DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

CENTERS for MEDICARE & MEDICAID SERVICES

Division of Survey and Certification, Region VI

July 1, 2011

Our Reference: CMS Certification Number (CCN): 044011

Charles Smith, Administrator
Arkansas State Hospital
305 S. Palm St.
Little Rock, AR 72203

Dear Mr. Smith:

Based on the survey dated June 13-15, 2011, the Centers for Medicare & Medicaid Services (CMS) has determined that Arkansas State Hospital no longer meets the requirements for participation in the Medicare program. The enclosed statement of deficiencies (Form CMS-2567) shows that the following Medicare Conditions of Participation remained out of compliance:

42 CFR 482.61 Special Medical Records for Psych Hospitals
42 CFR 482.13 Patient Rights

A psychiatric hospital may participate in the Medicare program if it meets provisions of Sections 1861(e) and (f) of the Social Security Act, remains in compliance with each of the Conditions of Participation, and is free of hazards to patient health and safety.

The Medicare agreement of your hospital will terminate on **July 18, 2011**. Medicare will not make any payment for patients admitted on or after that date. For patients admitted prior to **July 18, 2011**, payment may continue to be made for up to 30 days of covered inpatient hospital services furnished on and after **July 18, 2011**. You should send a list showing the names and health insurance claim numbers of the Medicare patients remaining in your hospital on **July 18, 2011**. The list should be sent to:

Centers for Medicare & Medicaid Services,
Division of Survey and Certification, Attention: Ginger Odle,
1301 Young Street, Room 833,
Dallas, TX. 75202

If you believe this determination is not correct, you may request a hearing before an Administrative Law Judge of the Centers for Medicare & Medicaid Services', Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 CFR 498.40 et seq.

You must file a written request for a hearing no later than 60 days from the date of receipt of this letter to:

Departmental Appeals Board
Attention Chief, Civil Remedies Division
Cohen Building Room G-644, MS 6132
330 Independence Avenue, S.W.
Washington, D.C. 20201

In addition, send a copy of your request to this office.

A request for a hearing should identify the specific issues, findings of fact, and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

If your hospital is terminated from the Medicare program, a new agreement will not be accepted until we can verify that the reason for the termination of the previous agreement has been removed and there is reasonable assurance that it will not recur. See 42 CFR 489.57. Your hospital will need to operate for a period of time, during which the reasonable assurance requirement will need to be satisfied. Your hospital must fulfill, or make satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of the previous agreement during this period.

You have indicated that you are interested in pursuing a System Improvement Agreement with CMS, in lieu of termination from the Medicare program.

If you have any questions, please contact, Dodjie Guioa at 214-767-6179 or dodjie.guioa@cms.hhs.gov.

Sincerely,

Ginger Odle, Manager
Non-Long Term Care Certification and Enforcement Branch

Enclosure

Cc: Arkansas Department of Health
CMS Baltimore
The Joint Commission
John Selig
Janie Huddleston

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044011	A. BUILDING _____ B. WING _____	R 06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS STATE HOSPITAL	305 S PALM STREET LITTLE ROCK, AR 72205

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B 000	INITIAL COMMENTS An unannounced follow-up recertification survey was conducted by federal consulting surveyors from June 13, 2011 to June 15, 2011. The census at the time of the survey was 61. The sample of active patients was ten patients, all on unit 3 Lower. An additional 18 non sample patients (total census of Unit D) were added for a complaint investigation on Unit D. The complaint was substantiated by state and federal consulting surveyors.	B 000		
B 103	482.61 SPEC MEDICAL RECORD REQS FOR PSYCH HOSPITALS The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. This CONDITION is not met as evidenced by: Based on observations, interviews and record review, the facility failed to: I. Ensure that patient treatment plan interventions were updated after episodes of seclusion and/or restraint for 6 of 6 non-sample patients who were reviewed for seclusion/restraint episodes that occurred after 6/6/11 (D3, D6, D9, D16, D17 and D18), and/or where seclusion/restraint episodes prior to 6/6/11were not addressed at treatment team meetings occurring on or after 6/6/11 (D16 and D17).The failure of the treatment team to develop alternative plans of treatment has resulted in continued episodes of seclusion/restraint for each of these patients, and has resulted in continuing violence on the unit	B 103		

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

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

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B 103	Continued From page 1 and criminal charges being filed against patients for assault and lewd conduct. (Refer to B125-I) II. Ensure that 18 of 18 patients on Unit D were provided active treatment during the time surveyed, starting 6/6/11 through the date of the survey 6/15/11. There was a loss of programming stemming from the unit's Activity Therapist being reassigned elsewhere without replacement, as well as a two week hiatus from unit schooling without structured programming provided for the patients. This failure of active treatment has led to more unstructured time for patients on the unit and may have contributed to increased incidents of violent behavior exhibited by patients over the days prior to the survey. (Refer to B125-II)	B 103		
B 125	482.61(c)(2) TREATMENT PLAN 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: I. Based on observation, interview and record review, the facility failed to ensure that patient treatment plan interventions were updated after episodes of seclusion and/or restraint for 6 of 6 non-sample patients whose records were reviewed for treatment team responses on or after 6/6/11 to the patients' recent seclusion/restraint episodes (D3, D6, D9, D16, D17 and D18). For all six patients, no changes were made to treatment plans. The failure of the treatment team to develop alternative plans of treatment has resulted in continued episodes of seclusion/restraint for each of these patients and has resulted in continuing violence on the unit	B 125		

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and criminal charges being filed against patients for assault and lewd conduct.

II. Based on observation, interview and document review, the facility failed to provide active treatment for 18 of 18 non sample patients on Unit D (D1 through D18) during the period of time starting 6/6/11 through the date of the survey 6/15/11. These failures were secondary to a loss of programming stemming from a reassignment of the unit's Activity Therapist elsewhere without replacement, as well as a current two week hiatus from unit schooling, without having structured programming provided for the patients. These failures of active treatment have led to more unstructured time for patients on the unit and may have contributed to increased incidents of violent behavior exhibited by patients over the month prior to the current survey.

I. Seclusion and Restraint Treatment Team Reviews

Findings include:

A. Observation

In an observation on June 14, 2011 between 1:45PM and 2:30PM, the surveyor witnessed escalating verbal arguing between two adolescent patients on unit D (D9 and D16). The two patients started yelling at each other with increasingly verbal threats of violence. There was one Mental Health Assistant (MHA) in the day room at the time, as well as 5 other non sample patients. The staff did not intervene until the two boys started fist fighting and wrestling. Another staff member (MHA) located in the nurse's station was unable

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to assist with stopping the fight because other patients blocked the exit door to the day room and would not let the staff member out. Both boys were separated after a few minutes by other staff coming to the unit in response to a panic button activation. Both patients had physical holds placed on them in order to control the fight and subsequent agitation that followed with de-escalation. Neither patient ended up with any other form of restraint or seclusion. The unit RN was not present at the time of the incident (off the grounds obtaining lunch); no other RN was present at the time on the unit. A Licensed Practical Nurse (LPN) was outside in a courtyard disarming another patient that had secreted rocks in his clothes with the intent to harm staff later that day as part of a riot attempt (per LPN staff report).

B. Interviews

1. In an interview on 6/13/11 at 1:30PM, the unit manager for unit D stated that "the kids here are troubled kids that have nowhere else to go. We do more criminal behavior management than mental health work here." In a second interview with the unit manager on 6/14/11 at 2:30PM, just after the observed incident noted above, the unit manager stated that "we talk about each episode of seclusion and restraint during treatment team meetings on Tuesdays and Fridays." She was then asked about changing the master treatment plans to address the behaviors that led to the seclusion or restraint; she stated "occasionally we make changes, but usually we wait until there are enough citations (criminal charges) that the probation officer takes them to juvenile hall for a few days; the kids are usually better when they

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return here from detention."

2. In an interview on 6/14/11 at 2:30PM with RN2 on unit D, s/he stated that "the two MHAs out on the unit are agency (outside agency) people and they don't know what to do for the patients,.... We can't keep these kids in control."

3. In an interview on 6/14/11 at 2:45PM with the Medical Director of the Adolescent Programs, who is also an attending physician on unit D, she was shown the master treatment plan for Patient D16, who had had 14 episodes of seclusion or restraint in the prior month, and was asked to compare the master treatment plan updates from 2/11 and 6/6/11. She stated, "the interventions haven't been changed." When asked if the interventions should have been changed to address the increase in aggressive behaviors, she stated, "I guess we should have done that." She was then asked if other patient's master treatment plans looked the same from month to month, she stated, "you'll find that to be true for most patients."

4. In an interview on 6/15/11 at 10:00AM, Patient D16 stated "I don't really get help with my behaviors here; there are fights every day and I don't feel safe here; staff isn't very nice to me and then don't stop fights before they happen."

5. In an interview on 6/15/11 at 10:15AM, Patient D9 stated, "I don't go to the treatment plan meetings, I don't care, nothing ever changes about my treatment here, and I'm just waiting until they tell me I'm going home."

C. Record Review

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B 125	Continued From page 5 1. Patient D3: An Adolescent Master Treatment Plan updated 6/10/11 noted that Patient D3 had been secluded on 6/8/11 for "exposed [himself], swallowed a patient's pill, threw chairs, and while in seclusion smeared feces on the wall." The Master Treatment Plan (MTP) did not have any goals or interventions included that addressed these issues and was similar to a MTP dated 5/6/11. Patient D3 was charged with Assault and Lewd Conduct for this incident, noted in summonses left in the patient's medical record by police. 2. Patient D6: Physician's Order dated 6/7/11 at 2:50 PM noted "1. Physical Hold for 2 minutes to escort to seclusion. 2. Closed Door Seclusion for up to 2 hours for aggression." Treatment teams met on 6/10/11 and 6/14/11; Patient D6's MTP had not been updated after this episode of seclusion as of 6/15/11. 3. Patient D9: Patient was placed in closed door seclusion on 6/6/11 at 8:39AM for threatening peers; MTP update on 6/6/11 did not note the episode of seclusion earlier that day and remained unchanged compared to a MTP dated 2/14/11. Patient D9 was charged with two counts of assault for the 6/6/11 incident; Patient D9 also had two public sexual indecency charges pending from 6/4/11, noted from summonses left in the patient's medical record by police. There was no update in the patient's MTP related to these incidents. 4. Patient D16: In spite of the observed incident on 6/13/11 of the patient's aggression and subsequent hold by staff, there was no update to	B 125		

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the Adolescent Master Treatment Plan. In the most recent Adolescent Master Treatment Plan update 6/6/11 the narrative section noted that "[Patient D16] required 2 chemical restraints, was placed on Shut Down once, 6 physical holds, 2 closed door seclusions and 2 open door seclusions" between the period of 5/13/11 and 6/5/11. Further review revealed that the MTP updated 6/6/11 was identical to the previous update of 4/15/11 with regard to aggressive and disruptive behaviors; there were no changes made to goals or interventions by 6/6/11 to address the patient's behavioral problems.

5. Patient D17: In an Adolescent Master Treatment Plan updated 6/6/11 the narrative section noted that "[Patient D17] required four chemical restraints for aggressive, disruptive, or assaultive behavior during this two week review period." The MTP dated 6/6/11 was exactly the same with regard to aggressive and disruptive behaviors as the update of 4/25/11; there had been no changes made to goals or interventions by 6/6/11 to address the patient's behavioral problems.

6. Patient D18: In an Adolescent Master Treatment Plan dated 6/13/11 the narrative section noted that "[Patient D18] required (between 5/13/11 and 6/12/11) 10 physical holds, 8 chemical restraints and 5 seclusions during this review period." The MTPs updated 5/13/11 and 6/13/11 were identical with regard to aggressive and disruptive behaviors; there had been no changes made to goals or interventions by 6/6/11 to address the patient's behavioral problems.

7. Incident Report reviews: Surveyors reviewed

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incident reports for Unit D. The unit averaged between 5 and 6 reports per day, several of which included physical holds, chemical restraint, open and closed door seclusion and mechanical restraint.

D. Policy Review

Arkansas State Hospital Policy and Procedure #ASH 11.12.01 titled "Treatment Planning" dated 3/3/03 and reviewed 5/7/04 under the section titled "Policy" stated: "In addition, a TPU (treatment plan update) meeting should be held whenever clinical circumstances have changed in a manner that requires revision of the MTP."

II. Lack of Active Treatment

Findings include:

A. Observations

1. In an observation on 6/13/11 at 3:00PM on unit D, the surveyors observed 4 female non- sample patients in a day room either watching television or coloring pictures; these activities continued for approximately 70 minutes. In a second day room there were 7 male non-sample patients similarly engaged in diversional activities like coloring, playing with paper dashboards or watching television; two non-sample patients were sleeping on the floor of the dayroom during most of the observation period. Half of the unit patient population was supposed to be in school (per the schedule; however, school was on hiatus) and the other half was scheduled for "Problem Solving and Stress Management" group which did not occur.

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B 125	Continued From page 8 2. In an observation on 6/14/11 at 2:30PM on unit D, 5 male non- sample patients were in the day room either watching television, coloring or sleeping on the floor. There were two staff members (MHAs) in the room, neither of whom was engaged with the patients. On the female side of the unit, there were 4 non-sample patients in the day room; 1 was engaged with her interpreter, the other 3 patients were watching cartoons on television. Half of the patients were scheduled for school at this time and the other half were scheduled for "Expressive Art" group; neither activity occurred that day. 3. In an observation on 6/15/11 at 10:00AM on unit D, approximately 9 of the 14 male non-sample patients were in the dayroom at one time or another, again watching television, playing with paper dashboards or sleeping on the floor. On the female side of the unit, the four non-sample patients were coloring or watching television. There were four non-sample male patients attending "Survivor's Group" that morning (5 non-sample patients did not attend) and 9 non-sample patients were scheduled to attend school, which was on hiatus. B. Interviews 1. In an interview on 6/13/11 at 1:00PM the Adolescent unit manager stated that "when school is out we don't have a lot of activities on the unit for the kids; we just go outside in the mornings and try to keep the kids out of trouble the rest of the day. We haven't had much activity in treatment since our activities therapist was transferred to an adult unit earlier this year. We	B 125		

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just try to keep them busy to keep them out of trouble; we've had too many riots here lately."

2. In an interview on 6/14/11 at 2:30PM with RN2 on unit D, s/he stated that "the two MHAs out on the unit are agency (outside agency) people and they don't know what to do for the patients.... We can't keep these kids in control."

3. In an interview on 6/15/11 at 9:30AM, Patient D16 stated that "there aren't many groups during the day; I just play with my car (paper dashboard) and use my imagination. I like the gym and the art room, but I don't get to go because my level is always too low."

4. In an interview on 6/15/11 at 10:00AM, Patient D17 stated, "I go to school from 1 to 4; in the mornings I lay on the floor and sleep because I don't have the level to go to art, RT (recreation therapy), or gym (all off unit activities). On the unit, I watch TV, play cards or dominoes or sleep."

5. In an interview on 6/15/11 at 10:30 AM the supervisor of Activities Therapy stated that "Unit D hasn't had a lot of structured activity since the therapist transferred to another unit." She agreed that without school being in session there was more unstructured time on the unit.

C. Document Review

1. Review of the "Adolescent Unit D" schedule dated 4/7/10 noted that without the 3 hour daily school activity in session the patients on unit D were scheduled to receive up to 3 hours per day of structured therapeutic activities/groups either in

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B 125	Continued From page 10 a morning block or an afternoon block. There were no structured activities after 4 PM on weekdays and only 4 hours of structured activities on the weekends (Recreation, Explorers, Role Model, and Home Economics). 2. Incident Report reviews: Surveyors reviewed incident reports for Unit D. The unit averaged between 5 and 6 reports per day, several of which included physical holds, chemical restraint, open and closed door seclusion and mechanical restraint.	B 125		
B 144	482.62(b)(2) MEDICAL STAFF The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the Medical Director failed to: I. Ensure that patient treatment plan interventions were updated after episodes of seclusion and/or restraint for 6 of 6 non-sample patients whose records were reviewed for treatment team responses on or after 6/6/11 to the patients' recent seclusion/restraint episodes (D3, D6, D9, D16, D17 and D18). For all six patients, no changes were made to treatment plans. The failure to ensure that the treatment team developed alternative plans of treatment resulted in continued episodes of seclusion/restraint for each of these patients and has resulted in continuing violence on the unit and criminal charges being filed against patients for assault and lewd conduct. (Refer to B125-I.)	B 144		

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B 144	Continued From page 11 II. Ensure that 18 of 18 non-sample patients on Unit D (D1 through D18) were provided active treatment during the time reviewed, starting 6/6/11 through the time of the survey 6/15/11. This failure was in part secondary to a loss of programming stemming from a reassignment of the unit's activity therapist without replacement, as well as a two week hiatus from unit schooling without structured programming provided for the patients. These failures of active treatment have led to more unstructured time for patients on the unit and may have contributed to increased incidents of violent behavior exhibited by patients over the month prior to the survey. (Refer to B125-II)	B 144		
B 157	482.62(g)(1) THERAPEUTIC ACTIVITIES The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. This STANDARD is not met as evidenced by: Based on observation, document review and interviews, it was determined that the facility has failed to plan and implement structured programming of therapeutic activities for the needs of 18 of 18 non-sample patients (D1 through D18) on adolescent unit (Unit D). Seven of the male patients and 2 of the female patients did not have off unit privileges in order to participate in gym, art, recreation therapy or outings; the only substitute activities were diversional, such as viewing commercial television or coloring, without active engagement by facility staff. The lack of structured therapeutic	B 157		

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activities has contributed to a chaotic milieu. The unit has not had an activities therapist since February 2011 and does not provide evening activities, and provides only 4 hours of programmed activities on the weekends. These failures to provide increased structure for this population has led to an inability to deliver an important mode of treatment that may lead to more comprehensive inpatient care and more timely discharge.

Findings include:

A. Observations

1. In an observation on 6/13/11 at 3:00PM on unit D, the surveyors observed 4 female non- sample patients in a day room, either watching television or coloring pictures; these activities continued on for approximately 70 minutes. In a second day room there were 7 male non-sample patients similarly engaged in diversional activities like coloring, playing with paper dashboards or watching television; two non-sample patients were sleeping on the floor of the dayroom during most of the observation period. Half of the unit patient population was scheduled to be in school during that time (school was on hiatus and there was no indication that a substitute program had been developed) and the other half were scheduled for "Problem Solving and Stress Management," group which did not occur.

2. In an observation on 6/14/11 at 2:30PM on unit D, 5 male non-sample patients were in the day room watching television, coloring or sleeping on the floor. There were two staff members (MHAs) in the room, neither of whom was engaged with

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the patients. On the female side of the unit, there were 4 non-sample patients in the day room; 1 was engaged with her interpreter, the other 3 patients were watching cartoons on television. Half of all the patients on the unit were scheduled for school at this time and the other half were scheduled for "Expressive Art" group; neither activity occurred that day.

3. In an observation on 6/15/11 at 10:00AM on unit D, nine of the male non-sample patients were in the dayroom at one time or another, again watching television, playing with paper dashboards or sleeping on the floor. On the female side of the unit, the four non-sample patients were coloring or watching television. There were four non-sample male patients attending "Survivor's Group" that morning (5 non-sample patients who were scheduled to attend did not) and 9 non-sample patients were scheduled to attend school (the 9 patients included the four female patients in another dayroom watching television), which was on hiatus.

B. Interviews

1. In an interview on 6/13/11 at 1:00PM the Adolescent unit manager stated that "when school is out we don't have a lot of activities on the unit for the kids; we just go outside in the mornings and try to keep the kids out of trouble the rest of the day. We haven't had much activity in treatment since our activities therapist was transferred to an adult unit earlier this year. We just try to keep them busy to keep them out of trouble; we've had too many riots here lately."

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2. In an interview on 6/14/11 at 2:30PM with RN2 on unit D, s/he stated that "the two MHAs out on the unit are agency (outside agency) people and they don't know what to do for the patients.... We can't keep these kids in control."

3. In an interview on 6/15/11 at 9:30AM with Patient D16, he stated that "there aren't many groups during the day, I just play with my car (paper dashboard) and use my imagination. I like the gym and the art room, but I don't get to go because my level is always too low."

4. In an interview on 6/15/11 at 10:00AM, Patient D17 stated, "I go to school from 1 to 4; in the mornings I lay on the floor and sleep because I don't have the level to go to art, RT (recreation therapy), or gym (all off unit activities). On the unit, I watch TV, play cards or dominoes or sleep."

5. In an interview on 6/15/11 at 10:30AM the supervisor of Activities Therapy stated that "Unit D hasn't had a lot of structured activity since the therapist transferred to another unit." She agreed that without school being in session there was more unstructured time on the unit.

C. Document Review

Review of the "Adolescent Unit D" schedule dated 4/7/10 noted that without the 3 hour daily school activity in session the patients on unit D were scheduled to receive up to 3 hours per day of structured therapeutic activities/groups either in a morning block or an afternoon block. There are no structured activities after 4PM on weekdays and only 4 hours of structured activities on the

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B 157	Continued From page 15 weekends (Recreation, Explorers, Role Model and Home Economics).	B 157		

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A 000	INITIAL COMMENTS An entrance conference was conducted with facility representatives at 0930 on June 13, 2011. The representatives were informed that a complaint investigation will be investigated along with the follow-up survey for the Medicare Condition of Participation noncompliance findings. An exit conference was conducted with facility representatives at 1600 on June 15, 2011.	A 000		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on document review, interview, video observation, clinical record review and observation on 06/13/11-06/15/11, it was determined the Condition of Patient Rights is not met. On 06/15/11 a situation of IMMEDIATE JEOPARDY to patient health and safety existed. This decision was based on the following: A. Based on document review, interview, clinical record review and observation it was determined the facility failed to provide care in a safe setting for 1 (#2) of 1 (#2) patients on Unit D. This failed practice resulted in actual harm to Patient #2 and had the potential to affect the other 17 patients on Unit D. See A 144 B. Based on document review, interview and observation it was determined the facility failed to protect one (#1) of one (#1) patients from neglect on Unit D. The facility staff failed to identify,	A 115		

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

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

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A 115	Continued From page 1 prevent and report neglect. This failed practice resulted in neglect of Patient #1 and had the potential to affect the other 17 patients on Unit D. See A 145 C. Based on interview, document review and video observation on 06/15/11 at 0940 it was determined the facility failed to provide care in a safe setting for one (#3) of one (#3) patients on Unit D. This failed practice had the potential for harm for all patients placed in seclusion. See A 144 D. Based on interview, policy and procedure review, and clinical record review, it was determined Unit D did not consider the Intensive Treatment Protocol to be seclusion. The failed practice had the potential of placing patients in seclusion who did not exhibit violent or self destructive behaviors that immediately jeopardized the physical safety of patients, staff or others. The failed practice affected one (#3) of one (#3) sampled patients and had the potential to affect all patients in which the Intensive Treatment Protocol was initiated. See A162 E. A continuing deficiency based on review of the Plan of Correction for the deficiency cited on the complaint investigation dated 05-18-2011. There has not been enough time for the facility to monitor and evaluate the effectiveness of the Plans of Correction put in place to assure facility staff would be able to prevent, identify and report verbal abuse and psychological abuse, and ensure continued compliance. See A 145	A 115		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING	A 144		

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A 144	Continued From page 2 The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on document review, interview, clinical record review and observation, it was determined that the facility failed to provide care in a safe setting for 1 (#2) of 1 (#2) patient on Unit D. This failed practice resulted in actual harm to Patient #2 and had the potential to affect the other 17 patients on Unit D. The findings follow: A. On 06/13/11 the Arkansas State Hospital Patient Complaint Response Form dated 06/01/11 was reviewed. Attached to the form were complaints written by Patient #2 dated 05/27/11,(Patient #2 wrote "wanted off sleeping medication"); 05/28/11,(Patient #2 wrote "(Named) said going to kill everyone I do not feel safe"); 05/30/11,(Patient #2 wrote "I do not feel safe when I sleep"); 05/31/11, (Patient #2 wrote "I do not feel safe"). Under the heading "RESPONSE," the following was documented by the Patient Advocate: "06/01 Complaints emailed to Dr (Named), Social Worker #1 and Unit D Director." The complaint dated 05-28-11 from Patient #2 stated Patient #1 said going to kill everyone and I do not feel safe. The complaint from Patient #2 dated 05/30/11 was I do not feel safe when I sleep. The complaint from Patient #2 dated 05/31/11 was I do not feel safe here. B. On 06/14/11 review of the Seclusion and Restraint Report dated 06/08/11 at 2023 revealed Patient #1 and Patient #3 teamed up in room and was hitting Patient #2.	A 144		

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A 144	Continued From page 3 C. On 06/14/11 the Surveyor saw Patient #2 in a line of patients waiting to go outside and observed the left eye of Patient #2 was still bruised. D. On 06/15/11 review of the medical record for Patient #2 revealed an entry on 06/08/11 at 1045 by the MD which stated -"Pt (patient) was attacked by two peers. On examination patient has swollen left eye intraorbitally, tender and bruised on right side of neck." E. On 06/15/11 at 0910 an interview was conducted with the Unit D Director and Social Worker #1. The Unit D Director and Social Worker #1 were asked if anyone did a follow-up on the complaints submitted by Patient #2 to the Patient Advocate. Both staff informed the surveyors that they were aware of Patient #2's complaints but no investigations were conducted and staff did not initiate any action to have prevented the assault.. Based on interview, document review and video observation on 06/15/11 at 0940 it was determined the facility failed to provide care in a safe setting for one (#3) of one (#3) patients on Unit D. This failed practice had the potential for harm for all patients placed in seclusion. Findings follow: A. Video observation at 0940 on 06/15/11 revealed Patient #3 in seclusion. Staff could be seen watching Patient #3 through the glass	A 144		

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A 144	Continued From page 4 window in the door. At 0924 the patient removed his white under shirt, tore it into strips that stretched out the length of his arms, then proceeded to wrap it around his neck. The strips of shirt remained around the patient's neck while standing in front of the glass window in the door of the seclusion room. Staff could be seen viewing the patient through the glass window of the door. Patient #3 eventually removed the shirt from his neck at 0927. Staff did not intervene to remove the strips of shirt from the patient's neck. B. The Unit D Director was interviewed on 06/15/11 at the time of the video observation and confirmed the name of the patient.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on document review, interview and observation it was determined the facility failed to protect one (#1) of one (#1) patients from neglect on Unit D. The facility staff failed to identify, prevent and report neglect. This failed practice resulted in neglect of Patient #1 and had the potential to affect the other 17 patients on Unit D. The findings follow: A. 04/22/11- Complaint from Patient #1 was sent to the Patient Advocate- Date received by Patient Advocate was 04/28/11. Patient complained "Dr. (Named) will not get my glasses." Under the heading "RESPONSE" it was stated "The complaint you submitted was sent to Dr. (Named) requesting an appointment for your glasses-----.	A 145		

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There was no date in the area titled RESPONSE given to patient. There was a signature from Patient #1 and the Patient Advocate and the date of 05/09/11 at the bottom of the page.

B. 05/02/11-Complaint from Patient #1 sent to Patient Advocate-Date received by Patient Advocate was 05/02/11. Patient complained "need to go to Wal-Mart to get glasses." Under the heading "RESPONSE" it was written-

"The complaint concerning your need to go to Wal-Mart to get glasses was submitted to the Unit Charge Nurse. She stated there is no indication of an appointment set up for you at this time. However, it was explained to me that you are only allowed one pair of glasses yearly which makes it very important that you take responsibility of caring for your glasses at all times. Keep them in a safe place and do your best to prevent anything from happening to them. If you feel your peers are going to break your glasses let the staff know right away. I understand you are upset because you can't see well and I will ask for another pair or get your old pair repaired."

C. 06/13/11-Surveyor interviewed the Patient Advocate and requested information as to where Patient #1's glasses were. The Patient Advocate stated she did not have any information regarding the patient's glasses.

D. 06/14/11-Surveyor interviewed the Unit Director for Unit D. The Unit Director did not know where the patient's glasses were. The Unit Director stated they were probably sent to the Clinic.

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E. 06/15/11-Surveyor interviewed the Unit Director for Unit D and Social Worker #1 and Social Worker #2 that worked on Unit D and the Social Worker Director at 0910. The Surveyor asked where Patient #1's glasses were. The Unit Director stated she would call the Clinic and see if the glasses were there. Social Worker #1 and #2 did not know.

F. During review of medical records on Unit D, at 1415 on 06-15-11, the Unit Director approached the Surveyor and was holding a pair of glasses that were found in the medication room. The glasses had a side missing and were not wearable. The Unit Director stated the patient had identified the glasses as belonging to the patient.

This is a continuing deficiency based on review of the Plan of Correction for the deficiency cited on the complaint investigation dated 05-18-2011. There has not been enough time for the facility to monitor and evaluate the effectiveness of the actions put in place based on the Plan of Correction to assure facility staff will be able to prevent, identify and report verbal abuse and psychological abuse, and to ensure compliance. The deficiency cited on 05-18-11 follows:

Based on interview, observation, observation of video with audio recording, facility document review, and clinical record review, it was determined that the facility failed to protect patient's right to be free from verbal and psychological abuse. Three (#1, #3 and #11) of 11 (#1- #11) patients with dual diagnosis on Unit 3 Lower, did not have an environment that was

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free from verbal and psychological abuse. The facility staff failed to prevent, identify and report verbal and psychological abuse, therefore the potential existed for further instances of abuse. The failed practice resulted in actual verbal abuse to Patient's #1, #3 and #11 and had the potential to affect the other 8 patients on the 3 Lower Unit. The findings are:

A. Patient #1 was in the Recreational Day Area on 05/11/11 at 1524 asking for crackers.
1) Patient #1 was served milk and cereal. Patient #1 knocked the unopened cartons of milk and cereal off the table and onto the floor.
2) At 1525, Public Safety Officer #1 walked by Patient #1 in the Recreation Day Area and stated "Wouldn't give him nothing."

B. The video recording confirmed the above findings and were verified by the Risk Manager Director and her assistant at 1537 on 05/12/11.

C. Patient #3 was playing ball in the Recreational Day Area on 05/12/11 at 1911.
1)At 1916, Patient #3 entered Pod C (open area surrounded by four semi-private rooms) with his ball.
2) Mental Health Worker #1 stated to Patient #3 "Boy, you need to go somewhere in your room."

D. Patient #11 was standing in the Recreational Day Area on 05/12/11 at 1951 asking Charge Nurse #3 "Why can't we come out?"
1)Another unidentifiable patient was heard asking Charge Nurse #3 a question. Before Charge Nurse #3 could respond, Patient #11 answered the question.
2) As Charge Nurse #3 was walking across the

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A 145	Continued From page 8 Recreational Day Area he responded to Patient #11 "Thank you staff member." E. The above findings were confirmed by the Risk Management Director and her assistant at 05/13/11 at 1115.	A 145		
A 162	482.13(e)(1)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. This STANDARD is not met as evidenced by: Based on interview, policy and procedure review, and clinical record review, it was determined Unit D did not consider the Intensive Treatment Protocol to be seclusion. The failed practice had the potential of placing patients in seclusion who did not exhibit violent or self destructive behaviors that immediately jeopardized the physical safety of patients, staff or others. The failed practice affected one (#3) of one (#3) sampled patients and had the potential to affect all patients in which the Intensive Treatment Protocol was initiated. The findings were: Review of Policy #223-Intensive Treatment Protocol (ITP)-revealed the following: A doctor's order specifying the level of staff supervision is required to initiate. ITP status will be reviewed every 24 hours and if continued a new order is required. Patients assigned to ITP will be separated from the general milieu and one staff member from each shift will be assigned to provide supervision.	A 162		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS STATE HOSPITAL	305 S PALM STREET LITTLE ROCK, AR 72205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 162	Continued From page 9 Assignments based on identified problem behaviors as well as a routine format for daily work will be set. If more than one individual is on ITP status at the same time, there will be limited interactions between such patients. The level of compliance and participation will be scored on the ITP Flow Sheet every 15 minutes as a " O " or a " + " . Meals will be served at regular meal times and will be eaten on the Unit with staff observing. Patients will be Unit restricted while on ITP but may be allowed some RT, i.e. exercise, stretching activities. Patients may be allowed to go outside (at staff discretion) once per shift on 7-3 and 3-11 shifts if 12 " + " are earned during the preceding 4 ½ hour time period. Fluid intake and bathroom privileges will be offered as needed and requested by the patient. Medical record review on 06/15/11 revealed a Physician order on 06/08/11 for " .....pt (patient on ITP x 24 hours to be done on Unit E. Surveyor asked in an interview on 06/14/11 at 1530 with the Unit D Director what a ITP (Intensive Treatment Protocol) was. The Unit D Director stated " It was a program ordered by the Physician. The patient was separated from others. It was a written assignment for the patient to complete and the patient must complete it before they could attend regular activities. For example it there was a Unit activity like a barbeque the patient could not attend but would be brought a plate of the food fixed."	A 162		