Official Accreditation Report

Burke Center
2001 South Medford Drive
Lufkin, TX 75901

Organization Identification Number: 1171

Unannounced Full Event: 7/13/2015 - 7/17/2015
Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.
Executive Summary

Program(s)               Survey Date(s)
Behavioral Health Care Accreditation 07/13/2015-07/17/2015

Behavioral Health Care Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

• Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.
Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.
Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

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Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

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Requirements for Improvement – Detail

Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.02.01.05

Standard Text: For organizations providing care, treatment, or services in non–24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual’s need for a medical history and physical examination. Note 1: This standard does not apply to foster care and therapeutic foster care. (See also CTS.02.04.01, EP 1) Note 2: This standard does not apply to organizations that provide physical examinations to all individuals served as a matter of policy or to comply with law and regulation.

Element(s) of Performance:

4. For organizations providing care, treatment, or services in non–24-hour settings: The organization determines whether the date of the individual’s most recent physical examination exceeds one year. If the date exceeds one year, a medical history and physical examination is performed. Note: Securing the individual’s agreement to receive a medical history and physical examination may be undertaken as a process, and the organization may incorporate this process into the individual’s plan for care, treatment, or services. If performing a medical history and physical examination is not within the organization’s scope of services, it may refer the individual to another organization. (Refer to CTS.03.01.07, EPs 1-3)

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
Observed in Individual Tracer at Angelina Mental Healthcare Center (Jasper Satellite) (1250 Marvin Hancock Drive, Jasper, TX) site. During intake, organization Physical Examination policy 7.0.11 states that the client’s physical health status is assessed. Information about current conditions is obtained. There is no documentation when the client’s last history & physical occurred.

Observed in Individual Tracer at Polk Mental Healthcare Center (1100 Ogletree Drive, Livingston, TX) site. While reviewing the case record of an OP client at the Livingston MHC, it was noted that the completed health assessment did not address the date of the client’s most recent physical examination.

Observed in Individual Tracer at Angelina Mental Healthcare Center (1522 West Frank Ave., Lufkin, TX) site. While reviewing the case record of an adult outpatient at the Angelina Mental Health Center in Lufkin, it was noted that the completed health assessment did not address the date of the client’s most recent physical examination.

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Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.02.01.06

Standard Text: For organizations providing residential care: The organization screens all individuals served to determine the individual’s need for a medical history and physical examination.
Note 1: This standard does not apply to foster care, therapeutic foster care, and emergency shelters. (See CTS.02.04.01, EP 1)
Note 2: This standard does not apply to organizations that provide physical examinations to all individuals served as a matter of policy or to comply with law and regulation.
Note 3: ‘Residential care’ includes residential settings, group home settings, and 24-hour therapeutic schools.

Element(s) of Performance:

5. For organizations providing residential care: The organization determines whether the date of the individual's most recent physical examination exceeds one year. If the date exceeds one year, a medical history and physical examination is performed.

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
Observation(s):

Score : Partial Compliance

Scoring Category : C

Observation(s):

Element(s) of Performance:

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.

Program: Behavioral Health Care Accreditation

Standard: CTS.03.01.01

Standard Text: The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served. Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

Chapter: Care, Treatment, and Services

Program: Behavioral Health Care Accreditation

Standard: CTS.03.01.01

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Element(s) of Performance:

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.

Score : Partial Compliance

Observation(s):
EP 1

Observed in Individual Tracer at Angelina Mental Healthcare Center (Jasper Satellite) (1250 Marvin Hancock Drive, Jasper, TX) site.

During record review and discussion with the therapist / case manager of an outpatient at the Jasper Mental Health Clinic, it was noted that the patient goals / objectives were not clearly individualized. The objective, "develop 2 coping skills", did not document any individualization until the first treatment review six months after entry into the program. Staff indicated that the organization is "going to 'Recovery Plans' " instead of "treatment plans" which more clearly reflect the client need and personal preference.

Observed in Individual Tracer at Angelina Mental Healthcare Center (Jasper Satellite) (1250 Marvin Hancock Drive, Jasper, TX) site.

During a second tracer at the Jasper Mental Health Center, the listed patient goals/ objectives were the same as the record previously reviewed ("develop 2 coping skills"). When the six month treatment review was documented, clear client preference / need was identified.

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Chapter: Environment of Care
Program: Behavioral Health Care Accreditation
Standard: EC.01.01.01

Standard Text: The organization plans activities that minimize risks in the environment of care. Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

Element(s) of Performance:

1. Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the environment of care, collect information on deficiencies, and disseminate summaries of actions and results.
   - Note 1: This information is disseminated to individuals with responsibility for the issues being addressed.
   - Note 2: Deficiencies include injuries, problems, or use errors.

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
EP 1

Observe in Individual Tracer at Shady Lake ALU (111 Lakewind, Lufkin, TX) site.
The risk assessment did not identify resident behaviors or patterns of behavior that can result in physical aggression towards other residents and staff at the residence, on the bus and at the Day Treatment Program at Burke Industries in the risk assessment.

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Chapter: Environment of Care
Program: Behavioral Health Care Accreditation
Standard: EC.02.01.01
Standard Text: The organization manages safety and security risks.

Element(s) of Performance:
1. The organization identifies safety and security risks associated with the environment of care that could affect individuals served, staff, and other people coming to the organization’s facilities. (See also EC.04.01.01, EP 14)
   Note 1: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.
   Note 2: Examples of risks associated with the physical environment include those that might contribute to suicide or acts of violence.

Scoring Category: A
Score: Insufficient Compliance

Observation(s):

EP 1

Observe in Building Tour at Lost Pines ALU (111 Lost Pines, Lufkin, TX) site.
One spray bottle of glass cleaner observed on the shelf with other cleaning products contained a cleaning product other than what was in the spray bottle when it was purchased. The word “cleaner” was marked on the bottle but there was no identification of the cleaning solution in the bottle at this time.
The organization conducts fire drills.

Element(s) of Performance:

5. The organization critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. (See also EC.02.03.01, EP 10)

Scoring Category: A
Score: Insufficient Compliance

Observation(s):

EP 5

Observed in Document Review at West Bay Group Home (No. 46 West Bay, Jasper, TX) site. Fire drill records were reviewed at the West Bay Group Home. Information about dates and times, including the time for evacuation is included. None of the review records documented any critique of staff response or other items included in drills.

Chapter: Human Resources Management
Program: Behavioral Health Care Accreditation
Standard: HRM.01.04.01
Standard Text: Staff are supervised effectively.

Element(s) of Performance:

1. The scope and depth of supervision that staff receive is based on their job duties and responsibilities; their experience with the care, treatment, or services they are providing; and the population(s) served.
Note: Refer to the Glossary for definition of staff.

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
EP 1

**Observed in Building Tour at Polk Mental Healthcare Center (1100 Ogletree Drive, Livingston, TX) site.**
While touring the Burke Industries facility in Livingston, one of the direct care staff members was queried about how emergency medical information would be accessed if a client experienced a medical emergency. Several staff members indicated that the information was online and easily available. Several unsuccessful attempts to locate the information lead to a phone call for assistance. In essence, staff appeared to be unaware of the process for obtaining such information in a crisis situation which highlights a need for appropriate inservice activity. It appears unclear if the difficult was site specific or system wide.

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**Chapter:** Human Resources Management  
**Program:** Behavioral Health Care Accreditation  
**Standard:** HRM.01.06.01  
**Standard Text:** Staff are competent to perform their job duties and responsibilities.

**Element(s) of Performance:**

2. Staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence. 
Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.

**Scoring Category:** A  
**Score:** Insufficient Compliance

**Observation(s):**

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**EP 2**

**Observed in HR File Review at ECI - Lufkin (2211 N. John Redditt Drive, Lufkin, TX) site.**
The HR files of the Speech Pathologist, OTR, COTA and Physical Therapists did not contain documentation of the evaluation of competencies specific to the scope of each of the specialty treatments conducted at the ECI. Information obtained from the Director of Human Resources was that peer reviews are regularly conducted through the team process but the process has not been documented. Each of these clinicians had timely performance evaluations but the job duties that were evaluated did not include the treatments rendered by the specialties.
Chapter: Infection Prevention and Control
Program: Behavioral Health Care Accreditation
Standard: IC.02.01.01
Standard Text: The organization implements its infection prevention and control plan.

Element(s) of Performance:

1. The organization implements its planned infection prevention and control activities and practices, including surveillance, to reduce the risk of infection.
   
   Note: The purpose of surveillance is to support the organization’s efforts to reduce the risk of spreading infections where individuals are served. Information from the surveillance activities is used within the organization to improve processes and outcomes related to infection prevention and control.

Scoring Category: C
Score: Partial Compliance

Observation(s):

EP 1

Observed in Building Tour at Burke Center (2001 S. Medford, Lufkin, TX) site.
The vinyl mat that was lying on top of the examination table that was used as a changing-table for clients at Burke Industries in Lufkin had a large worn area on the surface of it. The site director of Burke Industries said that a member of the client cleaning crew regularly cleaned the mat but the schedule of the cleaning was not documented so that a cleaning after each use could not be established.

Observed in Environment of Care Session at Burke Center (2001 S. Medford, Lufkin, TX) site.
While discussing housekeeping activities throughout the organization’s sundry service sites with members of the risk management committee, the issue of cleaning protocols were addressed. Specifically, how the cleaning agents used across the organization were selected and by whom? Some of the facilities are cleaned by Burke Industries workers while other sites are cleaned by house staff assigned to the respective group homes. However, there is not a systematic quality control process in place relative to the selection and purchasing of cleaning and disinfection agents.

Chapter: Leadership
Program: Behavioral Health Care Accreditation
Standard: LD.03.01.01
Standard Text: Leaders create and maintain a culture of safety and quality throughout the organization.
Element(s) of Performance:

5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Scoring Category : A
Score : Insufficient Compliance

EP 5

Observe in Building Tour at Shadylake ALU (111 Lakewind, Lufkin, TX) site. Specific reference is made to the management of resident/client behaviors that jeopardize the safety of other residents/clients and staff. Incident reports submitted in the past thirty days for one resident identified a total of six incidents that occurred while on the van or at the Day Treatment Program whereby other residents/clients and staff were struck. One incident report dated 6/18/2015 documented the van driver having to stop the van two times due to the disruptive behavior. One incident report documented an event on 6/9/2015 where one client in wheelchair was "slapped hard resulting in redness and bruising" and another event was reported on 6/29/2015 where a client in a wheelchair was "slapped hard on left side of shoulder." The last 30-days of progress notes at the residence documented three additional events where other residents in the residence were struck by this resident.

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Chapter: Leadership
Program: Behavioral Health Care Accreditation
Standard: LD.04.01.07

Standard Text: The organization has policies and procedures that guide and support care, treatment, or services.

Element(s) of Performance:

1. Leaders review and approve policies and procedures that guide and support care, treatment, or services.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):
EP 1

Observed in Document Review at Mental Health Emergency Center (105 Mayo Place, Lufkin, TX) site. The organization did not have an approved policy that addressed the routine application of restraint by the police who provide transportation to all patients to a higher level of care at MHEC.

Chapter: National Patient Safety Goals
Program: Behavioral Health Care Accreditation
Standard: NPSG.15.01.01

Standard Text: Identify individuals at risk for suicide.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.

Scoring Category: C
Score: Insufficient Compliance

Observation(s):
EP 1

Observed in Individual Tracer at Angelina Mental Healthcare Center (Jasper Satellite) (1250 Marvin Hancock Drive, Jasper, TX) site.
Review of an outpatient mental health record revealed that the suicide assessment reflected on the client’s current ideation but did not reflect a clinical assessment of overall risk. Factors which are considered to be “protective” are not identified. This 6 or 7 question procedure is completed during the intake and not repeated at other times. The patient did not see the psychiatrist until one month following admission to the program.

Observed in Individual Tracer at Burke Center (2001 S. Medford, Lufkin, TX) site.
While tracing the care of an active Crisis Stabilization Unit client, it was noted that the completed suicide risk assessment did not draw any specific conclusions about the relative risk of self-harm posed by the client despite the presence of several risk factors (i.e., suicidal thoughts, history of recent suicide gestures, homelessness and assertions of despair and hopelessness). The assessment was fairly comprehensive but lacked closure.

Observed in Individual Tracer at Mental Health Emergency Center (105 Mayo Place, Lufkin, TX) site.
While tracing the care of a second Crisis Stabilization Unit client, it was noted that the completed suicide risk assessment did not specifically address the relative risk of self-harm posed by the client despite several significant risk factors (i.e., recent suicide gesture, extreme impulsivity, recent reckless gambling (lost $39,000), assaulative and explosive behavioral outbursts). While a multitude of information was found in the case record, there was essentially a lack of closure.

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Element(s) of Performance:

1. According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

Scoring Category: C
Score: Insufficient Compliance

Observation(s):
EP 1

Observed in Individual Tracer at Pineland Group Home (707 S. Temple, Pineland, TX) site.
The medication administration record for one resident was not completed on 7/8/2015 and 7/11/2015.

Observed in Individual Tracer at Shadylake ALU (111 Lakewind, Lufkin, TX) site.
Documentation in the clinical record and information obtained from the Manager of the ALU indicated that the rate of one resident’s episodes of hyperactivity were occurring at a higher rate than what was reported in the monthly occurrence rate documented in the psychologists progress note in the clinical record. Information provided to the surveyor by the PI Coordinator indicated that the data was correct but the form used to report the data was not the recently updated form that would have presented the data with greater clarity.

Observed in Individual Tracer at Pineland Group Home (707 S. Temple, Pineland, TX) site.
Three residents who reside in three of the ICF residences had clinically ordered diets in their clinical records. The treatment plans (PCP’s) for these residents did not identify the diets and other documentation in the clinical record did not document implementation of the diets. Information provided to the surveyor by the PI Coordinator indicated that the menus that are established for the ICF’s are established to meet the dietary needs of all of the residents in the ICF’s whether a regular diet or special diet. Daily notes for all residents routinely record what each resident at eats at each meal. However, documentation specific to the resident’s progress in complying with the clinically ordered diet and/or understanding diet substitutions or restrictions was not documented in the clinical records of residents with clinically ordered diets.

Chapter: Waived Testing
Program: Behavioral Health Care Accreditation
Standard: WT.03.01.01
Standard Text: Staff performing waived tests are competent.
Element(s) of Performance:

4. Staff who perform waived testing that requires the use of an instrument have been trained on its use and operator maintenance. The training on the use and operator maintenance of an instrument for waived testing is documented.

Scoring Category: C
Score: Insufficient Compliance

5. Competency for waived testing is assessed using at least two of the following methods per staff per test:
   - Performance of a test on a blind specimen
   - Periodic observation of routine work by the supervisor or qualified designee
   - Monitoring of each user's quality control performance
   - Use of a written test specific to the test assessed

Scoring Category: A
Score: Insufficient Compliance

Observation(s):
Observed in Tracer Activities at Newton Group Home (700 McMahon, Newton, TX) site. Staff at the Newton House perform several glucometer tests / week for a patient. When queried about any manufacturer’s instructions about “Quality Control” testing, staff indicated that they have never done this; have never been trained to do this. In discussion with one of the RNs who does staff training, he indicated that to date, this has not been part of the training.

Observed in Tracer Activities at Oscar Berry ALU (Oscar Berry Road 776 N. FM 1194, Lufkin, TX) site. During tracer activity at the Oscar Berry ALU, staff was asked about waived testing (glucometer) for a specific resident. This resident does her own testing but staff stand by for any needed assistance or reminders. Staff reported that no “Quality Control” testing of the instrument had been done nor had staff been trained in this behavior.

Observed in Tracer Activities at Cherry ALU (2308 Cherry, Lufkin, TX) site. During discussions with group home staff at Cherry, it was learned that the staff who perform glucometer testing had not been doing any quality control or other maintenance issues on the glucometer; there had been no education on this. The manufacturer’s recommendations were that test controls be completed “periodically.”

EP 5

Observed in Tracer Activities at Newton Group Home (700 McMahon, Newton, TX) site. During an individual tracer at the Newton Group Home, a patient who requires Glucometer testing was reviewed. Staff report that competency was determined by a return demonstration. There was no second confirmatory assessment. Discussion with the RN who does some of the training revealed that return demonstration was the only method of competence. By the end of day 4 of the survey, all staff had completed their annual training for waived testing and competence assessed using two methods of assessment.

Observed in Tracer Activities at Oscar Berry ALU (Oscar Berry Road 776 N. FM 1194, Lufkin, TX) site. During a second tracer at the Oscar Berry Group Home, it was learned that a resident completes her own glucometer testing but staff stand by for directions or any needed assistance. This staff also reported that a return demonstration was the method of assessing staff competence.

Observed in Tracer Activities at Cherry ALU (2308 Cherry, Lufkin, TX) site. During staff discussions at the Cherry ALU, it was learned that competency was assessed by one method. The organization began training staff on all required issues during the survey.
Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

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Opportunities for Improvement – Detail

Chapter: Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: CTS.03.01.03
Standard Text: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Element(s) of Performance:
4. The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual's needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):
EP4
Observed in Individual Tracer at Shadylake ALU (111 Lakewind, Lufkin, TX) site.
A review of monthly data associated with the outcome of the implementation of a non-contingent behavior plan developed for one resident indicated a need to re-evaluate the plan due to a lack of change and the risk associated with the behaviors to other residents and staff.

Chapter: Environment of Care
Program: Behavioral Health Care Accreditation
Standard: EC.02.01.01
Standard Text: The organization manages safety and security risks.

Element(s) of Performance:
3. The organization takes action to minimize identified safety and security risks associated with the physical environment.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):
EP3
Observed in Tracer Activities at West Bay Group Home (No. 46 West Bay, Jasper, TX) site.
During the building tour and review of environmental records of the West Bay group home, it was noted that
evening and weekend staffing is one staff for six intellectually disabled residents. One of the residents was
severely disabled and required much assistance in Activities of Daily Living; this resident was wheelchair
bound. Review of the fire drill logs revealed a weekend drill in which it took more than 5 minutes to evacuate
the premises. Staff report that several neighbors (non agency employees) are very willing to assist should an
emergency occur. The organization had preformed an “Evacuation Assessment” on all the residents of the
home; scores were mathematically analyzed into an average for the entire home. The organization had made
environmental changes (sprinkled building, self-closing doors, fire resistant furnishings) to mitigate overall
“home” risk. The organization had not developed an action plan for the specific patient with his needs and
capabilities considered.

Chapter: Environment of Care
Program: Behavioral Health Care Accreditation
Standard: EC.02.06.01
Standard Text: The organization establishes and maintains a safe, functional environment.

Element(s) of Performance:
1. Interior spaces meet the needs of the individuals
served for safety and suitability for the care,
treatment, or services provided.

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):
EP1
Observed in Building Tour at Kirbyville/Newton NDI (910 South Margaret, Kirbyville, TX) site.
During the building tour of the Kirbyville/Newton "dayhab" or workshop program, it was noted that many
ceiling tiles were either badly stained or had tears which disturbed the integrity of the tiles. The program
manager indicated that she had sent a work request for this but this could not be located. She entered and
sent a new request for repair during the surveyor visit. All damaged or stained tiles had been replaced by
day 4 of survey.

Chapter: Environment of Care
Program: Behavioral Health Care Accreditation
Standard: EC.03.01.01
Standard Text: Staff are familiar with their roles and responsibilities relative to the environment of
care.
Element(s) of Performance:

3. Staff can describe or demonstrate how to report environment of care risks.

Scoring Category: C
Score: Satisfactory Compliance

Observation(s):

EP3
Observed in Building Tour at Kirbyville /Newton NDI (910 South Margaret,Kirbyville,TX) site. During the building tour of the Kirbyville/Newton work/rehab program, a prominent button marked "emergency" was noticed on several walls. None of the staff could identify what this button did. Later during the tour, a staff person indicated that she contacted the facilities person who reported that this button was a buzzer which, if activated, would signal that someone needed some assistance immediately. None of the staff have been educated or oriented to this item.

Element(s) of Performance:

3. The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following:
   - U,u
   - IU
   - Q.D., QD, q.d., qd
   - Q.O.D., QOD, q.o.d, qod
   - Trailing zero (X.0 mg)
   - Lack of leading zero (.X mg)
   - MS
   - MSO4
   - MgSO4

Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

Scoring Category: C
Score: Satisfactory Compliance
Observation(s):

EP3
Observed in Individual Tracer at Kirbyville Group Home (703 West Martin Luther King, Kirbyville, TX) site. During record review of Kirbyville Group Home residents, it was noted that in one of two records the unapproved abbreviation, “QD”, was used by the physician in indicating medications to be ordered / given to the patient.

Element(s) of Performance:

13. For organizations that prescribe medications:
The organization implements its policies for medication orders.

Score:
Satisfactory Compliance

Observation(s):

EP13
Observed in Individual Tracer at Shadylake ALU (111 Lakewind, Lufkin, TX) site. Medication orders in one clinical record for one resident for seizures dated 5/8/2015 and 11/11/2015 were written "continue all medications."
Element(s) of Performance:

1. Obtain and/or update information on the medications the individual served is currently taking. This information is documented in a list or other format that is useful to those who manage medications.
   
   Note 1: The organization obtains the individual's medication information during the first contact. The information is updated when the individual's medications change.
   
   Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.
   
   Note 3: It is often difficult to obtain complete information on current medications from the individual served. A good faith effort to obtain this information from the individual and/or other sources will be considered as meeting the intent of the EP.

Scoring Category: C  
Score: Satisfactory Compliance

Observation(s):

EP1  
Observed in Individual Tracer at Angelina Mental Healthcare Center (Jasper Satellite) (1250 Marvin Hancock Drive, Jasper, TX) site.

A the record of a patient admitted to the Jasper Mental Health Clinic was reviewed. Organization policy is that medications are listed. During intake, the medications were cited as "for blood pressure, discomfort, and stomach problems." (The intake process is not a face-to-face one; electronically, the staff and patient talk with each other) The patient was seen by her therapist / case manager one week later; medications were not referenced. One month later when the patient was seen by the psychiatrist, the medicines listed were "for HTN, fibromyalgia and reflux". No names, dosing, frequency were listed. Five or six weeks later, the client was seen by the RN who completed a listing of medications the client was taking, dosing and reasons for taking.

Chapter: Record of Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: RC.01.01.01
Standard Text: The organization maintains complete and accurate clinical/case records.
Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation.

Scoring Category:  C
Score:  Satisfactory Compliance

Observation(s):

Program: Behavioral Health Care Accreditation
Standard: RC.02.03.07
Standard Text: Qualified staff receive and record verbal orders. Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.

Element(s) of Performance:

5. The clinical/case record contains the information needed to support the diagnosis or condition of the individual served.

Scoring Category:  C
Score:  Satisfactory Compliance

Observation(s):

EP5
Observed in Individual Tracer at Newton Group Home (700 McMahon, Newton, TX) site. A resident of the Newton Group Home is to have Glucometer readings recorded “3 times/week in the mornings and 1 time a week in the evenings.” Review of the record revealed an entry on 6/30/15; the next entry was 7/6/15; two morning readings were missing. In discussion with staff it was finally discovered that the resident was on pass/leave from 7/2 until 7/5/15. There was no documentation on the “readings” form that the resident was not in the home.

EP11
Observed in Individual Tracer at Angelina Mental Healthcare Center (1522 West Frank Ave., Lufkin, TX) site. The policy "2.0 Restraint" requires that the ordering physician must personally sign, time and date telephone orders within 2-days of the time the order was originally issued. An order for restraint on 11/18/2014 was signed but not timed. A restraint order on 1/21/2015 was signed but not dated or timed and a restraint order on 10/7/2014 was signed but not dated or timed.

Chapter: Record of Care, Treatment, and Services
Program: Behavioral Health Care Accreditation
Standard: RC.02.03.07
Standard Text: Qualified staff receive and record verbal orders. Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.

Element(s) of Performance:

11. All entries in the clinical/case record are dated.

Scoring Category:  C
Score:  Satisfactory Compliance

Observation(s):
EP4
Observed in Individual Tracer at Shadylake ALU (111 Lakewind, Lufkin, TX) site.
Documentation in one clinical record noted that on 5/11/2015 the nurse notified the resident's
provider of a medication error that occurred on 5/11/2015. The documentation was incomplete
because the provider's response to the notification was left blank. The "order/treatment plan"
section of the form was not completed. An undated signature was affixed to the document but
authentication was not dated.
Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0