The Joint Commission Survey March 2012
Corrective Action Taken

Standard Text EC 02.05.07 EP 8
Does the 36-month emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers' exhaust gas temperature?

Surveyor Findings:

EP 8
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
The 36-month emergency generator test for the ATC building generator did not achieve the required dynamic or static load that is at least 30% of the nameplate rating of the generator.

Corrective Action Taken:

Who =
Duane Dipman, Safety Officer
John Golightley, Physical Plant Supervisor Specialist

What: =
1. New contract
2. Policy modification
3. Monthly Preventative Maintenance form update
4. Staff training

When: =
1. A new contract was secured with Foley Equipment on 3/20/2012.
2. Policy EO-1P was updated and approved on 4/9/2012
3. Monthly preventive maintenance form update was complete on 4/9/2012
4. Training of power plant staff (those performing the generator test) was complete on 5/3/2012.

How: =

The Joint Commission Survey March 2012
Corrective Action Taken

1. Larned State Hospital (LSH) contracted with a vendor (Foley Equipment) to place a load bank tester on the Adult Treatment Center (ATC) generator. The generator test was completed on March 20, 2012 by Foley Equipment. The test lasted four hours and the generator tested at approximately 80% capacity. The load bank test ensured that the ATC generator achieved the required dynamic or static load. The test exceeded the required 30% of the nameplate rating. The generator will be tested every three years by Foley Equipment. The safety officer will provide assessment of contractor compliance with requirements at least annually.

2. Engineering Policy EO-1P has been updated to state "when staff discover code compliance discrepancies, they will bring it to their department supervisor's attention who in turn will report it to the Physical Plant Supervisor Specialist". The supervisors then process every Preventive Maintenance form.

3. The monthly Preventative Maintenance documentation form has been updated to show generators must reach 30% of load capacity. The program is designed to generate a "pass/fail" report based on the information provided. If there is a "fail" report, a work order is generated by the supervisor to correct the problem.

4. Staff training will continue on an annual basis and upon hire for new staff.

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Standard Text EM 02.02.13; EP 5
Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, does the organization obtain his or her valid government-issued photo identification (for example, a driver’s license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation?
- A current license to practice?
- Primary source verification of licensure?
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response hospital or group?
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances?
- Confirmation by a licensed independent practitioner currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster?

Surveyor Findings
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site. The medical staff by laws included a section about disaster privileging; however, it did not include the correct verbiage of requiring a government issued photo ID and "at least one of the following..." as required by standard. The emergency operations plan also did not address this issue.

Corrective Action Taken:

Who =
Emmanuel Okeke, M.D. Supervisor, Psychiatric Services
Wineetha Fernando, M.D., Supervisor, General Medical Services
Tony Schwabauer, Safety/Security Chief

What: = Medical Staff Bylaws Section 3.6.4 amendment.

When: = May 4, 2012
The Joint Commission Survey March 2012
Corrective Action Taken

How: = Medical staff bylaws Section 3.6.4 was amended (with the addition of the requirement of a government issued Photo ID) to read as follows:

"In the event of a disaster, the Hospital activates the Emergency Management Plan. During this time, a volunteer practitioner is considered eligible to function as a volunteer licensed practitioner, after the hospital obtains his or her valid government issued photo identification (for example, a driver's license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster."

Medical staff supervisor will continue to monitor future updates to the TJC standards and modify its medical staff bylaws accordingly. In case of a disaster, and if voluntary privileges are granted using this mechanism, a review of this process will be conducted by Safety/Security Chief after the disaster is completed, to ensure compliance with this requirement.

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Standard Text IM 02.02.01; EP 3

3. The hospital follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following:
- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

Surveyor Findings:
EP 3
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The unapproved abbreviation "u" was discovered in the medical record for January 25, 26, and February 3 referencing "units" of insulin.

Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The unapproved abbreviation "u" was discovered in the medical record for December 13 referencing "units" of insulin.

Corrective Action Taken:

Who =
Zena Jacobs, RN, DON
Sid Smith, Lead Application Developer
Dr. Emmanuel Okeke, MD. Supervisor, Staff Psychiatrist

What: =
1. Nursing staff training
2. Nursing staff competencies modification
3. Auditing of records - nursing documentation of insulin MARs
4. Review of prohibited abbreviations audit data by Pharmacy & Therapeutics Committee
The Joint Commission Survey March 2012
Corrective Action Taken

5. Development and implementation of eMARs

6. Revision of computer generated insulin MARs

**When:**

1. Nursing staff training - a list of prohibited abbreviations was added to all treatment files and these lists are also posted in all nursing stations as of 4/1/2012. Training of nursing staff on prohibited abbreviations was completed by 5/4/2012.

2. Nursing staff competencies - modification completed on 5/1/2012.

3. Auditing of records (nursing documentation of insulin MARs) - weekly audits of insulin MARs of 90 records have been completed by 4/30/2012. These records were randomly selected by a computer generated list and rate of compliance for documentation was 92%.

4. Data regarding chart audits and compliance was reviewed at the monthly Pharmacy and Therapeutics Committee meetings on 5/3/2012. Recommendation was made to continue collecting data.

5. Phase I of the eMAR implementation was complete by 5/1/2012.

6. Revision of computer generated insulin MARs was completed by 5/1/2012.

**How:**

1. A list of prohibited abbreviations was posted on all units and was included in each treatment file.

2. Nursing staff competencies were modified to include the list of prohibited abbreviations which will be used upon hire and annually on an ongoing basis for all licensed staff.

3. Auditing of records (nursing documentation of insulin MARs) - an audit tool was developed to include assessment of nursing documentation on the insulin MARs. This audit tool will continue to be used each week using a computer generated sample size. A random sample of records will be selected by Sid Smith, Lead Application Developer for this audit.

4. Audit data will be submitted to Pharmacy & Therapeutics Committee for review and recommendation monthly.

5. A committee composed of above parties has met and outlined 3 phases for completion of implementation of eMARs. Phase I consisted of development of medication protocols and linkage of these protocols to STAT PRN pain medications, high-alert (including insulin) and look-alike/sound-alike medications.
The Joint Commission Survey March 2012
Corrective Action Taken

6. Computer generated insulin MARs were revised to pre-print "units given" for each insulin order which now required the licensed staff to only document the quantity administered (example: "20").

Audit:

1. Director of nursing will continue to oversee training of all licensed staff upon hire and annually.

2. Director of nursing will continue to oversee competencies of all licensed staff upon hire and annually.

3. The audit tool includes the question "is quantity documented versus "U" or "Unit" in the insulin amount slot?" Sample size is selected using a computer generated list of records. Audits will continue on a weekly basis for four months.

4. Data collected using this tool will be reviewed by Pharmacy & Therapeutics Committee every month. The compliance rate will be no less than 90% for each month. The person responsible for conducting these audits is Zena Jacobs, RN, DON.

5. Phase II (completion of the pilot on Isaac Ray North I) of the eMAR implementation project will be complete by 6/1/2012. Phase III (go live) of the eMAR implementation project will be complete by 7/1/2012. Upon full implementation of the eMARs, potential for possible use of prohibited abbreviations will be completely eliminated as users will be prompted to enter quantity of insulin administered and not "Units" or "U."

6. Computer generated MARs will continue to be used until the full implementation of eMARs.

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The Joint Commission Survey March 2012
Corrective Action Taken

Standard Text LD 03.06.01; EP 3
Those who work in the hospital are focused on improving safety and quality.

Ep 3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3)
Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.

Surveyor Findings: EP 3
EP 3
§482.62(g)(2) - (B158) - (2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.
This Standard is NOT MET as evidenced by:
Observed in Record Review at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
A random review of the staffing data for the 1st week of December 2011, the 1st week of January 2012, and the 1st week of February 2012. Significant staffing concerns were noted, namely: 1) During the week of December 1-7, 2012, the SPTP unit (sexual predator treatment program) was short staffed 56 shifts. The SSP unit was short staffed 33 shifts and the PSP unit was short staffed 8.5 shifts. 2) During the week of January 1-7, 2012, the SSP was short staffed 48 shifts; the SPTP 40 shifts; and the PSP 11 shifts. 3) During the week of February 1-7, 2012, SSP was short staffed 44 shifts; SPTP 42 shifts, and PSP 14 shifts. These shortages were a combination of RNs, LPNs, licensed mental health techs, and non-licensed mental health techs. It was noted during various reviews of records, particularly as it relates to the medication administration process (from ordering to dispensing) was lacking. A variety of reports reviewed indicated "due to short staffing..." It was also discovered that when a particular unit is staffed with one RN (often to serve 30 patients) and a new admission arrives, that nurse is occasionally called away from the unit to go and assess the patient (who is elsewhere on the unit), thus leaving the unit not covered by a registered nurse. The hospital does not have any "house supervisors" or RNs who float across with campus without a specific patient assignment. Leaders mentioned there had been significant reductions in force of late. A conversation with the Director of Nursing revealed that the current nursing staff turnover is 29.9%. The RN turnover is 42.5%. The LPN/LMHT turnover is 32.1% and the MHDD (non-licensed) turnover is 26.3%. The hospital currently has 84.5 fillable positions with 53.5 of them being in direct patient care. A review of the Human Resources report dated March 7, 2012 showed that the hospital is not market competitive in salaries. A prison is located on the same campus as the hospital being surveyed and offers more salary for the same type of nurse than the hospital is able to offer. There have been significant efforts by nursing leaders and human resource personnel to hire additional staff; however, these vacancies still exist. The staff turnover and vacancies are alarming and may have directly contributed to care concerns identified throughout this report, such as medication management, provision of care, and record of care.

Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The certified part of the facility has three units each with a usual census of at least 30 patients. One RN is assigned to each unit on each shift. There is no additional RN available to provide for additional nursing supervision or assessment when the RN leaves the unit. during the tracer activity, it was noted that there had been 32 patients on the west unit. There were two admissions and two discharges on that unit. There were two high risk patients requiring frequent reassessments. There were catheter patients and patients with multiple-drug-resistant infections The one RN was unable to complete all the required responsibilities. It was noted that the change of shift hand off had not provided the appropriate information. One patient had multiple orders which were not carried out because of the inadequate staffing
and lack of effective communication. A patient admitted at night did not have an adequate initial nursing plan of care. The patient had critical blood pressure and diabetes. The nurse did not initiate a plan of care. The physician wrote nursing orders for glucose testing and more frequent BP but the orders were not carried out. In addition, the patient was on a high risk medication which require blood test. No test was obtained. The intake worker is only available during regular hours. After hours one of the nurses from one of the three units must provide the intake service taking that nurse of the unit for an extended period of time, leaving the unit without supervision by a nurse.

**Corrective Action Taken:**

**Who** = Christopher Burke, Ph.D., Superintendent, will be responsible to help improve staff shortages.

**What:** =

1. A list of staffing deficiencies were created

2. A meeting was scheduled with state officials to review TJC findings and request additional funding

**When:** =

1. A list of staffing deficiencies were created on 3/14/2012.

2. The meeting with State of Kansas Social and Rehabilitation Services was held on 4/3/2012.

3. State Legislature approved $1.9 Million on 5/2/2012 in the state budget.

**How:** = The approved budget provides salary increases to the licensed nursing staff to create parity with the surrounding market. Additionally, twenty three (23) full time positions were appropriated for hire by the State Legislature. The state of Kansas is scheduled to release these funds by 7/1/2012 with the implementation of the fiscal year 2013 budget. Positions will be posted and recruited for as soon as above is complete.

New Patient Admissions are now being done on the patient units ensuring availability of RN on the unit at all times of the day and night.

Turnover rate is expected to decrease with the addition of 23 new positions.

The funds are expected to be released as of July 1, 2012.

Monies will be utilized to hire new staff to fill in the vacancies in the organization. Staffing shortages, turnover rate, utilization of overtime, vacancy rate will be monitored by the Superintendent every two weeks.
The Joint Commission Survey March 2012
Corrective Action Taken

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Entered in TJC website
The hospital safely manages high-alert and hazardous medications

3. The hospital implements its process for managing high-alert and hazardous medications. (See also EC.02.02.01, EPs 1 and 8)

Surveyor Findings:
EP 3
§482.23(c) - (A-0404) - §482.23(c) Standard: Preparation and Administration of Drugs
Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient’s care as specified under §482.12(c), and accepted standards of practice.
This Standard is NOT MET as evidenced by:
Observed in Medication Management Tracer at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
A patient starting on warfarin for ten days did not have INR levels over 1-3 days as required by policy and procedure.

Observed in Medication Management Tracer at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
A patient was readmitted after regular working hours. The admitting physician restarted Clozaril but did not order an ANC as would be the standard of practice. The regulation does permit restarting the medication after a period of time but practice would usually indicate a newly admitted patient who was restarted would have an ANC ordered at the time of admission to be obtained the next day.

Corrective Action Taken:

Who =
Emmanuel Okeke, MD, Supervisor, Staff Psychiatrist
Zena Jacobs, RN, Director of Nursing
Janet Finger, Director of Pharmacy

What: =
2. Application upgrade in the medication module of the Plexus software system
3. Medical, nursing and pharmacy staff training

When: =
1. Clozapine Protocol was updated and approved on 5/3/2012 by Pharmacy & Therapeutics Committee. Warfarin Protocol was updated and approved on 5/3/2012 by Pharmacy & Therapeutics Committee.
The Joint Commission Survey March 2012
Corrective Action Taken

drug and food-drug interactions, appropriateness of medications for dose, frequency and route, potential impact as indicated by lab values, and therapeutic duplication, contraindications, and age/weight specific dosing.

Nursing Policy E-6 was approved on 4/30/12 which indicates review of medications for appropriateness during the after hours, weekends, and holidays by the nurse. The nurses will continue to use the paper form which lists the name of the drug, route, dose, frequency and monitor vital signs before and one hour after the administration of a new medication. The nurses also will utilize the online tools provided in the electronic medical record for review of new medication orders for allergies, drug-drug & food-drug interactions, appropriateness of medication for dose, frequency and route of administration, impact on lab values, and therapeutic duplication prior to sending the order to medication dispensing system (Omnicell). Pharmacy will review these orders in the next business day.

When: =

Updated Pharmacy policy is effective as of 5/1/12.

Nursing Policy updated and approved as of 4/30/12.

How: = Once the pharmacy review is done, it is marked off on the EMR as acknowledged. Once the after hours nursing review is done, it is marked off in the EMR as a temporary acknowledgment, with a flag to the pharmacy for further review on the next business day. If the appropriateness check is not done by the pharmacy staff or the nursing staff, the licensed nursing staff will have to do an override of the medication prior to medication being taken out of omnicell. Pharmacy staff will generate an automatic daily report of overrides during the work days and monitor if the review of medications is being done as per the policy. Overrides are only done by an RN. Overrides are done during an emergency situation for STAT orders.

A monthly report on overrides will be submitted to Pharmacy & Therapeutics Committee for review and recommendations.

Nursing staff were required to attend a mandatory training during the week of 4/23/12 to 4/27/2012. During the sessions offered, Zena Jacobs, RN, DON, provided training to staff on the new policies. An attendance roster was completed.

Pharmacy staff were trained on the new policy by Janet Finger, Director of Pharmacy on 5/1/2012.

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The hospital addresses the safe use of look-alike/sound-alike medications

EP2. The hospital takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.

Surveyor Findings: EP 2
Observed in Individual Tracer at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
Tracer activity included review of insulin storage for a diabetic patient. A bin in the refrigerator with a high alert label included a multi-dose vial of each of the following: Humalog, Humalin, and Regular insulin. The placement of these medications in one bin does not indicate a process to prevent errors in the interchange of medications which are lookalike/sound/alike.

Corrective Action Taken:

Who =
Zena Jacobs, RN, Director of Nursing
Sid Smith, Lead Application Developer

What =
Larned State Hospital (LSH) Nursing Policy T-12: Look Alike Sound Alike Medication Policy, which was implemented as of May 3, 2012. The policy states that the look alike sound alike medications will be separated out in the pharmacy, Omnicell, refrigerators and there will be utilization of tall man lettering.

Larned State Hospital (LSH) Nursing Policy T-11: High Alert Medication Policy was implemented on May 3, 2012 to ensure high alert medications are stored, handled, and administered in a safe manner. All high alert medications require two licensed nursing staff to remove and verify medications from the automatic dispensing system (OmniCell). All high alert medications requiring refrigeration (ex: Insulin) will be stored in a red bin in the medication room refrigerator. Each high alert medication will be labeled and placed in its own designated bin with the front of the bin baring a label with the name of the medication and a high alert sticker. The medication rooms will have laminated signs posted that list all the high alert and look-alike sound-alike medications.

Nursing training on new policies

When =
Policies were implemented on 5/3/2012.
Nursing training was complete by 4/27/12.
The Joint Commission Survey March 2012
Corrective Action Taken

How: All nursing staff were required to attend a mandatory meeting during the week of 4/23 to 4/27/2012. During these meetings, new policies on medication administration were reviewed with all staff. Training was provided by Zena Jacobs, RN, DON and an attendance roster was completed.

Weekly audits of a random sample of ninety (90) records will be selected using a computer generated list. This list will be provided by Sid Smith, Lead Application Developer. Audits will be completed to evaluate compliance with this policy for (4) months.

Training will be provided to new staff and annually by Zena Jacobs, RN, DON.

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The Joint Commission Survey March 2012
Corrective Action Taken

Standard Text MM 05.01.01 EP 5
A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

ep5. All medication orders are reviewed for the following: Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.

Surveyor Findings:
EP 5
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The hospital's process for 1st dose review of medications is that the nurse completes a form which lists the name of the new drug, the route, the dose, and the frequency. The nurse additionally documents a set of vital signs before the administration of the new medication and a set of vital signs one hour after the administration of the new medication. The first of three 1st dose reviews did not document that anyone (including the nurse) reviewed the medication for potential interactions. The pharmacy director was then consulted who verified that the 1st dose of review only occurs during pharmacy hours (Monday thru Friday. 0730-1800) and that any new medications that start after 7pm on Friday are not reviewed by the pharmacist until the next business day - Monday at the earliest. This extremely high risk activity had apparently not been identified as such by the hospital prior to the discovery by the surveyor.

Corrective Action Taken:

Who = Janet Finger, Director of Pharmacy, Zena Jacobs, Director of Nursing, and Sid Smith (Application Development)

What: Pharmacy policy (No.1) regarding written prescriptions/medication orders was updated, and approved for use as of 5/1/12. It describes the pharmacist review of medications during established pharmacy hours. The policy describes the following to be verified by the pharmacist during appropriateness review. This includes allergies, sensitivities, drug-drug and food-drug interactions, appropriateness of medications for dose, frequency and route, potential impact as indicated by lab values, and therapeutic duplication, contraindications, and age/weight specific dosing.

Nursing Policy E-6 was approved on 4/30/12 which indicates review of medications for appropriateness during the after hours, weekends, and holidays by the nurse. The nurses will continue to use the paper form which lists the name of the drug, route, dose, frequency and monitor vital signs before and one hour after the administration of a new medication. The nurses also will utilize the online tools provided in the electronic medical record for review of new medication orders for allergies, drug-drug & food-drug interactions, appropriateness of medication for dose, frequency and route of administration, impact on lab values, and therapeutic duplication prior to sending the order to medication dispensing system (omincell). Pharmacy will review these orders in the next business day.

When: Updated Pharmacy policy is effective as of 5/1/12.

Nursing Policy updated and approved as of 4/30/12.
The Joint Commission Survey March 2012
Corrective Action Taken

**How:** Once the pharmacy review is done, it is marked off on the EMR as acknowledged. Once the after hours nursing review is done, it is marked off in the EMR as a temporary acknowledgement, with a flag to the pharmacy for further review on the next business day. If the appropriateness check is not done by the pharmacy staff or the nursing staff, the licensed nursing staff will have to do an override of the medication prior to medication being taken out of omnicell. Pharmacy staff will generate an automatic daily report of overrides during the work days and thus monitor if the review of medications being done as per the policy. Overrides are only done by a RN. Overrides are done during an emergency situation for STAT orders.

**Audit** = Pharmacist will pull a weekly report of review of the medication orders by the nursing staff and the pharmacy staff.

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Entered in TJC website
A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

ep7. All medication orders are reviewed for the following: Current or potential impact as indicated by laboratory values.

Surveyor Findings: EP 7
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site. The hospital's process for 1st dose review of medications is that the nurse completes a form which lists the name of the new drug, the route, the dose, and the frequency. The nurse additionally documents a set of vital signs before the administration of the new medication and a set of vital signs one hour after the administration of the new medication. The 1st of three 1st dose reviews did not document that the anyone (including the nurse) reviewed the medication for current or potential impact as indicated by laboratory values. The pharmacy director was then consulted who verified that the 1st dose of review only occurs during pharmacy hours (Monday thru Friday, 0730-1800) and that any new medications that start after 7pm on Friday are not reviewed by the pharmacist until the next business day - Monday at the earliest. This extremely high risk activity had apparently not been identified as such by the hospital prior to the discovery by the surveyor.

Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site. The hospital's process for 1st dose review of medications is that the nurse completes a form which lists the name of the new drug, the route, the dose, and the frequency. The nurse additionally documents a set of vital signs before the administration of the new medication and a set of vital signs one hour after the administration of the new medication. The 2nd of three 1st dose reviews did not document that the anyone (including the nurse) reviewed the medication for current or potential impact as indicated by laboratory values. The pharmacy director was then consulted who verified that the 1st dose of review only occurs during pharmacy hours (Monday thru Friday, 0730-1800) and that any new medications that start after 7pm on Friday are not reviewed by the pharmacist until the next business day - Monday at the earliest. This extremely high risk activity had apparently not been identified as such by the hospital prior to the discovery by the surveyor.

Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site. The hospital's process for 1st dose review of medications is that the nurse completes a form which lists the name of the new drug, the route, the dose, and the frequency. The nurse additionally documents a set of vital signs before the administration of the new medication and a set of vital signs one hour after the administration of the new medication. The 3rd of three 1st dose reviews did not document that the anyone (including the nurse) reviewed the medication for current or potential impact as indicated by laboratory values. The pharmacy director was then consulted who verified that the 1st dose of review only occurs during pharmacy hours (Monday thru Friday, 0730-1800) and that any new medications that start after 7pm on Friday are not reviewed by the pharmacist until the next business day - Monday at the earliest. This extremely high risk activity had apparently not been identified as such by the hospital prior to the discovery by the surveyor.

Corrective Action Taken:

Who = Janet Finger, Director of Pharmacy, Zena Jacobs, Director of Nursing, and Sid Smith (Application Development)

What: = Pharmacy policy (No.1) regarding written prescriptions/medication orders was updated, and approved for use as of 5/1/12. It describes the pharmacist review of medications during established pharmacy hours. The policy describes the following to be verified by the pharmacist during appropriateness review. This includes allergies, sensitivities, drug-drug and food-drug interactions, appropriateness of medications for dose, frequency and route, potential impact as indicated by lab values, and therapeutic duplication, contraindications, and age/weight specific dosing.
The Joint Commission Survey March 2012
Corrective Action Taken

Nursing Policy E-6 was approved on 4/30/12 which indicates review of medications for appropriateness during the after hours, weekends, and holidays by the nurse. The nurses will continue to use the paper form which lists the name of the drug, route, dose, frequency and monitor vital signs before and one hour after the administration of a new medication. The nurses also will utilize the online tools provided in the electronic medical record for review of new medication orders for allergies, drug-drug & food-drug interactions, appropriateness of medication for dose, frequency and route of administration, impact on lab values, and therapeutic duplication prior to sending the order to medication dispensing system (omincell). Pharmacy will review these orders in the next business day.

When:  

Updated Pharmacy policy is effective as of 5/1/12.

Nursing Policy updated and approved as of 4/30/12.

How:  

Once the pharmacy review is done, it is marked off on the EMR as acknowledged. Once the after hours nursing review is done, it is marked off in the EMR as a temporary acknowledgement, with a flag to the pharmacy for further review on the next business day. If the appropriateness check is not done by the pharmacy staff or the nursing staff, the licensed nursing staff will have to do an override of the medication prior to medication being taken out of omnicell. Pharmacy staff will generate an automatic daily report of overrides during the work days and thus monitor if the review of medications are being done as per the policy. Overrides are only done by a RN. Overrides are done during an emergency situation for STAT orders.

Audit:  

Pharmacist will pull a weekly report of review of the medication orders by the nursing staff and the pharmacy staff.

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The Joint Commission Survey March 2012
Corrective Action Taken

Standard Text MM 05.01.01 EP8
A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

ep8. All medication orders are reviewed for the following: Therapeutic duplication

Surveyor Findings
EP 8
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The hospital's process for 1st dose review of medications is that the nurse completes a form which lists the name of the new drug, the route, the dose, and the frequency. The nurse additionally documents a set of vital signs before the administration of the new medication and a set of vital signs one hour after the administration of the new medication. The 1st of three 1st dose reviews did not document that the anyone (including the nurse) reviewed the medication for therapeutic duplication. The pharmacy director was then consulted who verified that the 1st dose of review only occurs during pharmacy hours (Monday thru Friday, 0730-1800) and that any new medications that start after 7pm on Friday are not reviewed by the pharmacist until the next business day - Monday at the earliest. This extremely high risk activity had apparently not been identified as such by the hospital prior to the discovery by the surveyor.

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Corrective Action Taken:

Who = Janet Finger, Director of Pharmacy, Zena Jacobs, Director of Nursing, and Sid Smith (Application Development)

What: = Pharmacy policy (No.1) regarding written prescriptions/medication orders was updated, and approved for use as of 5/1/12. It describes the pharmacist review of medications during established pharmacy hours. The policy describes the following to be verified by the pharmacist during appropriateness review. This includes allergies, sensitivities, drug-drug and food-drug interactions, appropriateness of medications for dose, frequency and route, potential impact as indicated by lab values, and therapeutic duplication, contraindications, and age/weight specific dosing.
The Joint Commission Survey March 2012
Corrective Action Taken

Nursing Policy E-6 was approved on 4/30/12 which indicates review of medications for appropriateness during the after hours, weekends, and holidays by the nurse. The nurses will continue to use the paper form which lists the name of the drug, route, dose, frequency and monitor vital signs before and one hour after the administration of a new medication. The nurses also will utilize the online tools provided in the electronic medical record for review of new medication orders for allergies, drug-drug & food-drug interactions, appropriateness of medication for dose, frequency and route of administration, impact on lab values, and therapeutic duplication prior to sending the order to medication dispensing system (omnicell). Pharmacy will review these orders in the next business day.

When:  
Updated Pharmacy policy is effective as of 5/1/12.
Nursing Policy updated and approved as of 4/30/12.

How:  
Once the pharmacy review is done, it is marked off on the EMR as acknowledged. Once the after hours nursing review is done, it is marked off in the EMR as a temporary acknowledgement, with a flag to the pharmacy for further review on the next business day. If the appropriateness check is not done by the pharmacy staff or the nursing staff, the licensed nursing staff will have to do an override of the medication prior to medication being taken out of omnicell. Pharmacy staff will generate an automatic daily report of overrides during the work days and thus monitor if the review of medications are being done as per the policy. Overrides are only done by a RN. Overrides are done during an emergency situation for STAT orders.

Audit:  Pharmacist will pull a weekly report of review of the medication orders by the nursing staff and the pharmacy staff.

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Corrective Action Taken

Standard Text MM 05.01.01 EP9
A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

ep9. All medication orders are reviewed for the following: Other contraindications.

Surveyor Findings
EP 9
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The hospital's process for 1st dose review of medications is that the nurse completes a form which lists the name of the new drug, the route, the dose, and the frequency. The nurse additionally documents a set of vital signs before the the administration of the new medication and a set of vital signs one hour after the administration of the new medication. The 1st of three 1st dose reviews did not document that the anyone (including the nurse) reviewed the medication for contraindications. The pharmacy director was then consulted who verified that the 1st dose of review only occurs during pharmacy hours (Monday thru Friday, 0730-1800) and that any new medications that start after 7pm on Friday are not reviewed by the pharmacist until the next business day - Monday at the earliest. This extremely high risk activity had apparently not been identified as such by the hospital prior to the discovery by the surveyor.

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Corrective Action Taken:

Who = Janet Finger, Director of Pharmacy, Zena Jacobs, Director of Nursing, and Sid Smith (Application Development)

What = Pharmacy policy (No.1) regarding written prescriptions/medication orders was updated, and approved for use as of 5/1/12. It describes the pharmacist review of medications during established pharmacy hours. The policy describes the following to be verified by the pharmacist during appropriateness review. This includes allergies, sensitivities, drug-drug and food-drug interactions, appropriateness of medications for dose, frequency and route, potential impact as indicated by lab values, and therapeutic duplication, contraindications, and age/weight specific dosing.
The Joint Commission Survey March 2012
Corrective Action Taken

Nursing Policy E-6 was approved on 4/30/12 which indicates review of medications for appropriateness during the after hours, weekends, and holidays by the nurse. The nurses will continue to use the paper form which lists the name of the drug, route, dose, frequency and monitor vital signs before and one hour after the administration of a new medication. The nurses also will utilize the online tools provided in the electronic medical record for review of new medication orders for allergies, drug-drug & food-drug interactions, appropriateness of medication for dose, frequency and route of administration, impact on lab values, and therapeutic duplication prior to sending the order to medication dispensing system (omnicell). Pharmacy will review these orders in the next business day.

When: =
Updated Pharmacy policy is effective as of 5/1/12.
Nursing Policy updated and approved as of 4/30/12.

How: =
Once the pharmacy review is done, it is marked off on the EMR as acknowledged. Once the after hours nursing review is done, it is marked off in the EMR as a temporary acknowledgement, with a flag to the pharmacy for further review on the next business day. If the appropriateness check is not done by the pharmacy staff or the nursing staff, the licensed nursing staff will have to do an override of the medication prior to medication being taken out of omnicell. Pharmacy staff will generate an automatic daily report of overrides during the work days and thus monitor if the review of medications being done as per the policy. Overrides are only done by a RN. Overrides are done during an emergency situation for STAT orders.

Audit: = Pharmacist will pull a weekly report of review of the medication orders by the nursing staff and the pharmacy staff.

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The Joint Commission Survey March 2012
Corrective Action Taken

Standard Text MM 05.01.01; EP 1
A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

1. Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation.

Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient back-up. The first exception allows medications ordered by a licensed independent practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A licensed independent practitioner is not required to remain at the bedside when the medication is administered. However, a licensed independent practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient.

Note 2: A hospital's radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the licensed independent practitioner in the direct supervision of a patient during and after IV contrast media is administered including the licensed independent practitioner’s timely intervention in the event of a patient emergency.

Surveyor Findings:
EP 1
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The nursing staff bypassed the hospital's normal process for pharmacy 1st dose review of a new medication on October 3 at 1:30pm. The pharmacy was open at this time; however, nursing completed its new medication form and removed the antibiotic from the Omnicell device and administered the medication WITHOUT the pharmacy reviewing the medication first for allergies, interactions, appropriateness, lab values, therapeutic duplication, and contraindications

Corrective Action Taken:

Who =
Janet Finger, Director of Pharmacy,
Zena Jacobs, Director of Nursing
Sid Smith, Lead Application Developer

What: = Pharmacy policy (No.1) regarding written prescriptions/medication orders was updated, and approved for use as of 5/1/12. It describes the pharmacist review of medications during established pharmacy hours. The policy describes the following to be verified by the pharmacist during appropriateness review. This includes allergies, sensitivities, drug-
The Joint Commission Survey March 2012

Corrective Action Taken

drug and food-drug interactions, appropriateness of medications for dose, frequency and route, potential impact as indicated by lab values, and therapeutic duplication, contraindications, and age/weight specific dosing.

Nursing Policy E-6 was approved on 4/30/12 which indicates review of medications for appropriateness during the after hours, weekends, and holidays by the nurse. The nurses will continue to use the paper form which lists the name of the drug, route, dose, frequency and monitor vital signs before and one hour after the administration of a new medication. The nurses also will utilize the online tools provided in the electronic medical record for review of new medication orders for allergies, drug-drug & food-drug interactions, appropriateness of medication for dose, frequency and route of administration, impact on lab values, and therapeutic duplication prior to sending the order to medication dispensing system (Omnicell). Pharmacy will review these orders in the next business day.

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A monthly report on overrides will be submitted to Pharmacy & Therapeutics Committee for review and recommendations.

Nursing staff were required to attend a mandatory training during the week of 4/23/12 to 4/27/2012. During the sessions offered, Zena Jacobs, RN, DON, provided training to staff on the new policies. An attendance roster was completed.

Pharmacy staff were trained on the new policy by Janet Finger, Director of Pharmacy on 5/1/2012.

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The Joint Commission Survey March 2012
Corrective Action Taken

Standard Text MM 05.01.09; EP 10
Medications are labeled.

10. When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: The patient's name.

Surveyor Findings
EP 10
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
A medication pass was observed on Dillon East 1 Wing where the nurse administered multiple medications to multiple patients. It was discovered that the nurse removed the medications from the automated dispensing unit earlier in the morning and placed the medications for each patient in a small unlabeled cup. Multiple cups were then placed side by side on a table top which had bored out spaces for the unlabeled cups to be placed. Behind each of the medications was a photograph of the patient. At the time of administration, the nurse often said, "How are you, Mr...?" Hospital policy required the nurse to use the patient name (whether recited or inquired) AND a photo ID as the means for identifying the patient prior to medication administration. The nurse was not observed looking at these photographs. Of note, all the medications and the cups on this table top were not labeled with the patient's name. Instead, multiple medications were in multiple unlabeled cups. Additionally, the nurse did not reference the medication administration record (MAR) at the time of actually administering the medications. As such, the medication administration process represented a significant vulnerability for the hospital and its patients.

Corrective Action Taken:

Who = Zena Jacobs, RN, Director of Nursing

What: =

1. Nursing Policy E6 modification
2. Training of nursing staff
3. Modification of nursing competencies to include new policy
4. Random observation of nursing medication pass

When: =

1. Nursing Policy E6 was revised on 4/13/2012.
2. All nursing staff was trained on the policy between 4/23/2012 and 4/27/2012. Process was implemented campus-wide on 4/30/2012.
3. Modification of nursing competencies was done to include this policy on 4/23/2012.
The Joint Commission Survey March 2012
Corrective Action Taken

4. Random observation of nursing medication pass started on 4/1/2012 and was completed on 5/1/2012 which showed 90% compliance. Random sample was selected using a computer generated list.

How:

1. Policy E-6 was revised to include labeling of medications using patient’s name, time, location if other than where medication prepared and instructions if applicable.

2. Nursing staff training occurred between 4/23/2012 through 4/27/2012 and was provided by Zena Jacobs, RN, DON. Each licensed staff member signed roster indicating attendance and understanding of the policy.

3. A standard competency form was completed by the attending instructors to demonstrate staff competency. Nursing competencies will include this policy for all new nurses and annually.

4. Observation of random sample of licensed staff (8) from all shifts and units per week using a computer generated list of staff will continue for (4) weeks.

Medication Administration/Documentation Policy refers to the labeling and administration of medication. The policy section labeled “Procedure for Administering Medication” explains the process of labeling medications. The medications will be removed from the automated dispensing system (OmniCell) and placed into medication cups. The medication cups are labeled with the patient’s name, the location where the medication is to be delivered and directions for use and applicable instructions.

Licensed nursing staff have received the education and training detailed above. Training is also provided for new employees during licensed nursing orientation. Nursing orientation related to medications is specific to the licensed nursing staff that has been granted access to the OmniCell machine. Training and policy updates are provided to the licensed nursing staff via email notifications. Staff Development tracks all completed training.

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Standard Text MM 05.01.01 EP 6

A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Ep6. All medication orders are reviewed for the following: The appropriateness of the medication, dose, frequency, and route of administration.

Surveyor Findings:
EP 6
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
The hospital's process for 1st dose review of medications is that the nurse completes a form which lists the name of the new drug, the route, the dose, and the frequency. The nurse additionally documents a set of vital signs before the administration of the new medication and a set of vital signs one hour after the administration of the new medication. The 1st of three 1st dose reviews did not document that the anyone (including the nurse) reviewed the medication for appropriateness of the medication, dose, frequency, and route of administration. The pharmacy director was then consulted who verified that the 1st dose of review only occurs during pharmacy hours (Monday thru Friday, 0730-1800) and that any new medications that start after 7pm on Friday are not reviewed by the pharmacist until the next business day - Monday at the earliest. This extremely high risk activity had apparently not been identified as such by the hospital prior to the discovery by the surveyor.

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Corrective Action Taken:

Who = Janet Finger, Director of Pharmacy, Zena Jacobs, Director of Nursing, and Sid Smith (Application Development)

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The Joint Commission Survey March 2012  
Corrective Action Taken

Nursing Policy E-6 was approved on 4/30/12 which indicates review of medications for appropriateness during the after hours, weekends, and holidays by the nurse. The nurses will continue to use the paper form which lists the name of the drug, route, dose, frequency and monitor vital signs before and one hour after the administration of a new medication. The nurses also will utilize the online tools provided in the electronic medical record for review of new medication orders for allergies, drug-drug & food-drug interactions, appropriateness of medication for dose, frequency and route of administration, impact on lab values, and therapeutic duplication prior to sending the order to medication dispensing system (omnicell). Pharmacy will review these orders in the next business day.

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Audit: = Pharmacist will pull a weekly report of review of the medication orders by the nursing staff and the pharmacy staff.

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Corrective Action Taken

Standard Text NPSG 15.01.01; EP 2
Identify patients at risk for suicide.
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

EP 2. Address the patient's immediate safety needs and most appropriate setting for treatment.

Surveyor Findings:
EP 2
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
In September 2011, the hospital became aware that its patient bathroom doors represented a risk for suicide. Two months later, the hospital's risk assessment was updated. As of the survey in March 2012, nothing had been done to the doors to make them safer. LATE NOTE: On the fourth day of the survey, a unit director invited the surveyor to revisit the area where the "safe rooms" were located. One of the rooms was inspected and was found to be redesigned to substantially obviate risks associated with potential suicide. Three of the planned 18 safe rooms had been completed as of this survey, a full six months after the hospital identified its risks.

Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
In September 2011, the hospital became aware that its patient bathroom plumbing fixtures represented a risk for suicide. Two months later, the hospital's risk assessment was updated. As of the survey in March 2012, nothing had been done to the plumbing fixtures to make them safer. LATE NOTE: On the fourth day of the survey, a unit director invited the surveyor to revisit the area where the "safe rooms" were located. One of the rooms was inspected and was found to be redesigned to substantially obviate risks associated with potential suicide. Three of the planned 18 safe rooms had been completed as of this survey, a full six months after the hospital identified its risks.

Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
In September 2011, the hospital became aware that its patient assessment methods represented a risk for suicide. As of the survey in March 2012, only 315 (of 800+) employees had been trained on recognition of changing symptoms which might enable the employee to "catch" an impending suicide. The training only began in February 2012, a full five months after the hospital became aware of its vulnerability in patient assessment.

Corrective Action Taken:

Who =
Cory Turner, Administrative Program Director - PSP
John Golightley, Physical Plant Supervisor
Duane Dipman, Safety Officer
Dr. Thomas Kinlen, Ph.D., Psychologist
Zena Jacobs, RN, Director of Nursing
Kathy Evers, Public Service Administrator II

What: =
1. Policy modification
The Joint Commission Survey March 2012
Corrective Action Taken

2. Physical plant modification
3. Training of staff
4. Staff competencies
5. Audits of training and assessment completion

When: =
1. Policies were completed and implemented on 3/14/2012
2. Safe Room were completed by 5/1/2012
3. "Suicide Risk Factors, Warning Signs, and Triggers” and CAMS approach assessment trainings began 2/16/2012 and was complete on 5/1/2012. 96.6% of staff have completed training (goal was to have 95% trained by 5/1/2012).
4. Above trainings were added to staff competencies on 4/1/2012 and will be complete upon employment and annually.
5. Audit tool was developed for assessment of training and suicide assessment completion by 5/1/2012. This is to assess continued compliance.

How: =
1. PSP has completed and implemented two (2) policies in response to the completed suicide and TJC survey, PSP-5.18 Safe Rooms which delineates features necessary for Safe Rooms and how said rooms are to be utilized, and PSP-5.19 Prevention of Self Harm which describes the numerous options LSH has at its disposal for keeping patients safe from self harm. LSH policy P8-12, Suicide Assessment and Management was revised on 4/2012 to include the updated assessment process (CAMS) as well as measures to mitigate risk.

2. Larned State Hospital (LSH) has completed work on one (1) Safe Room on each of the three (3) Psychiatric Services Program (PSP) units for a total of three (3) Safe Rooms for the PSP. In addition to the rooms currently completed, LSH has identified and completed work on three (3) additional rooms [one (1) per unit]. This equates to six (6) total Safe Rooms. LSH will not designate eighteen (18) Safe Rooms as previously discussed. In addition, LSH has conducted risk assessments on both standard and Safe Rooms on March 15, 2012.

3. LSH has already prepared and implemented training titled, “Suicide Risk Factors, Warning Signs, and Triggers,” and all clinical and direct care staff which was complete by May 1, 2012 with compliance rate of 96.8% (goal was 95% by 5/1).
   LSH has also implemented a nationally recognized suicide assessment tool, the Collaborative Assessment and Management of Suicidality (CAMS) approach which will be in addition to the currently utilized Suicide Assessment Checklist (CPR-392), which has been completed on every admission.
The Joint Commission Survey March 2012
Corrective Action Taken

4. Staff development provided training on these policies to all staff. In addition, competencies of staff regarding these policies were documented for all clinical and direct care staff.

Audit:

Weekly audits of all LSH admissions has started on 5/1/2012 for compliance with suicide assessment completion. A tracking sheet has been developed to monitor progress toward goals. Staff training is 96.8% complete. All training will be complete by 6/1/2012 by Kathy Evers. Staff development will conduct training on the new policies and provide ongoing training to new staff and annually. Audits will determine competency of clinical staff to complete the suicide assessment form on every admission. Staff will demonstrate competency by completing an online training on suicide risk assessment and will be required to obtain a score of 100% to pass.

The LSH Clinical Executive Committee (CEC) will review the frequency of self-harm incidents and suicide attempts each month. Increasing data trends will be evaluated and interventions will be implemented and overseen by the Medical Director, the Director of Psychology and the respective Program Director. Environment of Care tours will be completed by the LSH Safety Officer twice per year on all patient units. Proactive Risk assessments are conducted annually.

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The Joint Commission Survey March 2012
Corrective Action Taken

Standard Text PC 01.02.07; EP 3
The hospital assesses and manages the patient's pain

Ep3. The hospital reassesses and responds to the patient’s pain, based on its reassessment criteria.

Surveyor Findings
EP 3
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
A patient's pain was not documented as being reassessed four times as required by policy.
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
An additional patient's pain was not documented as having been reassessed three times as required by policy.
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
An additional patient received narcotics for pain on Feb 7 and there was no documented reassessment of pain as required by policy.

Corrective Action Taken:

Who =
Zena Jacobs, RN, Director of Nursing
Dr. Wineetha Fernando, Supervisor, General Medical Services
Dr. Emmanuel Okeke, Supervisor, Staff psychiatrist
Sid Smith, Lead Applications Developer

What: =
1. eMARs implementation
2. Licensed staff training and competency on Pain Assessment policy

When: =
1. Phase I implementation of eMARs was complete on 5/1/2012.
2. Licenses staff training completed by 5/4/2012

How: =
1. A committee composed of above parties met and outlined 3 phases for completion of implementation of eMARs. Phase I consisted of development of medication protocols and linkage of these protocols to STAT PRN pain medications, high-alert (including insulin) and look-alike/sound-alike medications.
The Joint Commission Survey March 2012
Corrective Action Taken

eMAR application development started on 3/12/12. Since that date, protocol mechanism was developed to include identification of all medications that constitute "pain medications." The system is designed to trigger outgoing messages to the nurses when these medications are administered and follow up assessment is required. Pain protocols have been attached to new medication orders in the electronic records.

2. Nursing training was complete by 5/4/2012 to include review of the Pain Assessment policy. As a part of admission intake assessment, the nurses are expected to screen the patient for pain (form CPR66-N1). Staff assesses pain by accessing form (CPR-23 Comprehensive Pain Assessment) online. After completion, the form will be forwarded to the physician for further follow up. Training was complete by posting above policy on all nursing units and requiring nursing staff to sign a form stating they have read the policy. Pain assessment was included in nursing orientation and nursing competencies. Nursing orientation is specific to the licensed staff. Staff Development tracks all employees training and competencies. Updates are provided via email notification for required to read policies.

Audit:

An audit tool will be used to assess compliance of nursing documentation with this standard. Weekly audits will be conducted using a computer generated random sample of Ninety (90) records to assess compliance with this policy. The weekly audits will be conducted under the supervision of Zena Jacobs, RN, Director of Nursing for (4) months. The result of these audits will be reviewed at Pharmacy & Therapeutics Committee meetings monthly.

Phase II (completion of the pilot on Isaac Ray North I) of the eMAR implementation project will be complete by 6/1/2012. Phase III (go live) of the eMAR implementation project will be complete by 7/1/2012. Upon full implementation of the eMARS, nurses will be prompted electronically to document assessment and reassessment of pain.

Computer generated paper MARs will continue to be used until the full implementation of eMARS on 7/1/2012.

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The medical record contains information that reflects the patient's care, treatment, and services.

2. The medical record contains the following clinical information:
   - The reason(s) for admission for care, treatment, and services
   - The patient's initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments (See also PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8)
   - Any allergies to food
   - Any allergies to medications
   - Any conclusions or impressions drawn from the patient's medical history and physical examination
   - Any diagnoses or conditions established during the patient's course of care, treatment, and services
   - Any consultation reports
   - Any observations relevant to care, treatment, and services
   - The patient's response to care, treatment, and services
   - Any emergency care, treatment, and services provided to the patient before his or her arrival
   - Any progress notes
   - All orders
   - Any medications ordered or prescribed
   - Any medications administered, including the strength, dose, and route
   - Any access site for medication, administration devices used, and rate of administration
   - Any adverse drug reactions
   - Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EPs 1 and 23)
   - Results of diagnostic and therapeutic tests and procedures
   - Any medications dispensed or prescribed on discharge
   - Discharge diagnosis
   - Discharge plan and discharge planning evaluation
   (See also PC.01.02.03, EPs 6-8)

Surveyor Findings

EP 2
§482.61(c)(2) - (B125) - (2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.

This Standard is NOT MET as evidenced by:

- Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
- Two medications were not documented as having been administered on Feb 27.
- Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
- A medication was not documented as being given on March 1.
- Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
- On March 2, seven medications were not documented as having been administered.
- Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
- On February 15, 2012 - none of the medications on the day or evening shift were documented as having been given.
- Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site for the Psychiatric Hospital deemed service.
- On February 28, none of the medications that were presumably given were documented as having been
The Joint Commission Survey March 2012
Corrective Action Taken

administered. 
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site. 
An additional patient had missing documentation of medications presumably administered on multiple days of medication administration records reviewed

Corrective Action Taken:

Who = Zena Jacobs, Director of Nursing

What: = LSH Medication Administration/Documentation Nursing Policy E-6 does indicate that the nursing staff have to initial the Medication Administration Record directly after the administration of medications. The nursing staff have been provided re-education on this process.

When: = Additional re-education/training was provided to the nursing staff from 4/23/12 thru 4/27/12.

How: = Random sample of ninety (90) records from all programs (SSP, PSP, SPTP) were reviewed. Sample size was selected by using a computer generated list. This audit showed a 90% compliance rate for medication documentation.

Audit: = Random sample Audits will be done by designated staff for a selected sample size of ninety (90) patients from all programs (SSP, PSP, SPTP) on a weekly basis for the next four months. Sample will be selected using a computer generated list. Zena Jacobs, Director of Nursing will oversee this audit. Results of these audits will be reviewed at Pharmacy & Therapeutics Committee meeting monthly.

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Standard Text UP.01.01.01; EP 2

Conduct a preprocedure verification process

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
- Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
- Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
- Any required blood products, implants, devices, and/or special equipment for the procedure

Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

Surveyor Findings

EP 2

Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.

No documented policy and procedure could be found addressing the preprocedure verification process for those patients undergoing dental extraction

Corrective Action Taken:

Who =

Dr. Dee Holman, DDS, Contract Dentist
Andrea Holman, Dental Assistant

Above staff will be responsible to perform the pre-procedure verification including the completion of site-marking as per policy E-13 Universal and Time Out Procedure.

What: = A new policy E-13 (Universal and Time Out Procedure) was created and approved with an effective date of 4/25/2012.

When: = Dr. Holman and her assistant were educated on this policy and have been using this process as of 4/25/2012.

How: = There will be audits conducted for 100% of dental extractions over the next four months by the clinic staff to evaluate that the Pre-procedure verification and Time Outs are being conducted prior to dental extractions. Data is kept on a spread sheets to demonstrate compliance with this standard.
The Joint Commission Survey March 2012
Corrective Action Taken

Entered in TJC website
Corrective Action Taken

Standard Text UP.01.03.01; EP 5
A time-out is performed before the procedure.

5. Document the completion of the time-out.
   Note: The hospital determines the amount and type of documentation.

Surveyor Findings
EP 5
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
No time out was documented in the record of a patient who had an extraction of #10.
Observed in Tracer Activities at Larned State Hospital (1301 KS HWY 264, Larned, KS) site.
No time out was documented in the record of a patient who underwent an extraction of #22.

Corrective Action Taken:

Who =
Dr. Dee Holman, DDS, Contract Dentist
Andrea Holman, Dental Assistant

Above staff will be responsible to perform the pre-procedure verification including the completion of site-marking as per policy E-13 Universal and Time Out Procedure.

What: = A new policy E-13 Universal and Time Out Procedure was approved with an effective date of 4/18/2012.

When: = Dr. Holman and her assistant were educated on this policy and they have been using this process from the effective date.

How: = There will be audits conducted for 100% of dental extractions over the next four months by the clinic staff to evaluate that the Pre-procedure verification and Time Outs are being conducted prior to dental extractions.

Audit: = There will be audits conducted for 100% of dental extractions over the next four months by the clinic staff to evaluate that the Pre-procedure verification and Time Outs are being conducted prior to dental extractions. Data is kept on a spread sheets to demonstrate compliance with this standard.

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