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A 000	INITIAL COMMENTS A substantial allegation survey was conducted to investigate complaint #H4002080 and H4002081 regarding alleged violations of the Conditions of Participation for hospitals participating in Medicare, specifically the Condition of Participation of Patient Rights at 42 CFR 482.13. The hospital was found not in compliance with Condition of Participation of Patient Rights as it related to complaint H4002080.	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 interview and document review it was determined that the hospital failed to provide patients with care in a safe setting when a patient was able to pull a portion of a blanket and mattress pad off and tie it around his neck as a suicide attempt on 2 occasions. The hospital further failed to provide care in a safe setting when it was required that hospital staff transport this patient from an acute care hospital back to this hospital and the patient repeatedly tried to harm himself and others during transportation. Findings include: Based on interview and document review the hospital failed to provide patients with care in a safe setting for 1 of 13 patients reviewed, Patient #1 (P-1), when the hospital failed to adequately supervise a patient who was able to tear a blanket and wrap it around his neck in a suicide attempt and later pulled apart a mattress pad and tied a long portion of the pad around his	A 115		

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

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A 115	Continued From page 1 neck several times in a suicide attempt. The hospital further failed to provide care to a patient in a safe setting when the hospital required staff to transport this same patient from an acute care hospital back to this hospital. P1 hit his head against the window repeatedly, kicking at staff and forcing the staff to turn around and drive back to the acute care hospital numerous times, eventually requiring staff to call 911 and the patient was transported restrained, in an ambulance, with law enforcement in the ambulance and following the ambulance.	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 interview and document review the hospital failed to provide patients with care in a safe setting for 1 of 13 patients reviewed, Patient #1 (P-1), when the hospital failed to adequately supervise a patient who was able to tear a blanket and wrap it around his neck in a suicide attempt and later pulled apart a mattress pad and tied a long portion of the pad around his neck several times in a suicide attempt. The hospital further failed to provide care to a patient in a safe setting when the hospital required staff to transport this same patient from an acute care hospital back to this hospital. P1 hit his head against the window repeatedly, kicking at staff, which forced the staff to turn around and drive back to the acute care hospital numerous times, eventually this required staff to call 911 and the patient was transported restrained, in an ambulance, with law enforcement in the	A 144		

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A 144	Continued From page 2 ambulance and following the ambulance. Findings include: P1 was admitted to the hospital on 7/1/2016 with diagnoses that included Borderline personality disorder, Post-Traumatic stress disorder, Antisocial personality disorder and a history of multi-substance abuse. The document titled Assault and Violence Assessment dated 7/2/2016 revealed the patient was placed on the frequent observation level of supervision (every 5 minute observations.) The document titled Suicide risk assessment, dated 7/2/2016 revealed the patient had previous serious suicide attempts. The document titled Violence Risk Assessment, dated 7/9/2016 revealed P1 had a history of being a victim of abuse as well as a history of a recent acts of aggression or violence resulting in injury to others. The document titled Clinical Review of Incident, dated 7/21/2016, revealed on 7/17/2016 at about 2:00 p.m., P1 became agitated, ran to his room, barricaded the door with a mattress and tore bedding to fashion a noose for his neck. Staff entered the patient room, removed the bedding from around his neck and the patient became combative toward staff. P1 was placed in the restraint chair and medication was provided. The document titled Incident report form, with the incident dated 7/24/2016, revealed the following: At 12:50 a.m., (P1) was banging loudly on the door to the nursing station. P1 then collapsed on the floor. He was noted to have profuse bleeding coming from his nose. He became unresponsive, but had pulses. He was placed on his right side.	A 144		

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Code Blue and 911 were called. Oxygen was administered via a face mask. Staff attempted to stop the bleeding from his nose. Vital signs were taken. Strips of a mattress pad were found wrapped tightly around his neck. Staff cut the mattress pad off. Staff checked P1's room for any other dangerous objects and found a frayed mattress pad.

The document titled Clinical Review of Incident, dated 7/25/2016 revealed On 7/23/2016 at 9:00 p.m. P1 removed stitches from his arm and was transported to the local acute care hospital. After return from acute care hospital the patient entered his room at about 12:45 a.m. on 7/24/2016. The patient came out of his room at 12:50 a.m., banged loudly on the nursing station door and then collapsed on the floor. P1 was bleeding from the nose and had strips of torn mattress pad tied tightly around his neck. P1 was transferred to the local acute care hospital via ambulance.

The document titled Nursing Progress, dated 7/24/2016 at 7:36 a.m. revealed P1 had returned to the hospital with no permanent injury form the suicide attempt.

During an interview on 8/2/2016 at 4:15 p.m., Registered Nurse (RN)-F stated, she was the Officer of the Day, Nursing Supervisor on the night shift of 7/23/2016 into 7/24/2016. At about 12:20 a.m., P1 returned from Hospital B. About 20 minutes later, she heard a code blue called and went to the patient's unit. P1 was on the ground by the nursing station with blood coming from his nose. P1 was conscious, but not responding much. His oxygen saturation was

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A 144	Continued From page 4 98%, but his face was reddened. When the staff members sat him up she noticed some binding material around his neck. RN-F stated she cut off the material and discovered it was the edging of a mattress pad that had been pulled off the pad and wrapped around his neck about 4 times. RN-F stated some of the linens at the hospital were worn and frayed. During an interview, General Maintenance Lead Worker-E, (MW)-E, on 8/3/2016 at 12:50 p.m., stated hospital staff do not check bedding for frayed or torn bedding. The linens are washed at an outside entity and then transported back the the facility. When housekeeping staff put the linens away, they visualize the edges they can see, but there is no attempt to visualize the linens and determine if replacement is needed. MW-E stated that as far as he knew, the linens had not been checked for wear since the incidents in which P1 was able to tear the bedding into strips to use in suicide attempts. During an interview, Deputy Administrator D, (DA)-D, on 8/3/2016 at 12:30 p.m. he stated the hospital has no policy related to checking linens for wear and tear before use in patient care areas. DA-D stated there had been no sweep of the units to check linens for wear since P1's suicide attempts using torn linens. A review of the document titled Nursing Progress Note, dated 7/24/2016 at 8:52 a.m. revealed: P1 was picked up from the local acute care hospital (Hospital B) by facility staff after emergency assessment related to his suicide attempt. P1 was saying he did not want to go back to this hospital. Hospital B security Officers spoke to P1	A 144		

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and he agreed to go back to the hospital. When staff members, RN-G, Licensed Practical Nurse (LPN)-H and Human Services Technician, (HST)-I, attempted to transport P1 to back to the hospital from hospital B, P1 started banging his head on the window and, turned onto his side and kicked staff, who were in the caged part of the transport vehicle with the patient. The vehicle turned around to go back to Hospital B. When back at Hospital B, the patient was not able to be redirected and ankle restraints were applied to P1 at 5:20 a.m. with the assist of Hospital B security. Staff again attempted to leave Hospital B and P1 started banging his head against the window, removed his seat belt, turned around in his seat and kicked both staff sitting in the seat with him. The vehicle was turned around again and went to the emergency department at Hospital B. P1 then stated he would cooperate and go back to the hospital if he was immediately placed into the restraint chair. Hospital staff attempted to transport the patient from hospital B back to the hospital. Again P1 began hitting his head on the window and kicked the staff. Again the vehicle returned to Hospital B's emergency department. RN-G spoke with the nursing supervisor at Hospital B and requested a reassessment of P1 in the ED, which was denied because the patient was medically stable. Security staff at Hospital B called the local police department. Five squad cars arrived and the Police Officers suggested that P1 be transported in restraints in an ambulance. P1 was then transported from hospital B back to this hospital via an ambulance. A police officer rode in the ambulance along with emergency medical personnel. Two squad cars followed the ambulance back to this hospital. P1 arrived back

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A 144	Continued From page 6 at this hospital at 6:30 a.m. The memo titled Medical Transportation after hours, dated 7/11/2016, and provided by facility staff revealed: In lieu of a recent incident where hospital security Officers were asked to transport a patient over to (Hospital B), it left us with no security officer on the hospital grounds. To insure that this does not happen again the hospital is asking all nurses and clinicians to carefully assess the patient status and determine if the situation requires Emergency Transportation (ambulance) or is it an urgent medical need and the patient can be safely transported in the State Van. This would require 1 driver and 1 escort from nursing staff. Security officers should not be asked to transport patients for medical reasons effective 7/11/2016. During an interview with HST-I on 8/2/2016 at 2:15 p.m. she stated that on 7/24/2016 she was with P1 in the emergency room at Hospital B after his suicide attempt. She was one of the staff that was in the van when the staff attempted to transport the patient from Hospital B back to this hospital. P1 did not want to return to the hospital from hospital B. P1 told HST-I that he did not want to return and he did not care who he hurt in order to ensure he did not go back. HST-I stated P1 kicked her repeatedly and banged his head on the window repeatedly during the attempted transfer from Hospital B's to this Hospital. HST-I stated that there was a recent memo from hospital administration that staff could no longer utilize reserve security officers (RO) to transport patients to and from another acute care hospital's emergency room anymore. She did not think this was a safe situation to have nursing staff	A 144		

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A 144	Continued From page 7 transport assaultive patients. During an interview with RN-G on 8/2/2016 at 3:00 p.m., he stated that when he went with another staff member to pick P1 up from Hospital B, he was given no radio and they are not allowed to have a phone with them during work hours. P1 kept hitting his head on the vehicle windows and kicked staff whenever they attempted to transport him. Staff had to go back to Hospital B with the patient. When he asked staff from Hospital B for assistance, they said that he should be able to deal with P1's behavior. RN-G stated there was a new procedure, sent out in a memo in July 2016, that nursing staff now have to transport patients, when prior to this, security staff transported patients. Nursing staff were provided no training on how to safely transport patients in a vehicle. During an interview on 8/2/2016 at 4:15 p.m., RN-F stated there was a recent change related to transporting patients to and from the hospital after hours. The change started this month and stated that the Hospital's reserve officer could no longer transport patients from an acute care hospital. Now, nursing staff had to pick patients up from any after hours hospital visit. In the case with P1, she had to send two staff to the pick up P1, and there was one staff member already there. RN-F stated she was not aware of any staff training that was provided related to the new transport procedure. RN-F stated the incident made her uncomfortable because it didn't seem safe to have nursing staff pick him up with his history. RN-F stated there was no written policy sent out with the memo regarding the transportation procedure change. RN-F stated	A 144		

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that she has worked at the hospital for many years, and security staff have always picked patients up from the hospital after an emergency department visit. RN-F stated P1 was not injured during the attempted transport, but HST-I suffered a bruised forearm after P1 kicked her.

During an interview on 8/3/2016 at 8:00 a.m., RN-C stated there was no new policy generated related to transporting patients to and from the hospital. The hospital policies related to patient escort do not cover what to do when a patient becomes assaultive during the escort. Additionally, the hospital census on 8/3/16 was 95 patients, and 74 of those patients have a history of assault and or violence. The hospital transfers about 6 - 10 patient's per month after hours to acute care hospitals.

During an interview on 8/3/2016 at 9:15 a.m. Director of Social Work, (SW)-J, stated he did not know why the patient transport procedure was changed, but many of the current patients have a history of violence. There is a risk when nursing staff transport patients to or from the hospital, because these staff are not police officers.

The document titled State of Minnesota Joint Powers Agreement, signed dated 7/11/2013, and representing the agreement between the "State of Minnesota, acting through its Department of Human Services, State Operated Services...and the City of Anoka" revealed: "2. Agreement between the parties... provide a full time licensed City of Anoka Peace Officer (PO) to provide a corps of trained Police Security Officers (PSOs) employed by the city of Anoka Police Department. ...B. 1. Police Security Officers are

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expected to perform the following duties or tasks at AMRTC under the direction of their supervisor. i. Escort patients on campus and/or assist with inter-unit transfers of patients when custody or safety risk is present. j. Transport or escort AMRTC staff who are transporting patients for non-emergency medical care, placement, or transfer of custody to another agency when custody or safety risk is present."

The document titled AMRTC Nursing Practice Guidelines Escorting Patients Off Grounds, undated was reviewed. The policy provides guidance to staff related to if a patient goes AWOL (absent without leave), but no guidance was found related to handling patients exhibiting assaultive or self injurious behavior in a moving vehicle.

The job description titled Licensed Practical Nurse, undated, and provided by facility staff revealed under 5. "Provide for accompaniment and supervision of patients." Tasks 3. "Escorts patients to medical appointments as assigned, and provides necessary information to care provider."

The training program EASE, dated 6/16/16, was reviewed. Although physical safety strategies are covered in the training, they are tailored for use in a hospital setting and no information to address physical violence in an enclosed, moving vehicle was located.