State of South Carolina
Department of Mental Health

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Mark Binkley
Interim State Director

August 8, 2019

The Honorable John Taliaferro (Jay) West, Subcommittee Chair
South Carolina House of Representatives
Legislative Oversight Committee
Healthcare and Regulatory Subcommittee
Post Office Box 11867
Columbia, South Carolina 29211

Re: July 26, 2019 Letter

Dear Chairman West:

Thank you for your letter of July 26, 2019 transmitting a number of requests for information following the July 23, 2019 Subcommittee hearing.

Mark W. Binkley, Interim State Director, is out of the office, so the attached response is being submitted on his behalf. Please let me know if you or other members have any questions about the information provided.

Sincerely,

Robert L. Bank, MD, Medical Director
Acting Interim State Director of Mental Health

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Answers to Questions from July 26, 2019 Letter of Subcommittee
South Carolina House of Representatives
Legislative Oversight Committee
Healthcare and Regulatory Subcommittee

Licensing and Certification

- **For the last five years, provide a list of DHEC licensing citations for DMH facilities licensed in accordance with S.C. Code of Regulations 61-16 (Minimum Standards For Licensing Hospitals And Institutional General Infirmaries), in a table that includes columns for the following:**
  - **date of the licensing visit resulting in the citation,**
  - **licensing regulation section number,**
  - **violation class,**
  - **summary of the comments, and**
  - **summary of the associated corrective action plan.**

  See Attachments 1-3.

- **Provide a list of immediate jeopardy citations from the last three years.**
  See Attachment 4.

- **Until six months following approval of the study by the full Committee, notify the Legislative Oversight Committee when one is issued and if the facility's agreement with the U.S. Department of Health and Human Services is terminated.**

Employees

- **Provide the number of new hires at G. Werber Bryan Psychiatric Hospital, by month, since July 1, 2018.**

	FULL TIME STAFF	CONTRACT STAFF
2018		
July	35	19
August	26	25
September	33	7
October	24	26
November	37	7
December	14	7
Total	*169*	*91*
2019		
January	26	11
February	19	17
March	18	12
April	11	19
May	13	20
June	17	9
Total	*104*	*88*

Discipline

- **Provide the number of employees suspended at each inpatient facility, divided by major reasons for the suspensions.**

Facility	Number of Suspensions	Reason for Suspension
C. M. Tucker	7	Policy Violation (Technique)
G. Werber Bryan	8	Policy Violation (Technique)

- **In the last three years, how many DMH employees have been suspended for failure to use authorized techniques?**
  See above table.

Training

- **Confirm that the BEST training cycle is annually in-person and every other year online. If not, please explain the training cycle.**
  Direct Care staff assigned to Hall, Harris and Bryan Hospitals must take BEST in the classroom once a year. In addition, they must complete and pass the BEST online modules once a year. These must be taken six (6) months apart. This is required by the Department of Health and Human Services.

- **When was retraining of current employees on BEST completed? Are there any employees who have not been trained on BEST revisions implemented in 2018?**
  From February 11 through March 4, 2019, 100% of the active direct care staff in the Division of Inpatient Services were retained in BEST. Staff returning from extended leave were/will be retrained before providing direct patient care.

- **<u>Does internal audit or the risk management office review employee training compliance?</u>**
  DMH Office of Internal Audit and Office of Risk Management do not review employee training compliance. Historically, managers and supervisors monitor compliance of their employees in timely and successful completion of mandatory trainings.
  The Division of Inpatient Services has established a Clinical Competency Oversight Committee to oversee the processes and systems that ensure staff providing patient care complete mandatory training. The Committee will report to DIS Leadership and the Inpatient Facilities Governing Body.

<u>Vulnerable Adult Fatalities Review Committee</u>

- **Who is the agency's current designee for the Vulnerable Adult Fatalities Review Committee?**
  Gary Ewing, MD, from SCDMH C. M. Tucker Nursing Care Center, is the agency's participant on this review committee.

- **How does that person provide feedback to the administration on the committee's discussions of statistical studies, cross-agency training and technical assistance needs, and service gaps?**
  Dr. Ewing attends meetings and provides consultation to the committee between scheduled meetings.
  See also:
  - SECTION 43-35-560. Vulnerable Adults Fatalities Review Committee; members; terms; meetings; administrative support.
  - SECTION 43-35-570. Purpose of Vulnerable Adult Fatalities Review Committee.
  - SECTION 43-35-580. Meetings discussing individual cases closed; disclosure of information identifying vulnerable adult or family member.
  - SECTION 43-35-590. Confidential and public information.
  - SECTION 43-35-595. Promulgation of regulations.

- **Please provide the Vulnerable Adult Fatalities Review Committee attendance record of the agency's designee for the last three years.**
  SCDMH has requested this information from the State Law Enforcement Division, the state agency responsible for coordinating the activities of the Committee.

<u>**Patient Deaths**</u>

- **How many deaths at DMH facilities were classified as homicides by a coroner in each of the last 3 years?**
  There were two deaths in DMH facilities classified as homicide by a coroner in the last 3 years. In August of 2017, the death of a patient in Bryan Psychiatric Hospital's Forensic Division was classified as a homicide. In January 2019, a patient death at Bryan Psychiatric Hospital's Civil Division was classified as a homicide. See Attachment 5.

Residencies

- **What percentage of the agency's current psychiatric staff were residents in the Prisma Health (formerly Palmetto Health) residency program and interacted with DMH during that residency?**
  - General Psychiatry Residency Program: In 2018 two joined DMH and are still employed.
  - Child Program: In 2017 two joined DMH and are working part time.
  - Forensic Program: In 2018 one joined DMH and is still employed.

Physical Plant

- **What is the exact amount in the deferred maintenance fund (2019-2020 General Appropriations Act Proviso 35.7)? How much of that is uncommitted?**
  - Cash balance is $52,711,018.20.
  - Restricted cash (sale of land/Columbia Area Match) is $1,700,000
  - Approved A1s cash balance total $49,774,877.60 (this includes the interest on the VA nursing homes, which SCDMH believes is to be used towards the Nursing Home construction only)
  - Agency commitments total $1,217,181.00
  - Uncommitted balance is $18,959.60

- **Is there anything in the physical plant plan that considers broadband access for new and existing buildings?**
  Bandwidth for new and existing facilities is determined by IT assessment of services/devices that require internet access (local area network computers and servers, teleconferencing, telepsychiatry equipment, fire alarms, video surveillance systems, access control systems, postage systems, phone systems and etc.) and the number of such devices that will be connected to the network. Once that is calculated, we consider the type of internet service that will be available in the area to accommodate the requirement (MPLS, Fiber, Dedicated Ethernet, etc…) and the construction cost to bring the internet services into the facility. Should an inpatient facility be required to provide internet access for the patients/residents, IT develops an estimated bandwidth used by streaming services. A separate internet service to accommodate these requirements.

- **What percentage of the agency's vehicles are within the service areas of the Columbia and Anderson garages?**
  Forty-eight percent of SCDMH vehicles are within the service area of the Columbia and Anderson garages. In FY2018, the garages provided 598 services to vehicles and equipment (e.g. generators, yard maintenance equipment).Columbia garage completed 1,500 work orders in FY2019.

[End]

SC DEPARTMENT OF MENTAL HEALTH

Division of Inpatient Services

All DHEC citations from the attached report for Morris Village have been cleared.

Morris Village Alcohol and Drug Addiction Treatment Center

SC Department of Health and Environmental Control (DHEC) Licensing Number HTL – 0516 Licensure Citations

Date of Visit	Licensing Regulation Number	Violation Class	Summary of Comments	Summary of Corrective Action Plan
2/21/2019	61-16 Section 1600	Class II	Administration building 2nd floor - heater found; Finance area - 2 heaters found in storage; Cottage 12 Beds 1-4, Utilization Management Office Space - heater found; Beds 5/6 - Patient Advocacy - Space heater found; Administration building/Admissions - "Mechanical Room" near Admission's entry. Room is electrical not mechanical. Cottage 12 beds 1-4, Utilization Management Electrical Room - missing blanks in breaker panel.	All heaters removed. Signage changed from "Mechanical Room" to "Electrical Room". Physical Plant Services installed blanks to the breaker panel and will conduct periodic inspections to ensure blanks ae installed in breaker panels when missing. All corrective action completed as of 4/10/2019.
9/21/2018	61-16	No violations	No violations	No violations
2/14/2017	61-16 Section 702	Class II	Resident eloped from facility on 12/23/2016. The report was submitted on 1/13/2017. Reports should be submitted within 10 days of the occurrence. Local police found resident and transferred her to a local hospital and the local hospital notified MV.	An internal tracking system was developed to log in and tract occurrences with an additional feature requiring entering a date notification was made to DHEC for those occurrences requiring DHEC notification. The tracking system is reviewed daily to ensure timely notification is provided to DHEC. Citation cleared.
1/23/2017	61-16 Section 1600 Maintenance	Class II	Use of portable space heaters found in numerous locations	Space heaters removed by staff. Citation cleared.

Morris Village Alcohol and Drug Addiction Treatment Center

SC Department of Health and Environmental Control (DHEC) Licensing Number HTL – 0516 Licensure Citations

Date of Visit	Licensing Regulation Number	Violation Class	Summary of Comments	Summary of Corrective Action Plan
3/18/2015	61-16 Section 1600 Maintenance	No violations	No violations	No violations
6/13/2014	61-16 Section 1101	Class II	Dining Room - Ice water dispenser soiled with brown and pink debris; drink nozzles for juice machine with sticky red build-up and top portion of microwave soiled with food debris.	Nutritional Services staff trained to cleaning juice and ice machines and microwave oven. Instructional sheets developed and used for training. Citation cleared.

SC DEPARTMENT OF MENTAL HEALTH

Division of Inpatient Services

All DHEC citations from the attached report for Harris Psychiatric Hospital have been cleared.

HPH DHEC Survey Information

Date of Visit Type	Regulation Section Number	Violation Class	Comments	Corrective Action Plan	Cleared
6-24-19 Licensing		Pool	Chlorine outside of regulatory range.	Chlorine adjusted.	Yes
			The emergency notification device was not operational.	IT department programmed the phone in pool area and now it is operational.	Yes
			Pool rules sign not completely filled out.	Sign completed as directed. No further action required.	Yes
6-20-18 Licensing		Food /Sanitation Audit	No Citations received. Food/Sanitation Grade A Overall score 100.	N/A	N/A
6-20-18 Licensing		Pool	Pool Closed due to HVAC renovation. Survey unable to be completed.	N/A	N/A
3-15-18 Licensing	602.B.2	Licensing	For one (1) of five (5) staff records reviews, there was no documentation available for review that showed a two-step TST was completed within CDC Guidelines. Staff A, hired 10-17-17, TST placed 10-2-17, read 10-4-17, TST placed 10-25-17, read 10-26-17. *Please note the test was done accurately but when information transferred to computer placed the wrong date. Worksheet presented with accurate dates.*	The typed TST screening form on five new employees was randomly audited monthly for six months to ensure compliance that a two-step TST was completed and documented according to CDC guidelines.	Yes

HPH DHEC Survey Information

	1208.G.		Outdated medical supplies were observed stored with current supplies on the unit. On Lodge J crash carts the following items were observed stored past the expiration date; Four (4) Monojet Safety Syringes 1ml 28G, expired 10-2017, Catheter Tip 60ml, expired 2015-2, USP Normal Saline expired 5-2017, and two (2) Safety Catheters 18G, expired 12-2017.	Immediate action on survey date 3-15-18 all outdated supplies were removed and replaced with current supplies. A new audit checklist was developed. The crash cart from each unit was checked to see if medical supplies were current with no out of date supplies for five months.	Yes
5-23-17 Licensing	47(4-601.11-C)	Food /Sanitation Audit	Accumulation of dust observed on the hood ventilation system over the deep fryer. Overall score of 99%.	Identified area was cleaned by staff. Had staff meeting day of survey stressing importance of cleaning routine and planned cleaning schedule.	Yes
5-12-17 Licensing		Pharmacy	Satisfactory in all areas.	N/A	N/A
4-4-17 Licensing		Fire Life Safety	Surge protectors are not UL 1363 Rated.	Recommended surge protectors were changed immediately in patient care areas. Availability of the UL 1363 surge protectors impacted timeline for changes in office areas. Surge protectors in office areas will be changed in correspondence with the HVAC project.	Yes
			Lint and clothing items behind dryer system.	Area cleaned on day of survey. HPH housekeeping added cleaning behind dryers to weekly list of assignments.	Yes
			3 penetrations through fire rated walls-air handler rooms.	Door sweeps were attached to doors in air handler rooms to eliminate gaps.	Yes
			Beauty shop sink needs GFI receptacle.	A GFI outlet was not required because it was on a GFI breaker. No further action required.	Yes
3-10-16 Licensing	4-601.11A	Food /Sanitation Audit	The ice machine observed with an accumulation of black and green debris.	Ice machine emptied, cleansed and sanitized. Supervisor will inspect during weekly preventative maintenance rounds.	Yes

HPH DHEC Survey Information

			An accumulation of ice buildup observed on walk-in freezer condenser. Overall score 96%	Freezer condenser was defrosted. Supervisors will inspect during weekly preventative maintenance rounds.	Yes
3-10-16 Licensing	1701.A	Routine	Microwaves in the patient nourishment areas on lodge J and K were observed with an accumulation of food residue on the inside top area and sides.	Microwaves were thoroughly cleaned on day of survey. Nurse Managers will check microwaves on a weekly schedule and clean when necessary.	Yes
6-24-15 Licensing	3-302.11 (AA3-8)	Food /Sanitation Audit	Apple slices were stored in the reach–in cooler without covering.	Apples were discarded. Conducted in-service "Kitchen Sanitation Update/Review" on 8-13-15. Monitored compliance thereafter.	Yes
	3-304.14		One wiping cloth was in the sink, and two in use cloths were on the counter.	In use cloths were placed in the appropriate chemical sanitizer pails at the time of inspection. Information included in "Kitchen Sanitation Update/Review" on 8-13-15.	Yes
	4.501.12		Two cutting boards were observed with multiple deep cuts within the surface. Black debris was embedded within the deep cuts. Overall Score 94%.	Cutting boards were cleaned thoroughly and sanitized on the day of inspection.	Yes
2-26-14 Licensing		Food /Sanitation Audit	Dish machine Final Rinse Temperature exceeded 195F. 1 @ 197F, 200F, and 198F.	Adjustment of final rinse thermostat completed 2-27-14. Monitored temps thereafter. Issue resolved.	Yes
			The tip and surrounding areas of the can opener were soiled with debris: top inside of microwave and inside of hot chocolate machine heavily soiled with debris.	Can opener cleaned and removed from kitchen. Alternative can opening solution researched for opening additional can sizes. Microwave cleaned on day of inspection. Hot chocolate machine cleaned before end of shift. In-service to staff "Kitchen Sanitation Update/Review".	Yes

HPH DHEC Survey Information

			Dead insects and other debris in four of the light fixtures. Overall score 89%.	Lights were cleaned. Added to twice monthly monitoring.	Yes
2-26-14 Licensing	204B	Licensing	4 of 4 staff reviewed had no physicals conducted within 1 year prior to employment.	Employee Health Nurse/designee will sign New Employee Health Physical form as validation of new hires ability to perform his/her duties.	Yes
			There no available documentation of a PPD within 3 months prior to employment for 1 of the 4 staff reviewed.	Reiterate HPH policy will be followed and documentation reflects that PPDs are administered within 3 months of employment,	Yes
	604.3		There were 6 Ativan 0.5 mg on the narcotic control sheet, only 5 Ativan 0.5 mg were available in medication cart.	On day of survey, the nurse administering medications was immediately educated on necessity of maintaining accurate documentation on the narcotic control sheet in a timely manner; the counts were immediately reconciled with the Nursing Supervisor on duty. On 3-14-14, the Director of Nursing again met with the nurse involved to discuss requirement of accurate documentation on the narcotic sheet. Nursing Education presented mandatory training for Nursing regarding importance of Narcotic accountability by 3-31-14. Changed the placement of the narcotic control sheet to be kept at front of the MAR notebook.	Yes
			There were 43 Klonopin 0.5 on the narcotic control sheet, only 40 Klonopin 0.5 mg available in medication cart.		
			There were 41 Klonopin 1mg on the narcotic control sheet, only 40 Klonopin 1mg available in the medication cart.		
			There were 18 Klonopin 2mg on the narcotic control sheet, only 17 Klonopin2 mg available in the medication cart		
	605.6		5 BD blunt fill needle filters with the use date of 10-2013 on the crash cart unit G.	BD blunt fill needle filters were replaced by Pharmacy. Pharmacy to add needles and syringes to expiration date on medication sheet.	Yes
	1101.1		Black and brown debris in the ice maker on lodge G.	Ice machine was cleaned. Ice machines were added to preventative maintenance plan to be inspected quarterly by Maintenance Department.	Yes

			Microwave heavily soiled with debris on lodge G.	Microwave cleaned 2-26-14. Director of Nursing established time-frames for daily monitoring and to clean as needed.	Yes
			Light Fixtures with bugs in them on G lodge.	All light were cleaned. Light fixture lens inspection and cleaning added to the preventative maintenance plan to be inspected.	Yes
			Refrigerator on G lodge soiled with debris.	Refrigerator cleaned day of survey. Director of Nursing established time-frames for daily monitoring of the refrigerator for cleanliness and clean as needed.	Yes

SC DEPARTMENT OF MENTAL HEALTH

Division of Inpatient Services

All DHEC citations from the attached report for Bryan Psychiatric Hospital have been cleared.

DHEC /CMS Certification Citationsz; All citations have been cleared.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.12 Governing Body	A0043 cross reference to A0049 & A0063	The hospital failed to ensure patients in restraint holds received care & services in a responsible manner to ensure the safety of 1 of 1 patients who died while in an inappropriate hold	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. Training provided to direct care staff on use of emergency equipment - Automated External Defibrillator (AED) and Ambu bag.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.13 Patient Rights	A0015 cross reference to A0144	Failure of Governance of hospital to ensure the oversight & monitoring & clear expectations for safety of patients in restraint holds were established for 1 of 1 patients how died in the hospital lodge while in an inappropriate hold.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.23 Nursing Services	A0385 cross reference to A0392	The hospital failed to ensure its nursing staff followed the hospital's policies & procedures when restraining patients to ensure the safety of its restrained patients for 1 of 1 patients who died while in an inappropriate hold.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	421.12 Governing Body	A043	The hospital failed to ensure patients in restraint received care in a responsible manner to ensure safety, failed to ensure the oversight & monitoring of patients in restraint holds, failed to ensure clear expectations for the patient's safety were established for 1 of 1 patients who died while in an inappropriate hold.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor.
	482.12(a)(5) Medical Staff Accountability	A049	There is no observed supervision by nursing, medical staff, or administrative staff during the restraint hold of any physical assessment for the patient's wellbeing during the restraint hold.	On 1/30/2019 Medical Director issued memo to medical staff regarding expectations for maintaining patient safety during restraints. On 2/8/2019 Hospital Director issued memo regarding implementation of Intervention Review Team reviewing each incident of restraint. Medical staff received re-training/training to BEST, Code Management policy revised and distributed to medical staff, Code Blue drills accelerated, training provided to emergency equipment (Automated External Defibrillator - AED) and Ambu bag with return demonstration.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.12 (c) Care of Patients	A063	The hospital failed to promote and ensure the safety of the 1 of 1 patient who died while in an inappropriate hold in the hospital with the potential to affect any restrained patient when crisis management, medical management, clinical leadership & clinical assessments are not implemented during restraint interventions.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. Training provided to direct care staff on use of emergency equipment - Automated External Defibrillator (AED) and Ambu bag. Licensed nursing staff checks of emergency equipment daily. Data reviewed, analyzed and reported to Director of Nursing and Nursing Leadership.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.13 Patient Rights	A115	The hospital failed to ensure its staff followed the hospital's policies & procedures when restraining patients to ensure protection & promote safety for patients in restraints for 1 of 1 patient who died while in an inappropriate hold.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. Training provided to direct care staff on use of emergency equipment - Automated External Defibrillator (AED) and Ambu bag. Licensed nursing staff checks of emergency equipment daily. Data reviewed, analyzed and reported to Director of Nursing and Nursing Leadership.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.13 (c)(2) Patient Rights: Care in a Safe Setting	A144	The governance of hospital failed to ensure the oversight & monitoring & failed to ensure clear expectations for safety were established for of patients in restraint holds were established for 1 of 1 patients how died in the hospital lodge while in an inappropriate hold.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.23 Nursing Services	A385	The hospital failed to ensure its nurses followed the hospital's policies and procedures to promote safety for restrained patients in high risk problem prone areas in the hospital's lodge, and for evaluating and assessing patients in restraints to ensure safety of 1 of 1 patient restrained and provide the supervision necessary to protect and assess patients in crisis situations for 1 of 1 patient who died.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.23(b) Staffing & Delivery of Care	A392	The governance of the hospital failed to ensure nursing oversight and monitoring of patients restrained in the hospitals' lodge to ensure clear expectations for safety were established, failed to ensure the appropriate level of supervision was in place for 1 of 1 patient with suicidal ideations (Patient 6) whose level of monitoring or other interventions were not appropriately implemented to ensure the patient's safety for 1 of 10 patient charts reviewed. The patient tied a strap around his/her neck and the level of supervision was not increased as a result of the incident. Nursing services failed to ensure the necessary monitoring and supervision of a patient in a restraint hold in which the patient died (Patient 5) and failed to institute the management of a code situation following the restraint hold episode.	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. 6) On 2/7/19, Nursing Director conducted in-service with Lodge H Nurse Manager for PC-36 Suicide Risk Evaluation and Mitigation Strategies for review with licensed staff. On 2/8/19, PC-36, PC-14 Special Treatment Modalities/Observation Levels, and PC-4 Code Blue were distributed to all Lodges for in-service with licensed staff regarding expectations for assessment of individuals who display suicidal ideation. Nursing Daily Suicide Risk Assessment and Special Treatment Modalities implemented and conducted each shift to audit assessment and documentation of patients who express suicidal ideations/gestures/attempts.

Date of Visit	Condition of Participation (COP)	CMS Tag Number	Summary of Comments	Summary of Corrective Action Plan
1/28/2019 through 2/1/2019	482.23(b)(3) Supervision of Nursing Care	A395	The governance of the hospital failed to ensure nursing oversight and monitoring of patients restrained in the hospitals' lodge and failed to ensure the appropriate level of supervision was in place for 1 of 1 patient with suicidal ideations whose level of monitoring or other interventions were not appropriately implemented to ensure the patients' safety for 1 of 10 patient charts reviewed (Patient 6).	BPH Leadership responded immediately to the lodge after the incident to assess and provide support. On 1/22/19, members of the Governing Body Committee met with the Hospital Leadership to include Medical, Nursing and Clinical Leadership to view the video of the incident and to assist with developing an immediate plan of action to ensure the safety of all patients. Subsequent meetings of members of the Governing Body Committee with Hospital Leadership on 2/1/19, 2/7/19, and 2/8/19 to evaluate progress following plan implementation and to provide support and assistance. Employees directly involved in restraint hold placed on suspension pending investigation. Employees received training in Behavior Emergency Stabilization Training (BEST), never restrain patients in a face-down position, safely restraining patients, and care of patients in restraints. Frequency of Code Blue drills accelerated to monthly versus every six months times three (3) months then every six (6) months. Code Management policy revised to include Registered Nurses (RN) supervising and assessing patient experiencing a crisis. Code Management critiques implemented. Education, Training and Research implemented auditing of staff compliance to BEST. Implemented Intervention Review Team to review each restraint episode by close of business day following the restraint episode. Audits conducted, data reviewed, analyzed and results reported to the hospital director. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. Hospital Seclusion and Restraint Policy revised to include information regarding prohibited restraints - restraining patients face-down and not restraining patients from a standing/laying position to the floor. 6) On 2/7/19, Nursing Director conducted in-service with Lodge H Nurse Manager for PC-36 Suicide Risk Evaluation and Mitigation Strategies for review with licensed staff. On 2/8/19, PC-36, PC-14 Special Treatment Modalities/Observation Levels, and PC-4 Code Blue were distributed to all Lodges for in-service with licensed staff regarding expectations for assessment of individuals who display suicidal ideation. Nursing Daily Suicide Risk Assessment and Special Treatment Modalities implemented and conducted each shift to audit assessment and documentation of patients who express suicidal ideations/gestures/attempts.

Date of Visit	Licensing Regulation Number	Violation Class	Summary of Comments	Summary of Corrective Action Plan
2/19/2019	61-16 Section 1600	Class II	Forensic Services - space heater found in rooms 1032 & 1033; Building Unit 1/Room 185 Rated door propped open with chair. Unit 2/Solarium Rated Door (20 minutes) Rated door propped open with door wedge. Unit 2/Smoke-Fire Rated Doors at Nurses' Station No positive latching when doors closed. Unit 4/Solarium Rated Door (20 minutes) Rated door propped open with trash can. Unit 4 & 5 -Smoke-Fire Rate Doors at Nurses' Station No positive latching hardware/no-latching Unit 6/Smoke-Fire Rated Door at Nurses' Station propped open with door wedge.	All deficiencies cited were corrected with the exception of the BPH Forensic fire rated doors on Units 2, 5, and 6 awaiting hardware/door delivery - anticipated completion date 9/30/19. Corrective action plan accepted.
2/15/2019	61-16 Section 505.A	Class II	Staff member A failed to provide safe & appropriate care. During an improper restraint, patient A expired. Staff member A suspended due to not informing staff that they were performing an improper hold & for not participating in the Code Blue call.	On 1/22/2019, the nurse leaders met with lodge Registered Nurses (RNs) and verbally emphasized that the RN is responsible for the safety of the patients and supervision of care during a crisis. This was followed by a memo dated 2/8/2019 form the Director of Nursing explaining the same. Of available licensed nursing staff, excluding those on leave, 100% received this review. The actions taken to prevent similar recurrences: Director of Nursing or designee will review RN practice related to the supervision and assessment of patients in crisis related to every Code Management and Code Blue by the close of business on the business day following the Code. Data will be reviewed, assessed and analyzed on an ongoing basis by the Director of Nursing and nursing leadership. The information will be utilized to support, coach and identify training needs of the registered nurse.Person Responsible: Director of Nursing Actual or expected completion date 02/18/2019.

Date of Visit	Licensing Regulation Number	Violation Class	Summary of Comments	Summary of Corrective Action Plan
2/15/2019	61-16 Section 507.B	Class III	Several staff had not completed required Behavioral Emergency Stabilization Training (BEST) as required. Three (3) of the thirteen (13) staff present during the Code Management failed to have the required training as outlined.	The actions taken to correct cited deficiency: On 2/1/19, the facility began Behavioral Emergency Stabilization Training (BEST) for all direct care staff through Evaluation Training and Research (ETR) with sessions to retrain all direct care staff who are not on leave status. Emphasis includes de-escalation and management of patients including effective/safe/appropriate restraint techniques. The immediate retraining focus was on the lodge where the incident occurred. As of the date of this report, 99% of employees hospital-wide have been retrained, excluding those on leave. The remaining employees are anticipated to complete training by 3/9/19. Those who are on leave status must receive competency-based BEST training and demonstrate competency prior to providing direct patient care. *Person Responsible:* Hospital Director Each new hire's competency or current employee's annual competency is verified by Education, Training & Research (ETR), to include online module in Pathlore, with notification to the Hospital Director, and documentation is filed in the Competency folder. New employees are required to have BEST training prior to providing direct care. ETR will audit Competency folders of 100% of current staff who were due to complete BEST in the previous month. ETR will notify the Hospital Director of bi-monthly audit results by the 1st and 15th of the month. Until the employee receives BEST training (30 days before/after their birth month) and demonstrates competency, direct supervisors ensure staff are removed from providing direct patient care. Person Responsible: Director of Evaluation, Training and Research & Hospital Director. The actual or expected completion date: 3/9/2019

Date of Visit	Licensing Regulation Number	Violation Class	Summary of Comments	Summary of Corrective Action Plan
2/15/2019	61-16 Section 1105.C	Class II	Staff failed to utilize the only approved physical hold that is taught in the BEST class for the facility.	The actions taken to correct cited deficiency: Effective February 2019, the restraint and seclusion policy was revised and approved to specifically prohibit restraining a patient in a face down or abdomen down position, laying on a patient, restraining a patient in any manner that may interfere with the patient's ability to breathe and/or compresses the chest, or use of any restraint in which a patient is intentionally taken to the floor from a standing/sitting position to a laying position. Medical and Nursing staff were in-serviced on the revised Restraint and Seclusion policy. This in-service included the requirement that there be a physician's order for any episode of restraint or seclusion. On 2/1/19, the facility began Behavioral Emergency Stabilization Training (BEST) for all direct care staff through Evaluation Training and Research (ETR) with sessions to retrain all direct care staff who are not on leave status. Emphasis includes de-escalation and management of patients including effective/safe/appropriate restraint techniques. The immediate retraining focus was on the lodge where the incident occurred. As of the date of this report (3/1/2019), 99% of employees hospital-wide have been retrained. The remaining employees are anticipated to complete training by 3/9/19. Those who are on leave status must receive competency-based BEST training and demonstrate competency prior to providing direct patient care. *Person Responsible:* Hospital Director, Medical Director, Director of Nursing The actions taken to prevent similar recurrences: Ongoing Monitoring Procedure for BEST training: Each new hire's competency or current employee's annual competency is verified by ETR, to include online module in Pathlore, with notification to the Hospital Director, and documentation is filed in the Competency folder. New employees are required to have BEST training prior to providing direct care. ETR will audit Competency folders of 100% of current staff who were due to complete BEST in the previous month.

Date of Visit	Licensing Regulation Number	Violation Class	Summary of Comments	Summary of Corrective Action Plan
2/15/2019	61-16 Section 1105.C	Class II	Staff failed to utilize the only approved physical hold that is taught in the BEST class for the facility.	(continued from page 3) ETR will notify the Hospital Director of bi-monthly audit results by the 1st and 15th of the month. Until the employee receives BEST training (30 days before/after their birth month) and demonstrates competency, direct supervisors ensure staff are removed from providing direct patient care. An Intervention Review Team was implemented 2/8/19. The team will review each incident of restraint by the close of business on the business day following the restraint using an established tool. The review will include findings and recommendations for corrective actions, if indicated, and will be forwarded to the Hospital Director and the Hospital Performance Improvement Committee. Data will be reviewed, assessed and analyzed on an ongoing basis by the Hospital Leadership. Person Responsible: Hospital Director. The actual or expected completion dates of the above actions. 3/9/19
8/24/2018	61-16	No violations	Food Service	No violations`
9/1/2017	61-16	No Violations	Complaint investigation - Attack on resident by a resident that led to hospitalization/death.	No violations

Date of Visit	Licensing Regulation Number	Violation Class	Summary of Comments	Summary of Corrective Action Plan
8/10/2017	61-16 Section 602.B2	Class II	1 of 9 staff records reviewed there was not documentation available to indicate a 2-step tuberculosis skin test (TST) was performed in a manner prescribed by the Centers for Disease Control (CDC).	Counseling provided to the nurse who did not follow policy. Employees receiving TST is given a card/form to let him/her know when to return for reading of the TST :& information reviewed with employee prior to entry into database
	61-16 Section 1902	Class III	2 oxygen tanks observed unsecured in the Unit 2 treatment room at Forensic Psychiatry.	Empty oxygen tanks removed by maintenance staff & properly secured on the date of the survey (08/10/2017). Staff informed of requirements to make sure tanks are secured. Added as an item to QUEST Rounds to check at least monthly.
1/23/2017 & 1/24/2017	61-16 Section 1600 Maintenance	Class II	220 Faison Drive (BPH Adult and C&A), BPH Forensic-7901 Farrow Rd (McClendon Building and Building 1). Various fire and life safety deficiencies found at each location (space heaters, rooms not properly labeled, exit signs not illuminated, etc.).	All deficiencies cited were corrected with a corrective action taken report provided to DHEC HFC/FLS and accepted.
8/31/2016	61-16	No violations	Complaint by family of unexplained bruises on patient. Family reported patient urinated on self due to slowness of staff to provide assistance.	No violations
5/1/2015	61-16	No violations	Complaint alleged a patient drank housekeeping cleaning fluid	No violations
3/19/2015	61-16 Section 1600 Maintenance	Class II	Fire door in Forensic glass not rated. Fire door on Unit 5 failed to complete a positive latch. Building 1 unproved appliances plugged into relocatable power strips.	Rated glass installed on fire door on 04/06/2015. Fire door latch repaired on 3/19/2015. Appliances disconnected from relocatable power strips on 3/19/2015
9/5/2014	61-16	No violations	Facility would not allow a foster parent to visit	No violations

South Carolina Department of Mental Health

Division of Inpatient Services

Immediate Jeopardy (IJ) Citations 2016-2019

Facility	Number of IJ's	Date of IJ	Summary of Citation
G. Werber Bryan Psychiatric Hospital	1	2/1/2019	Inappropriate use of restraint hold resulting in patient death. Cited in areas of: 482.12 - Governing Body; 482.13 - Patient Rights; 482.23 - Nursing Services; 421.12 - Governing Body; 482.12(a)(5) - Medical Staff Accountability; 482.12 (c) - Care of Patients; 482.13 - Patient Rights; 482.13 (c)(2) - Patient Rights: Care in a Safe Setting; 482.23 - Nursing Services; 482.23(b) - Staffing & Delivery of Care; 482.23(b)(3) - Supervision of Nursing Care. Citation cleared.
Morris Village Alcohol and Drug Addiction Facility	0	N/A	No Immediate Jeopardy citations – not Centers for Medicare and Medicaid Services (CMS) certified.
Patrick B. Harris Psychiatric Hospital	0	N/A	No Immediate Jeopardy citations.
C. M. Tucker Nursing Care Center - Roddey	1	8/16/2017	Cited in areas of: F 224 – physician order not carried out; F 225 – abuse because order not carried out; F 281 – services did not meet professional standards of quality as order not carried out; F 282 – failed to follow residents care plan; F 309 – failed to provide treatment related to order not carried out; F 490 failed to implement policies/procedures related to neglect, investigation and report of incidents due to failure to carry our order; F 514 medical records documentation not updated (resident's care plan, physician and nurses progress notes, failure to draw lab work). Citation cleared.
C. M. Tucker Nursing Care Center - Stone	0	N/A	No Immediate Jeopardy citations.
Richard M. Campbell Veteran's Nursing Home	0	N/A	No Immediate Jeopardy citations.
Veteran's Victory House	1	12/14/2018	Related to investigation of facility self-report on 16 incidents of abuse/neglect and injury of unknown origin: 12 resident-to-resident altercations, 2 injuries of unknown origin and 2 staff-to-resident verbal incidents. Cited in the areas of: F 607 - Develop/implement abuse policies; F 610 - Investigate/prevent/correct allegations; F 835 – Administration; F 837 - Governing body; and F 842 - resident records in which there was not enough information to determine the actual experience of the residents in 18 of 18 medical records reviewed for reportable incidents. Citation cleared.

South Carolina Department of Mental Health
Division of Inpatient Services
Patient Deaths Classified as Homicide by Coroner
1/1/ 2016 – 7/31/2019

Bryan Psychiatric Hospital (Adult, C&A, Forensics)	*Morris Village*	*Patrick B Harris Psychiatric Hospital*	*C.M. Tucker, Jr Nursing Care Facility*	*Veterans Victory House*	*Richard M. Campbell Veterans Nursing Home*
2 • 8/2017 • 1/2019	0	0	0	0	0