STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	244002	A. BUILDING _____ B. WING _____	C 07/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA-METRO REG TREATMENT CTR	**3301 SEVENTH AVE NORTH ANOKA, MN 55303**

(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 000	INITIAL COMMENTS A substantial allegation survey was conducted in connection with the investigation of complaint #H4002076 and complaint #H4002077. The standards within the Condition of Participation regarding Patient Rights (42 CFR 482.13) were evaluated. It was determined that the hospital was not in compliance with the Condition of Participation for Patient Rights based on a deficiency issued at Tag #A144 related to complaint #H4002077.	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 review of patient #1's medical record, document review and interviews, the hospital failed to promote and protect the rights of patient #1 when staff did not adequately supervise patient #1 who was on 1:1 distant observation. Patient #1 drank hand sanitizer (ethanol 70%) and had a blood alcohol level of 0.10 in one of 12 patients reviewed. Findings include: The hospital did not meet the Condition of Participation of Patient Rights at 42 CFR 482.13. This deficient practice had the potential to affect other patients on the same unit and other units when a patient is to be observed on 1:1 distant observation. See A-0144-Based on interview and document review the hospital failed to ensure each patient	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 received care in a safe setting for 1 of 12 patients reviewed. Patient #1 was on 1:1 distant observation, and patient #1 drank hand sanitizer (ethanol 70%) and had a blood alcohol level of 0.10.	A 115		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on review of patient #1's medical record, document review and interviews, the hospital failed to promote and protect the rights of patient #1 when staff did not adequately supervise patient #1 who was on 1:1 distant observation, drank hand sanitizer (ethanol 70%) and had a blood alcohol level of 0.10 in one of 12 patients reviewed. Findings include: Documentation in patient #1's medical record indicated patient #1 was committed to the hospital due to patient #1's chronic history of self-harm. A review of nurse practitioner-J's orders, dated 6/9/16 through 6/24/16, indicated patient #1 was to be observed on a distant 1:1 observation with privileges, eyes on at all times basis. A progress note written by RN-M on 6/24/16 at 12:16 a.m. revealed that during the evening shift of 6/23/16, patient #1 was noted to be loud and hyperactive in the dayroom and staff asked patient #1 and the group to keep quiet during the shift. Patient #1 continued to be loud. The staff	A 144		

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A 144	Continued From page 2	A 144		

obtained a "Snapple" bottle from the table that patient #1 and other peers were sitting at. The bottle smelled of alcohol. Staff confronted patient #1 about the bottle, and patient #1 denied drinking out of the bottle. Staff did a unit search and found a bottle of hand sanitizer in a peer's room who was sitting at the table. Patient #1 became aggressive and began threatening staff. A code green was called due to patient #1's behavior. Patient #1 agreed to have a breathalyzer and the police administered a breathalyzer that showed a 0.10 reading.

A progress note written by physician-N on 6/24/16 stated patient #1 and two other patients obtained hand sanitizer in order to "get drunk." Patient #1 stated he drank a Snapple bottle full of hand sanitizer in one gulp and said he was drunk as a result. Patient #1 was asked why the 1:1 staff did not notice that he was drinking alcohol and he said he had "no clue" how that happened. Patient #1 said he and the other two patients saw it as "the perfect opportunity" to drink.

Therapeutic observation records, dated 6/23/16 and 6/24/16 were reviewed. The records indicated patient #1 received 1:1 distant monitoring on 6/23/16 and 6/24/16, but the documentation revealed several staff conducted the observations during the shift and the observations were conducted for brief and inconsistent periods of time.

During a 7/11/16 interview with HST-K she stated she provided 1:1 monitoring of patient #1 from 7:00 p.m. to 8:00 p.m. on 6/23/16. She recalled that four unidentified patients were sitting at the table in the dayroom during the evening of

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A 144	Continued From page 3 6/23/16. She stated she was also doing 1:1 monitoring of another patient that evening and did not pay much attention to patient #1. She did not see any patients enter the storage room with staff on the evening of 6/23/16. During a 7/11/16 interview with HST-L he stated he provided 1:1 monitoring of patient #1 from 9:30 p.m. to 11:30 p.m. on 6/23/16. He recalled seeing patient #1 and two other unidentified patients sitting at the table in the dayroom and playing cards and watching a game on television. He denied taking any patient into the storage room and said he did not know how any patient got a bottle of hand sanitizer. During a 7/8/16 interview with RN-E she stated some changes occurred following the incident involving patient #1 and the hand sanitizer. The changes included the following: A Do Not Enter-Staff Only sign was placed on the storage room door (in case patients were following staff into the storage room); bottles of free standing hand sanitizers were removed from group setting patient care areas; wall mounted locked Purell stations were added to group setting patient areas and patients no longer have access to free standing bottles of hand sanitizer. The investigator conducted a tour of the hospital at the time of the site visit and observed that the changes identified during the interview with RN-E had occurred.	A 144		