHT #1) were assigned to the</p>	S 311		

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S 311	<p>Continued From page 39</p> <p>Youth Services unit on the 3 PM to 11 PM shift when the incident occurred. Seven patients were on the unit during the shift. Patient #2 was on line of sight supervision requiring constant observation by a staff member at all times. Six other patients required observation (checks) by staff every 15 minutes.</p> <p>The nursing daily schedule revealed that there were four RN's assigned to the 3 PM to 11 PM shift on 12/25/08. The hospital had four nursing units. The schedule revealed that there was no nursing supervisor available in the hospital to relieve the RN's during their meal time or break time on the 3 PM to 11 PM and 11 PM to 7 AM shifts. There was a note on the schedule that read "_____ - RN for both Adult and CD Leave Doors open" for the 11 PM to 7 AM shift. The chemical dependency unit was referred to as the CD unit.</p> <p>Review of the DON's investigative report dated 1/5/09, revealed that RN #1 left the unit for her break and left MHT #1 alone on the locked unit with the seven patients for the duration of her break. There was no RN on the locked unit when Patient #1 and Patient #2 were found hanging from the bathroom door.</p> <p>Review of the DON's investigative report revealed that the MHT was at the nurses' station for more than 30 minutes prior to the incident and did not conduct Patient #1's 15 minute checks or keep Patient #2 within line of sight. The report revealed that RN #1 allowed the MHT "to sit for more than 30 minutes in the nurses station and not complete face-to-face fifteen minute checks on the patients". The report revealed that RN #1 was at the nurses' station with the MHT until the RN left the unit for a break. The report revealed</p>	S 311		

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S 311	<p>Continued From page 40</p> <p>RN #1 returned to the unit as the MHT "was addressing the activity of the two female patients".</p> <p>The DON confirmed that RN #1 did not call the attending physician to report the attempted suicides. He called the attending physician as part of his investigation of the event and confirmed that the physician had not received a phone call regarding the suicide attempts until 12/26/08. The report revealed that the physician stated she would have come to the hospital to assess her patients if she were called. The DON also confirmed that the RN did not assess Patient #1 and Patient #2 following the attempted suicides.</p> <p>Review of the facility's policy and procedure entitled "Levels of Observation" revealed that all patients would be routinely observed in compliance with physician orders and prescribed protocols. The policy and procedure revealed that all patients were to be checked every 15 minutes without a physician's order. Line of sight observation required that staff maintain constant visual observation through direct observation or through the use of audio/visual monitoring</p> <p>Patient #3 was admitted to the facility on 2/4/09 with the diagnosis of substance abuse of prescription drugs, opiates. The chief complaint was "I have a lot of problems getting off OxyContin."</p> <p>Patient #3 admitted himself to the facility voluntarily</p> <p>Review of the nurse's notes dated 2/6/09 revealed Patient #3 was showing severe signs of detoxing with increase in vital signs, diaphoresis.</p>	S 311		

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S 311	<p>Continued From page 41</p> <p>agitation, and anxiety. A note was written by Employee #19 in the nurse's notes at 5:30 AM "Pt (patient) visible in room appeared asleep. Pt was awake most of the night and received medication." Nurse's notes dated 2/6/09 at 6:00 AM revealed, "Pt was anxious, restless, agitated for the first part of the night. Tossing and turning and up walking halls. required 1:1 supervision."</p> <p>The physician's progress note dated 2/6/09, revealed "severe withdrawals", "had horrible nite."</p> <p>The nursing notes and 15 minute Patient Observation Records revealed that Patient #3 was monitored continuously through out the night by Employees #17 and #18 but the video tape surveillance revealed a time gap of 30 to 60 minutes where Employees #17 and #18 were sitting at the nurse's station and the every 15 minute observation checks were not completed.</p> <p>An Incident Report dated 2/6/09, written by Employee #20 was reviewed. The RN stated "I came onto the unit this AM. Multiple patients started telling me about caring for _____ last night who was detoxing hard."</p> <p>An interview on 3/4/09 at 2:30 PM, was conducted with the DON. He stated the staff were terminated for not doing the every 15 minute patient checks as seen on the video surveillance tape, but documented the checks were done. He stated the tape showed four patients going in and out of Patient #3's room during the night, but the every 15 minute time checks revealed that those patients were in their rooms sleeping.</p> <p>An interview on 3/5/09 in the morning, was conducted with the Director of Risk Management (RM). She stated the films were reviewed and</p>	S 311		

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S 311	Continued From page 42 the every 15 minute checks were not done and stated that the every 15 minute time check reports were falsified. She stated the films showed patients walking with Patient #3 in the halls and in Patient #3's room. The patients assisting Patient #3 were to be checked every 15 minutes themselves. As a result the RN and two MHT's on the unit the night of the incident were terminated Severity 3 Scope 2	S 311		

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