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	024002	A. BUILDING _____ B. WING _____	C 05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA PSYCHIATRIC INSTITUTE	3700 PIPER STREET ANCHORAGE, AK 99508

(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 The following deficiencies were noted during an unannounced complaint investigation (AK #2613) conducted May 16-18, 2016. The sample included 11 patients (6 active patients and 5 closed records) and 2 non-sampled patients. State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503	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: . The hospital failed to ensure the Condition of Participation: CFR 482.13 Patient's Rights was met as evidenced by: A118 - The facility failed to ensure patients were notified of their right to file a complaint or grievance with the State Agency; A122 - The facility failed to investigate 1 patient's grievance in a timely manner; A123 - The facility failed to ensure 1 patient was notified of the corrective action taken by the facility and the date of completion in response to a grievance filed by the 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 A143 - The facility failed to ensure 1 patient's medical information was discussed in a confidential manner; A145 - The facility failed to ensure: 1) the abuse, neglect and misconduct policy included a procedure to notify the State Agency of suspected abuse, neglect and misconduct; 2) a process to protect patients during potential abuse investigations and timely response for corrective, remedial, or disciplinary actions; and 3) staff training included a mechanism for reporting any suspected abuse, neglect, and misconduct incident to the State Agency and the prevention, intervention, and detection of potential abuse and/or neglect in a hospital setting; and A154 - The facility failed to ensure 1 patient had evidence of skin integrity, range of motion and vital sign checks while in restraints and 2 patients had less restrictive measures implemented prior to initiating a manual hold and/or physical restraints. The cumulative effect of these systemic problems resulted in failure of the facility to ensure patients were receiving quality care in a safe manner that promoted the rights of the patients and afforded them due process.	A 115		
A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by:	A 118		

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A 118	Continued From page 2 . Based on observation and record review the facility failed to ensure patients were notified of their right to file a complaint or grievance with the State agency (SA) if they wished. Specifically: 1) the postings in all units and the admission paperwork did not contain all patient advocacy agencies or the SA contact information and 2) the facility policy did not list the SA as a contact in its grievance procedure. This failed practice denied patients the information needed to contact the SA or other agencies. Findings: Patient Rights and Responsibilities Observations on 5/16/16 at 9:15 am, during the initial walk through of all the hospital units, revealed signage's "Patient Rights & Responsibilities" were posted in every unit. The signage's did not have the SA contact information (name, address or phone number) under "To File a Complaint/Grievance/Suggestion". In addition the Adult Protective Services phone number listed on the signage was not correct and Office of Children's Services was not listed as a contact in the adolescent unit. Admission Paperwork Review of the patient admission packet revealed the following: · "...If you are unable to have your grievance resolved through the appeals process at API, you may forward it to any of the resources listed ..."; · The address and the phone number for SA was not correct;	A 118		

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A 118	Continued From page 3 · National Allegiance for Mental Illness phone number was not correct; · The Joint Commission's phone number was not correct; and · The Quality Improvement Organization - Livanta's (an organization which reviews Medicare rights if a patient has concerns regarding care) phone number was not correct. Review of the facility policy "Complaints, Grievances, Patient Rights", dated 8/7/14, revealed "...List of entities patient may contact to submit a verbal grievance/concern without first going through the API grievance..." did not include the SA.	A 118		
A 122	482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response. This STANDARD is not met as evidenced by: Based on record review interview, and policy review the facility failed to investigate 1 patient's (#10) grievance in a timely manner. Specifically, the facility failed to: 1) promptly initiate the investigation of a grievance, and 2) notify the patient of the resolution in a timely manner. The	A 122		

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A 122	Continued From page 4	A 122		

failure to address the patient's grievance within the required timeframes denied the patient the right of due process and a timely resolution.
Findings:

Record review on 5/17-18/16 revealed the 15 year-old Patient was admitted to the facility's adolescent unit with diagnoses that included post-traumatic stress disorder, major depression, suicidal attempts, and autism spectrum disorder (a developmental disorder that can be characterized by persistent deficits in social communication, behaviors, and intellectual disability).

During an interview on 5/17/16 at 11:20 am, Staff #1 stated Patient #10 had filed a grievance that Psychiatric Nursing Assistant (PNA) #4 used too much force during a manual restraint episode on 4/5/16 at 8:20 am.

Promptly Investigate a Grievance:

Record review on 5/16/16 of the complaint/grievance log revealed Patient #10 filed a grievance (#16-069) on 4/5/16 that was assigned a Level III, (Level III consists of the Chief Executive Officer (CEO) and a designated API [Alaska Psychiatric Institute] advisory board member review).

Review of the Patient's grievance on the facility's Unusual Occurrence Report (UOR #16-0570) with an incident date of 4/5/16, revealed Patient #10 reported to the facility that, "She said he tackled her to the ground. 'I was knocked unconscious for a few seconds' and had bruises on the back of the neck from his arm. She also stated, the impact reminded [Patient #10] of,

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A 122	Continued From page 5 throwing myself in front of the car when I hit the ground." The staff member completed the UOR on 4/14/16, 9 days after the grievance was received. Notify the Patient in a Timely Manner Review on 5/17/16 of the grievance response letter dated 4/22/16, 17 days after the grievance was filed, revealed the letter to the Patient stated the facility did a "...thorough investigation of the incident..." and was "...taking corrective action to address your concerns." Review of the facility's policy "Patient Grievance Procedures", dated 8/7/14 revealed "Level III...CEO and Designated API Advisory Board member will: Within 7 (seven) calendar days provide the patient with a written response to include...the proposed resolution and an opinion as to whether the complaint is of a rights violation..."	A 122		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by:	A 123		

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A 123	Continued From page 6 Based on record review and interview, the facility failed to ensure 1 patient (#10) was notified of the corrective action taken by the facility and the date of completion in response to a grievance filed by the patient. This failed practice denied the patient the right to a due process and timely resolution of the grievance. Findings: Record review on 5/17-18/16 revealed the 15 year-old Patient was admitted to the facility's adolescent unit with diagnoses that included post-traumatic stress disorder, major depression, suicidal attempts, and autism spectrum disorder (a developmental disorder that can be characterized by persistent deficits in social communication, behaviors, and intellectual disability). Record review of the complaint/grievance log revealed Patient #10 filed a grievance (#16-069) on 4/5/16 that was assigned a Level III, (Level III consists of the Chief Executive Officer (CEO) and a designated API [Alaska Psychiatric Institute] advisory board member review). During an interview on 5/17/16 at 11:20 am, Staff #1 stated Patient #10 had filed a grievance with concerns that Psychiatric Nursing Assistant (PNA) #4 used too much force during a manual restraint episode on 4/5/16 at 8:20 am. Review of the Patient's grievance on the facility's Unusual Occurrence Report (UOR #16-0570) with an incident date of 4/5/16, revealed Patient #10 reported to the facility that, "She said he tackled her to the ground. 'I was knocked unconscious for a few seconds' and had bruises	A 123		

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A 123	Continued From page 7	A 123		

on the back of the neck from his arm. She also stated, the impact reminded [Patient #10] of, throwing myself in front of the car when I hit the ground." The staff member completed the UOR on 4/14/16, 9 days after the grievance was received.

Review of a copy of the grievance response letter sent to the Patient, dated 4/22/16, 17 days after the grievance was filed, revealed "...thorough investigation of the incident...we are taking corrective action to address your concerns." The letter did not specify what corrective action it was taking or when the corrective action would be completed.

During an interview on 5/17/16 at 12:30 pm the Hospital Educator stated PNA #4 had not completed any extra training yet related to the patient grievance.

During an interview on 5/18/16 at 11:20 am, the Safety Officer (SO) stated the facility had determined the incident required a training opportunity for PNA #4. The SO further stated the training would include watching the video of the manual restraint episode. The SO confirmed the NAPPI (Non-Abusive Psychological and Physical Intervention) Trainer had not provided the opportunity for the staff member to watch the video or had provided any additional training. The SO stated "it was problematic that [Trainer's name] has not spoken with [PNA #4]."

Review of the facility's policy "Patient Grievance Procedures", dated 8/7/14 revealed "Level III...CEO and Designated API Advisory Board member will: Within 7 (seven) calendar days provide the patient with a written response to

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A 123	Continued From page 8 include...the proposed resolution and an opinion as to whether the complaint is of a rights violation... "	A 123		
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: . Based on observation and policy review the facility failed to ensure 1 patient's (#11) information was discussed in a confidential manner. This failed practice created a risk for a breach of confidentiality of patients' medical information. Findings: During an observation on 5/16/16 at 1:08 pm, the Psychiatrist #1 exited a conference room with Patient #11. The Psychiatrist then approached this Surveyor, who was standing at the nurses' desk, and asked if the Patient had told the Surveyor she was suicidal. Patient # 2 was seated at the desk within earshot of the conversation. The Psychiatrist then walked around the desk and approached 2 staff standing on the other side of the desk and began openly questioning the staff about Patient #11's earlier suicidal ideation and what had transpired. Patient #2 and Patient #13 were both at the nurses' desk and within earshot of the conversation. Review of the facility's policy, "Notice of Use if Private Health Care Information, updated 7/25/2015 revealed "We must keep your health care information from others who do not need it."	A 143		

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A 143	Continued From page 9 "You have the following rights with respect to your protected health care information: 1. to receive confidential communication."	A 143		
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 record review, interview, and policy review the facility failed to ensure: 1) abuse, neglect, and misconduct policies included a procedure to notify the State Agency (SA) of suspected abuse, neglect, and misconduct; 2) a process to protect patients during potential abuse investigations and timely response for corrective, remedial, or disciplinary actions; and 3) staff training included a mechanism for reporting any suspected abuse, neglect, and misconduct incidents to the SA and the prevention, intervention, and detection of potential abuse, neglect, and misconduct in a hospital setting. These failed practices placed vulnerable patients at risk for no SA oversight, no patient protection during investigations, and delayed investigations and responses to identified concerns. Findings: Abuse, Neglect and Misconduct Policy Review on 5/18/16 of the facility policy "Care, Job Performance, Staff, Work Rules, Abuse, Neglect, or Serious Misconduct with Patients", dated 10/31/14 revealed "...The Hospital Administrator or Quality Coordinator must report all incidents of	A 145		

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A 145	Continued From page 10 reasonable suspicion of abuse, neglect, or serious misconduct with patients to Licensing and Certification the next business day." There was no procedure that instructed staff in how to notify the SA. Continued review of the facility policy "...Abuse, Neglect, or Serious Misconduct with Patients" revealed the facility had no written procedure in place to protect patients during abuse investigations. Also the policy revealed "If reasonable suspicion exists [of abuse, neglect or serious misconduct], the matter will be referred for investigation by the appropriate agency as noted above." The facility did not state they would start an immediate investigation at the facility level. During an interview on 5/18/16 at 9:25 am, the Quality Improvement Director (QID) stated the facility did not have a procedure to contact the SA for allegations of abuse, neglect or serious misconduct with patients. Protection of Patients During Investigations and Timely Response to Corrective, Remedial, or Disciplinary Actions Patient #10 Record review on 5/17-18/16 revealed the 15 year-old female Patient had diagnoses that included post-traumatic stress disorder, major depression, suicidal attempts, and autism spectrum disorder (a developmental disorder that can be characterized by persistent deficits in social communication, behaviors, and intellectual disability).	A 145		

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A 145	Continued From page 11 Review of the Patient's medical record revealed the Patient was manually restrained and placed in seclusion on 4/5/16 at 8:20 am. Further review revealed the Patient had filed a grievance about PNA (Psychiatric Nurse Aid) #4 using too much force against her during the manual restraint episode. Review of the Patient's grievance revealed "She said he tackled her to the ground. 'I was knocked unconscious for a few seconds' and had bruises on the back of the neck from his arm. She also stated, the impact reminded [Patient #10] of, throwing myself in front of the car when I hit the ground." Review of the UOR (unusual occurrence report), revealed the grievance about the episode was not submitted until 4/14/16, 9 days after the manual restraint episode. During an interview on 5/17/16 at 1:17 pm the QID stated the department had received the grievance on 4/5/16 and had reviewed the case 4/15/16. During the interview the QID stated it had been determined PNA #4 had used more force than reasonable. The QID stated the case had been referred to the education department. Patient #12 Record review on 5/17-18/16 revealed the 14 year-old female Patient had diagnoses that included depression and a history of attempted suicide. Review of the medical record, revealed an episode where the Patient was manually held by staff and placed in physical restraints on 4/28/16 at 7:45 pm. Review of the documentation	A 145		

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revealed "[PNA #2] on unit reported Pt. [Patient] with another female began a verbal altercation with him in dining room with other peers present. This Pt. alleged screamed and tried to hit [PNA #2] in arm and code gray called and BMR [brief manual hold] administered as reported by [PNA #]. RN/NSS [Night Shift Supervisor] #2 and this NSS Relief arrived on unit with multiple PNAs in response to Code Gray. Pt. was yelling and spitting and spit hood [hood that goes over the head and covers the lower half of the face] placed by [RN #3] for Pt. on unit while Pt. was in dining room on unit. [RN #3] delegated for PNAs to transport Pt. via gurney to ASO clinic...Two PNAs remained with Pt. in ASO Clinic Oak at all times during restraints per P&P [policy and procedure]." The Patient was in restraints from 7:54 pm until 11:30 pm, a total of 1 hour and 36 minutes.

Review of the grievance investigation, dated 4/29/16, revealed " 'a Patient [#12] got restraints today. She turned around and [PNA #2] night staff put hands on her for no reason.' Followed up with alleged victim [Patient #12] who reported she was just finishing up in the dining area, [PNA #2] asked her something. She put up her hand to tell him to keep out of her space. She reported [PNA #2] grabbed her hand and bent back her fingers at the wrist. The emergency seclusion and restraint followed...She reported her fingers/wrist were sore today." Further review revealed "Video is not the best but initial physical altercation can be seen. The patient's perception of what occurred vs. staff's perception is more aligned with the video."

During an interview on 5/18/16 at 11:30 am the Safety Officer (SO) stated he also functions as the Risk Manager. When asked about the

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restraint episode with Patient #12, the SO confirmed the video had been reviewed and brought to the leadership team. The rest of the investigation was assigned to other team members for process review. The SO and the QID confirmed the investigation from the incident on 4/28/16 (19 days ago) had not been completed. Both staff confirmed PNA #2 had continued to work during the still ongoing investigation and there was no process to ensure patients were protected during the investigation. During the interview the SO confirmed the video tape had no sound therefore, the investigation could not be completed until the involved parties had been interviewed. Both staff confirmed the PNAs had continued to work with the patient #s 10 and 12 as well as other patients on the units, after the allegations and during the ongoing investigations. The SO stated the educational department had not provided any additional education for PNA #4 regarding the the manual restraint incident with Patient #10 on 4/5/16, over 42 days ago.

During an interview on 5/18/16 at 11:50 am, when asked about the facility's process for protecting patients after an allegation of abuse, the Assistant Director of Nursing (ADON) stated senior nursing leadership would make the decision depending on the nature of the grievance. If it was sexual abuse or aggression they would be temporarily assigned or moved to another unit depending on the outcome of the investigation. Sometimes he had to send a letter and move staff to a different unit "pending an ongoing investigation." The ADON stated many of the patients' grievances regarding abuse are unfounded.

Review of the facility policy "Conduct Involving

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	024002	A. BUILDING _____ B. WING _____	C 05/18/2016

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A 145	Continued From page 14 Patients", effective date 10/31/14, revealed " Patients at API [Alaska Psychiatric Institute] have the right to treatment in a setting that provides physical safely, emotional support, and freedom from abuse or inappropriate treatment...Physical abuse includes but is not limited to: a. hitting slapping, kicking, pinching, shoving, spitting on, or beating a patient...c. using more force than is reasonable for a patient's control, treatment, or management; (reasonable force is defined as the appropriate use of Mandt techniques [approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others] or actions necessary to remove self from imminent harm)..." Further review of the facility policy revealed "If the allegation of abuse and neglect is from a complaint or grievance generated by a patient or on behalf of a patient...the Nursing Supervisor (NS) who shall take immediate action and ensure safety of the patients and staff. The NSS may order the person involved in the alleged misconduct to be relieved of duty, pending investigation of the reported misconduct..." Staff Training of Abuse, Neglect, and Misconduct Review on 5/17-18/16 of all the education given to staff, provided by the facility, revealed no process or procedure for staff to know how to report to the State Agency abuse, neglect or misconduct of patients.	A 145		
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION	A 154		

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A 154	Continued From page 15 Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: Based on interview, record review, and policy review the facility failed to ensure 1 patient (#8) had evidence of skin integrity, range of motion (ROM), and vital sign checks while in restraints and 2 patients (#'s 10 and 12) had less restrictive measures implemented prior to initiating a manual hold and/or physical restraints. These failed practices placed patients at risk for injury and psychological harm from misuse of restraints. Findings: Patient #8 During an interview on 5/16/16 at 10:00 am, PNA #1 stated Patient #8 had to be placed in restraints in the seclusion room last Saturday. The PNA opened the closet in the seclusion room where the restraints were kept and stated staff used 4 limb restraints and a chest restraint tied to the bed for restraining a patient. Review of Patient #8's electronic medical record (EMR) on 5/17/16 revealed the adult patient had a diagnosis that included depression and suicidal ideation.	A 154		

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A 154	Continued From page 16 Continued review of the EMR revealed "Type: RN Emergency Restraint Initial", dated 5/14/16, "Emergency Restraint episode start date: 5/14/16...time: 9:39 am." Review of the initial order, dated 5/14/16, revealed "Bed restraints up to 4 hours." Review of the paper medical record revealed there was no documentation of the 15 minute checks for the following: Patient's circulation and skin integrity while in the restraints; ROM that was done to prevent injury; fluids or hygiene needs; or the vital signs taken during the episode. During an interview on 5/17/16 at 11:00 am, when asked for the documentation of the restraint incident, RN #1 confirmed the documentation wasn't in the Patient's medical record but stated the restraint flow sheets go upstairs for administrative review. During an interview on 5/17/16 at 1:55 pm, the Quality Improvement Director (QID) stated they were looking for Patient #8's flow sheet for the restraint episode on 5/14/16. No documentation was provided prior to the survey team's exit on 5/18/16 at 3:00pm. Patient #10 Record review on 5/17-18/16 revealed the 15 year-old female Patient had diagnoses that included post-traumatic stress disorder, major depression, suicidal attempts, and autism spectrum disorder (a developmental disorder that can be characterized by persistent deficits in social communication, behaviors, and intellectual disability).	A 154		

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Additional review revealed Patient #10 was manually restrained and then placed in seclusion on 4/5/16 at 8:20 am. An Unusual Occurrence Report (UOR) was completed and assigned for further investigation on 4/15/16. The Patient reported concerns of "[Staff's name] used too much force against [him/her]." The Patient also was reported on the UOR as saying, "I was knocked unconscious for a few seconds". The UOR also revealed the Patient complained of "...bruises on the back of the neck..."

Review of the "Seclusion FACE to FACE Flow Sheet" for the event on 4/5/16 revealed ...pt [Patient] hit Staff, trying to attack RN, continuing to threatening staff."

During an interview on 5/17/16 at 11:25 am, Staff #1 reported the Patient was concerned PNA #4 restrained her too quickly.

During a subsequent interview on 5/17/16 at 1:17 pm, the QID stated she received the UOR from the Protective Services Specialist on 4/5/16 and the video was reviewed on 4/15/16 by the CEO, Safety Officer, Training Specialist and herself and stated "The restraint was more forced than reasonable."

During an interview on 5/18/16 at 2:30 pm) the CEO stated she had watched the video of the manual restraint and felt PNA #4 reacted too quickly which resulted in the Patient being restrained.

Patient #12

Record review on 5/17-18/16 revealed the 14 year-old female Patient (#12) had diagnoses that

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A 154	Continued From page 18 included depression and a history of attempted suicide. Further review of the medical record, revealed an episode where the Patient was manually held by staff and placed in physical restraints on 4/28/16 at 7:45 pm. Review of the documentation revealed "[PNA #2] on unit reported Pt. [Patient] with another female began a verbal altercation with him in dining room with other peers present. This Pt. alleged screamed and tried to hit [PNA #2] in arm and code gray called and BMR [brief manual hold] administered as reported by [PNA #2]. [RN #2 Night Shift Supervisor (NSS)] and this NSS Relief arrived on unit with multiple PNAs in response to Code Gray. Pt. was yelling and spitting and spit hood [hood that goes over the head and covers the lower half of the face] placed by [RN #3] for Pt. on unit while Pt. was in dining room on unit. [RN #3] delegated for PNAs to transport Pt. via gurney to ASO clinic...Two PNAs remained with Pt. in ASO Clinic Oak at all times during restraints per P&P [policy and procedure]." The Patient was in restraints from 7:54 pm until 11:30 pm, a total of 1 hour and 36 minutes. Review of the "Restraint/Seclusion Event Descript, dated 4/28/16 at 10:05 pm, revealed "At about 7:40 pm, an argument broke out in the Chilkat [the adolescent unit] TV room between staff and two patients...The argument started when staff were redirecting these patients to use respectful and appropriate language. The argument escalated with these two patients screaming uncontrollably at staff. Patient [#12] is reported to have charged [PNA #2] swinging with fist raised. At that time she was put in brief manual hold...Less restrictive means were not and would not be successful." There was no	A 154		

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documentation that indicated required de-escalation techniques were used prior to the escalation of the behaviors.

Review of the "Restraint Face to Face Flow Sheet", dated 4/28/16 at 7:54 pm, revealed "Staff Interventions", where staff were to document interventions, listed "2" restraint, and "6" spit hood. At 10:00 pm, 20 minutes after the initiation of the behavior, staff documented "7" engaging patient, "4" medications, "2, 6" as staff interventions." There was no documentation of the initial de-escalation techniques used prior to the initiation of the restraints on 4/28/16 at 7:54 pm.

During an interview on 5/16/16 at 9:15 am, when asked about the procedure for initiating restraints, PNA #3 stated staff tries to "redirect" patients prior to initiating restraints.

During an interview on 5/18/16 at 11:30 am, when asked about Patient #12's episode, the Safety Officer stated there was no evidence of the de-escalation techniques (or redirection) used by staff prior to the Patient's escalating behavior in the video he reviewed.

During an interview on 5/17/16 at 11:25 am, Staff #1 stated there had been an ongoing concern on the adolescent unit of staff restraining and secluding too quickly.

Review of the facility's policy "Seclusion and or Restraint, Time-Out, Patient Safety Equipment (PSA)", effective date 6/1/15, revealed "Only NAPPI [Non Abusive Psychological and Physical Intervention] approved techniques for physical interventions will be used. Approved early

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A 154	Continued From page 20 intervention crises prevention techniques will be used to de-escalate conflict when possible." Review of the facility's "Restraint Skills Module" education revealed "All patients are entitled to be free of restraint except when the patient poses a threat of harm to themselves or others and less restrictive measures have been tried and failed." Review of the "Manual Holds by Unit and Quarter for FY016" graph revealed the adolescent unit (consists of 10 beds) had 59 holds for the quarter of July - September 2015; 81 for the quarter October - December 2015; and 53 for the quarter January - March 2016. The number of manual holds and restraints on the adolescent unit was more than double the number on the adult units. .	A 154		