Approved: February 16, 2007
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The joint meeting of the Senate Health Care Strategies and the House Health and Human Services Committee was called to order by Chairman Susan Wagle at 1:30 P.M. on January 30, 2007 in Room 231-N of the Capitol.

Committee members absent: Senator Mark Gilstrap- excused

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms, Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Mr. Roderick Bremby, Secretary, Kansas Department of Health and Environment
Mr. Don Jordan, Acting Secretary, Kansas Department of Social and Rehabilitation Services

Others in attendance: Please see attached guest list

Overview of Services Provided and Population Served at Larned State Hospital

Upon calling the meeting to order, Chairperson Wagle called on Ms. Emalene Correll , Kansas Legislative Research Department, to give background on Larned State Hospital. Ms. Correll stated that the hospital serves three distinct populations that are in need of mental health services:

1) The traditional role of providing psychiatric evaluation and treatment for persons who require inpatient care;

2) The population admitted under the Kansas forensic laws; and,

3) Convicted sexual predators who are deemed dangerous to the community but who have completed a prison term.

She explained:

1) The procedure of admission to the hospital once the patient has been screened by the community mental health centers that serve the hospital's 59 western county catchment areas that include 28% of the state's population.

2) The State Security Program which delivers specialized mental health services to persons committed by the district courts and persons transferred from the Department of Corrections in addition to non-forensic patients having severe behavioral problems and transferred from other hospitals.

3) The Sexual Predator Treatment and Transition Program for convicted sex offenders who have completed their prison sentences and who have been civilly committed by the courts for inpatient treatment under the Kansas Sexual Predator Act because they present a continuing danger to the community.

And lastly, she stated that Larned State Hospital provides support services for the Larned Juvenile Correctional Facility, the Larned Correctional Mental Health Facility, and the Kansas Soldiers Home at Fort Dodge. A copy of her testimony is (Attachment 1) attached hereto and incorporated into the Minutes by reference.

The Chair then called upon Mr. Roderick Bremby, Secretary, Kansas Department of Health and Environment who stated that KDHE, pursuant to the social Security Act as set forth in a contract between CMS and KDHE known as the 1864 Agreement, serves as the survey agent for CMS for hospitals which

participate in Medicare. He went on to say that this agreement requires KDHE to use only federally recognized surveyors and to follow all CMS survey policies, procedures, and interpretations.

Secretary Bremby then offered a time line beginning May, 2006, after complaints were received, through January 24, 2007, where a formal letter approved a plan of correction that was provided the hospital. He completed his testimony by stating that unless there were additional complaints or CMS directs another visit sooner, KDHE will follow normal protocol and revisit the hospital sometime in the next few months to evaluate correction of the cited violations and general compliance with federal and state regulation. A copy of his testimony is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

The Chair thanked Secretary Bremby and called upon Mr. Don Jordan, Acting Secretary, Kansas Department of Social and Rehabilitation Services, who assured the Committees that all of the findings in the survey will be corrected or mitigated. He stated that Larned State Hospital had already made corrections to many of the findings, and has changed or instituted new policies that will improve the oversight of the housekeeping and maintenance functions. A copy of his testimony is (Attachment 3) attached hereto and incorporated into the Minutes by reference.

The Chair then announced that handouts were available regarding the Larned State Hospital's "Statement of Deficiencies and Plan of Correction" including citations, patient rights, findings of KDHE's investigation, the surveyors reports, and a how correction has been or will be accomplished. A copy of this is (Attachment 4) attached hereto and incorporated into the Minutes by reference.

Chairperson Wagle thanked all of the conferees and then asked for questions or comments from both Committees. Questions came from Senators Journey, Palmer, Schmidt, Jordan and Wagle, Representatives Landwehr, Colyer, Schroeder, Ward, Mast, Neighbor including:

- were all buildings investigated and is one of the surveyors in attendance today?
- what complaints came from which program, any complaints prior to May, 06 and what was happening between May, 2006 and September, 2006 (4 months)?
- was the legislature notified of this problem and when?
- could this inhibit the recovery of these patients affected?
- are there Medicaid patients at Larned?
- what is normal protocol for inspections, what is the depth of a 3-year survey, are family members interviewed, and are they random or scheduled?
- regarding the enforcement issue, what does this entail?
- is the JCAHO survey public record, are copies available, and why are they unannounced?
- ex. If someone had special needs that were not being met, who would they report this to?
- as these are "regular" maintenance problems, has there been a turnover in management that the legislature is not aware of?
- 10% of the problems were in the children's area, what were these issues and were they in a clean, safe environment?
- concerns with unlocked files (1,000 records) even though limited access and was this the only place you checked?

As it was going on 2:30, the time set for Senate Session, all Senators left for session, but the House Committee remained with questions continuing to come from Representatives, Colyer, Rhoades, Mast, Landwehr, and Tietze including clarification of where all complaints came from and did all of this happen in the last three years?

Adjournment

As there were no further questions or comments and no further business, Representative Landwehr announced that the meeting was adjourned. The time was 2:55 p.m.

The next meeting is scheduled for February 5, 2007.

January 30, 2007

NAME	REPRESENTING
Mark E. Schutter PhD	Larned State Hospital/SRS
Michelle Peterson	Capitol Strategies
Ray Dalton	SRS
[illegible] Jordan	SRS
Rod Bremby	KDHE
[illegible]	KDHE
Yvonne Anderson	KDHE
PAT EAKES	KCDC
MATT Reams	Rep. Dom Hill
Roger Haden	KDOC
[illegible] Austin	KHA
[illegible] Holmes	KS HOUSE OF REPS
Richard Sommers	[illegible] Assoc.
Mary Ellen Conlee	Via Christi Health System
Crystal Yoning	Topeka Independent living
Kim Detrich	" Topeka Independent living "
Dan Morin	K Medical Society
[illegible] Henderson	PAWNEE COUNTY ECONOMIC DEV. COMM.
STEVE KEARNEY	PAWNEE COUNTY ECO DEV COMM.
Amy Campbell	KMHC

in att 34

SENATE HEALTH CARE STRATEGIES COMMITTEE
GUEST LIST

DATE: Tuesday, January 30, 2007

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

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January 31, 2007

To: Senate Committee on Health Care Strategies
House Committee on Health and Human Services

From: Emalene Correll, Research Associate
Susan Kannarr, Senior Fiscal Analyst

Re: Background on Larned State Hospital

Populations Served

Unlike the other state mental health institutions, Larned State Hospital serves three distinct populations that are in need of mental health services. One is the traditional role of providing psychiatric evaluation and treatment for persons who require inpatient care. A second is the population admitted under the Kansas forensic laws, and a third are convicted sexual predators who are deemed dangerous to the community but who have completed a prison term.

Psychiatric Service

Larned State Hospital provides psychiatric services and treatment for adults, adolescents, and children who require inpatient mental health evaluation and treatment. Patients are referred to Larned after being screened by the community mental health centers that serve the hospital's 59 western county catchment area that includes 28 percent of the state's population. On admission, an evaluation is conducted, and an individualized treatment plan is developed for each patient. Patient care is divided into subprograms. The adult psychiatric subprogram is directed to persons age 18 and older. The youth services subprogram is directed to children age 5 through 12 and to adolescents 13 through 18. There is also an eight-bed Social Detoxification Service Unit that provides up to 72 hours of care for individuals referred either by law enforcement or a district court.

Larned has a psychiatric treatment capacity of 99 beds.

The average daily census in FY 2006 for psychiatric services was 82, an increase over the average daily census of 72 in FY 2005, but still continuing an overall downward trend. Looking back to FY 1999, the average daily census was 110, 112 in 2000, 116 in 2001, 102 in 2002, 91 in 2003, and 92 in 2004. The decrease is attributed to Mental Health Reform under which community mental health centers act as gatekeepers and determine who is appropriate for admission to a state institution and the change in treatment philosophy that embodies moving away from long-term inpatient treatment toward community services, with beds available for crisis stabilization. The agency estimates the average daily census will remain at 82 in FY 2007 and 2008.

Senate Health Care Strategies Committee
Date: January 30, 2007
Attachment 1

In FY 2006, the average length of stay for adult psychiatric patients was 27 days, for adolescents, 21days, and for children, 23 days. For the first part of FY 2007 (July 1 to December 31,2006), the average length of stay was 31 days for adult psychiatric patients; 23 for adolescent patients; and 39 for children.

State Security Hospital

The State Security Program serves both male and female adults who are admitted under the state's forensic commitment laws. The program serves the entire state and provides a secure setting for criminal patients during evaluation and treatment. The program delivers specialized mental health services to persons committed by the district courts and persons transferred from the Department of Corrections. In addition, non-forensic patients having severe behavioral problems are transferred from other hospitals.

The State Security Program has 200 beds on seven separate units housed in the Isaac Ray Building. The units are:

- Assessment and Treatment: (60 beds for males)

  These units provide pre- and post-trial assessments for the courts; treatment related to forensic issues such as competency restoration and treatment in lieu of confinement in a correctional institution; and acute stabilization of persons referred by the Department of Corrections. A few patients are ordered by a court to complete their sentences at the State Security Hospital.

- Evaluation Unit: (30 beds for males)

  The primary role of this unit is to provide competency, mental state, pre-sentence, and sexual predator evaluations. Due to the nature of the unit, most patients do not receive psychotropic medication. (With the recent addition of 90 Department of Corrections' beds, some patients receive treatment for competency restoration which has reduced the number of beds available for evaluation.)

- Security Behavior Unit: (20 beds for males)

  This unit serves the civilly committed patients associated with the State Security Program and receives three different types of patients: chronically mentally ill patients who are dangerous to themselves or others; intermediate term patients who are referred from another treatment setting for stabilization; and short-term "hold order" patients who have been referred by reason of being threatening and dangerous to others. Admission to the unit is by administrative transfer.

- Isaac Ray North 3: (expanded to 30 beds during FY 2006)

  The unit serves female patients in need of pre- and post-trial assessments for the courts, treatment related to forensic issues such as competency restoration and treatment in lieu of confinement, and stabilization of patients referred by the Department of Corrections. Patients on the unit vary from those with severe and persistent mental illness to those displaying anti-social acting out behavior.

- <u>Residential Treatment Units:</u> (60 beds for males)

  These two units, which were opened in FY 2006 as part of the expansion of services for Department of Corrections' inmates, are residential living units serving Department of Corrections' prisoners preparing for reentry into the community. Vocational and pro-social training geared toward preparing inmates for reentry into society is provided.

In FY 2006, the average daily census for the State Security Program was 108. Estimates for FY 2007 and 2008 are 168 and 169, respectively. The average daily census estimates for FY 2007 and 2008 reflect the additional 90 beds opened between April and June of 2006 to serve Department of Corrections' inmates. The trend in the average daily census for the Security Program reflects decreases from 171 in FY 1999 and 170 in 2000 to 136 in 2001, 110 in 2002, 111 in 2004, and 112 in 2005.

The average length of stay for the State Security Program in FY 2006 was 102 days and for the first half of FY 2007 was 116 days.

Sexual Predator Treatment and Transition Program

This program provides treatment for convicted sex offenders who have completed their prison sentences and who have been civilly committed by the courts for inpatient treatment under the Kansas Sexual Predator Act because they present a continuing danger to the community. The Sexual Predator Transition House Program (phases 6 and 7 of the treatment program) is located on the Osawatomie State Hospital grounds. In FY 2007 and 2008, the program is to be funded through the Larned State Hospital budget rather than through the Department of Social and Rehabilitation Services budget.

The Sexual Predator Treatment Program was established in 1994 with enactment of the Sexual Predator Act (KSA 59-29A01 *et seq.*) In FY 2003, the program was incorporated as one of the three treatment programs at Larned State Hospital. Since 1994, 179 persons have been referred to the Sexual Predator Treatment Program. Of the 179, 154 are assigned to one of the seven program phases at either Osawatomie or Larned State Hospital. More than two-thirds of the patients have been assigned to the program within the past four years.

The current bed capacity of the program is 152 beds. A building is being remodeled to accommodate 65 patients in two units. The new units are scheduled to be ready for occupancy in FY 2007.

As of August 31, 2006, the program census was 151 on the Larned Hospital site. The census is expected to increase for the foreseeable future.

The average length of stay in FY 2006 was 619 days and for the first half of FY 2007, 1,025 days.

The Transitional House Services located at Osawatomie State Hospital serves clients deemed ready for transition from the Larned State Hospital Sexual Predator Treatment Program. The transitional services include shelter, monetary assistance, and transportation. Clients also are

encouraged to utilize community resources for services such as psychiatric treatment and vocational training.

Other Programs

Larned State Hospital provides support services for the Larned Juvenile Correctional Facility, the Larned Correctional Mental Health Facility, and the Kansas Soldiers Home at Fort Dodge.

Contact Emalene Correll or Susan Kannarr in the Legislative Research Department if you have questions or need additional information.

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DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony Provided To
Senate Health Care Strategies Committee
And Health and Human Services Committee
Regarding Larned Hospital

Presented by
Roderick L. Bremby, Secretary
Kansas Department of Health and Environment
January 30, 2007

Chairman Wagle and members of the Committee, I appreciate the opportunity to provide comments about the recent Larned State Hospital inspection. Larned State Hospital is owned and operated by the Kansas Department of Social and Rehabilitation Services. It consists of 6 buildings. The entire hospital is licensed as a Special Hospital pursuant to K.S.A. 65-425, and the entire hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations. Two of the 6 buildings are also certified to participate in the Medicare program.

KDHE, pursuant to the Social Security Act as set forth in a contract between CMS and KDHE known as the 1864 Agreement, serves as the survey agent for CMS for hospitals which participate in Medicare. This agreement requires KDHE to use only federally recognized surveyors and to follow all CMS survey policies, procedures and interpretations.

- May, 2006 - a number of complaints regarding physical environment, sanitation, maintenance and patient rights were received by KDHE and the health facilities hotline maintained by the Kansas Department on Aging. Complaints were filed by patients and family members. Because the hospital is certified these complaints were sent to CMS for a determination on whether to investigate.

- September 29, 2006 - CMS directed KDHE to investigate conditions at the hospital and requested the investigation commence within 45 days. CMS also specifically directed KDHE to determine if the hospital itself had received complaints regarding physical environment and what the hospital did or how they had responded to the complaints.

Senate Health Care Strategies Committee
Date: January 30, 2007
Attachment 2

- August 31, 2006 - The Joint Commission on Accreditation of Healthcare Organizations completed an inspection of the hospital and found the hospital was not in full compliance, placing the hospital on Conditional status.

- October 30, 2006 - KDHE assigned surveyor with psychiatric experience entered the hospital to begin the investigation.

- November 1, 2006 – Another surveyor arrived and the inspection continued through November 2 (The following week of November 6 was scheduled in-service training). On Monday November 13 the State Survey Manager joined the other two surveyors and these 3 completed the inspection November 16, exiting the hospital. Thirty-five staff were interviewed, 22 patients interviewed and facility policies, complaint records, and similar type documents evaluated.

The inspection identified numerous violations of both federal and state regulation. The general areas were physical environment and patient rights.

- On December 11, 2006 - the results of the inspection were emailed to the hospital with a request to provide a plan of correction for each violation.

- On December 21, 2006 (received December 22) the hospital sent a letter advising us the plan of correction would be emailed. The plan was received by email the same day December 21.

- January 11, 2007 - The hospital was advised by phone on January 11 of the results of our review of the plan of correction.

- On January 24, 2007 - a formal letter approving the plan was provided the hospital.

CMS has reviewed the inspection report and determined a plan of correction is the only remedy required for continued Medicare participation. KDHE has also determined that at this time a plan of correction is the appropriate remedy for continued licensing.

Unless there are additional complaints or CMS directs another visit sooner, KDHE will follow normal protocol and revisit the hospital sometime in the next few months to evaluate correction of the cited violations and general compliance with federal and state regulation.

Kansas Department of

Social and Rehabilitation Services

Don Jordan, Acting Secretary

Senate Health Care Strategies Committee
January 30, 2007

Corrective Action Report on LSH Inspection

Health Care Policy
Don Jordan, Acting Secretary
(785) 296- 3271

For additional information contact:
Public and Governmental Services Division
Kyle Kessler, Deputy Secretary

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Senate Health Care Strategies Committee
Date: January 30, 2007
Attachment 3

Kansas Department of Social and Rehabilitation Services
Don Jordan, Acting Secretary

Senate Health Care Strategies Committee
January 30, 2007

Corrective Action Report on LSH Inspection

Chairperson Wagle and members of the Committee, I am Don Jordan, Acting Secretary of the Kansas Department of Social and Rehabilitation Services. Thank you for the opportunity to appear before you today to provide information on the Kansas Department of Health and Environment survey of Larned State Hospital. Larned State Hospital was established in 1914 and has been providing Mental Health services to Kansans ever since. We are committed to providing the highest quality care in safe and humane facilities. The Department welcomes oversight visits, audits, or surveys from outside entities, as it provides us with a fresh set of eyes to review our programs. We are then able to use these findings from the surveys to help us improve the services to our customers.

I can assure you that all of the findings in the survey will be corrected or mitigated. Larned State Hospital has already made corrections to many of the findings, and has changed or instituted new policies that will improve the oversight of the housekeeping and maintenance functions. I am confident that the Superintendent and employees at Larned State Hospital are dedicated to providing high quality care to the patients at Larned.

I would be happy to answer any questions you might have.

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING ______ B. WING ______	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #17063, #17066, #17414, #18240, #18241, #18248, #18249, # 18258, #18260, and #18262 investigated in the State Licensed buildings including Dillon, Meyer, Jung, and Isaac Ray. The statement of deficiencies was e-mailed to the hospital on 12/11/06. ca	H 000	Double click in this areas to document your plan of correction and completion date.	
H 009	KAR 28-34-3b., (a) Patient Rights The governing body shall ensure that the facility establishes policies and procedures which support the rights of all inpatients and outpatients. This RULE: is not met as evidenced by: The facility identified a census of 319 patients. Based on observation, staff and resident interview, the facility failed to provide residents their right to respectful care, failed to provide humane treatment regarding the temperature of water for showers and handwashing, and failed to timely afford patients their right to religious services after request and approval. Findings included: - Tours of the multiple State licensed patient areas, between 10/30/06 and 11/15/06, revealed all licensed patient areas with multiple unsafe equipment, numerous areas with inhumane water temperatures for showers and handwashing, and lack of availability for religious services after approval, a sampling of which included the following: Review of the resident rights provided to them at the time of admission in the Patient's/Family	H 009		

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

Senate Health Care Strategies Committee
Date: January 30, 2007
Attachment 4

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: M073001	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/16/2006
NAME OF PROVIDER OR SUPPLIER: **LARNED STATE HOSPITAL**	STREET ADDRESS, CITY, STATE, ZIP CODE: **ROUTE #3 BOX 89 LARNED, KS 67550**		

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H 009	Continued From Page 1 Handbook informed residents of the right to "...12. To be treated humanely, consistent with generally accepted ethics and practices..." Tours of the buildings revealed the following sampling of unsafe, disrespectful, and inhumane living conditions: Jung Building: (1) The cement area around the volleyball and basketball courts contained large drop off areas around the perimeter between the cement and the ground varying between 1 &1/2 inches to 3 & 1/2 inches, creating a trip hazard. (2) A picnic table in the courtyard lacked a bench seat on 1 side, on the other it had exposed splintery wood. (3) A park bench with splintery wood slats. (4) An electric box in the Cafeteria with a lock on it that could be taken off and access to the box freely obtained. (5) One Janitor closet with a flushing rim sink, without any personal protective equipment available. This room also contained an electrical outlet very close to this water source, without the proper protection for the outlet. (6) A resident restroom with water temperatures at the handwashing sink of 62 degrees Fahrenheit. (7) The Living Room area contained a table with a large chunk out of the table, 6 inches wide by 6 inches long, covered over with clear tape. (8) Several Multi-plug electrical outlets, belonging	H 009	H 009 Jung Bldg 1 (page 2): How correction has been, or will be, accomplished: LSH Engineering Dept issued a job ticket to Grounds Dept. Dirt was used to fill in the drop off area. Work was completed on or about November 17, 2006. How others potentially affected by the same deficiency have been, or will be, identified: Notification will be sent to the Grounds Dept Supervisor to instruct Grounds Dept personnel to look for possible trip hazards as they conduct their day-to-day duties. Corrections will be made as identified. Processes that have been, or will be, established to ensure the deficiency does not reoccur: Observation of the court areas will be a component of the monthly safety tour check-list for staff to use during their monthly inspections. How performance will be monitored to ensure improvement is sustained: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Physical Plant Supervisor Specialist Refer to attachment 2 of 53 for deficiencies 2-8	

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING ___ B. WING ___	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H 009	Continued From Page 2	H 009		

to individual residents, requiring any other resident that needed electrical access to recharge equipment required the approval of the resident who owned the multi plug outlet to approve their use or the residents had to do without recharging their batteries. No electrical outlets were available in the resident's individual rooms on this unit. Resident #97 approached resident #2, on 10/31/06 at 8:30 pm. and asked to use their multi-plug electrical outlet to plug in their battery operated razor. Resident #2 explained the multi-plug outlet belonged to them, and since they plugged this in first, no other residents could use it without obtaining their permission. They further stated the entire unit contained only 2 or 3 individual electrical outlets for resident use, and all of those were by the staff station.

(9) A wooden chair with a split arm rest, splintery.

(10) Counter with formica missing creating sharp edges.

Dillon Building

(1) The wood shop restroom revealed a 72 degree Fahrenheit water temperature at the handwashing sink. Water temperature at this sink only reached 77 degrees Fahrenheit (F) after several minutes of running.

(2) Multiple wood tables with formica missing, causing splintery areas and uncleanable surfaces.

(3) A loose circle in the middle of the floor in the Activity Area of the Basement, which created a trip hazard.

H 009 Jung Bldg 9 (page 3):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept on December 14, 2006. Spare furniture has been refinished and will replace the damaged furniture while it is being repaired. Completion date on or before January 20, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H 009	Continued From Page 3 (4) Multiple nurses stations with gouged areas in the formica causing sharp edges. (5) Multiple wooden chairs with gouges in the wood, causing splintery areas. Meyer Building (1) The exit foyer contained a door with splintery edges, 1 foot long by 1/4 inch wide. (2) A shower room on Meyer East with hot water reaching 129 degrees F. (3) Multiple tables in patient common areas with splintery wood exposed in varying sizes. (4) Multiple sinks and showers in central bathrooms with water temperatures between 124 degrees F and 129 degrees F. (5) Another central restroom with a hot water temperature of 131 degrees Fahrenheit in the handwashing sink, with steam rising when running the water. Staff member V, on 11/1/06 at 8:30 am., verified facility residents routinely used this sink. (6) A handwashing sink in the cleaning room with a water temperature of 135 degrees F. Isaac Ray Building (1) A shower room in the East 2 unit with 4 showers that reached a maximum water temperature of 75 degrees Fahrenheit. (2) Multiple shower rooms with water temperatures in both the showers and the sinks between 73 degrees Fahrenheit and 90 degrees	H 009	H 009 Dillon Bldg 4 (page 4): How correction has been, or will be, accomplished: LSH Engineering Dept issued a job ticket to the Carpentry Dept staff on December 14, 2006 to repair the nursing stations. Completion date on or before January 20, 2007. How others potentially affected by the same deficiency have been, or will be, identified: Notification will be sent to Program Directors to instruct line level supervisors to identify damaged nursing stations on other patient units. Corrections will be made as identified. Processes that have been, or will be, established to ensure the deficiency does not reoccur: This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections. How performance will be monitored to ensure improvement is sustained: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Physical Plant Supervisor Specialist	

Bureau of Health Facilities

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LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

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H 009	Continued From Page 4 Fahrenheit, requiring the button to be pushed several times to get the water temperature to this level. (3) Book case shelves with formica missing exposing splintery wood. Review of resident Grievances, on 10/30/06, revealed multiple resident grievances, from most of the facility's buildings, regarding cold water temperatures in the shower and bathroom facilities. - Review of the Sexual Predator Treatment Program Leadership Meeting, dated 5/4/06, revealed the team discussed the Intensive Treatment Unit (ITU) being allowed to be involved in others' services, and the team determined they would be separate. Other issues discussed during this meeting involved residents asked if the staff could use the van for transport of the residents to some of the activities, such as Gym and Swim or to Activities at Isaac Ray. The team approved this if it could be worked out and if the van was secure. Review of the Activity schedule for the residents in the ITU revealed the residents had free time for most of the day on Saturdays and Sundays. Further review of the activity schedule failed to reveal regularly scheduled religious services for these residents. Interview with Facility staff member T, on 11/15/06 at 11:45 am., revealed the ITU needed to be Isolated from the rest of the programs, and at this time there were no Swim or Gym times available. They further stated they were trying to get step 9 or 10 residents to go to the pool, but had not been able to do so. They further stated they couldn't go on weekends because they were	H 009	H 009 Isaac Ray Bldg 3 (page 5): How correction has been, or will be, accomplished: LSH Engineering Dept issued a job ticket to the Carpentry Dept staff on December 14, 2006 to repair the book case shelves. Completion date on or before January 20, 2007. How others potentially affected by the same deficiency have been, or will be, identified: Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified. Processes that have been, or will be, established to ensure the deficiency does not reoccur: This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections. How performance will be monitored to ensure improvement is sustained: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Physical Plant Supervisor Specialist	

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H 009	Continued From Page 5	H 009		

filled up with Youth Groups, and they didn't go in the evenings. They further stated they had problems scheduling the buses to transport the residents.

Interview with Administrative staff member #EE, on 11/15/06 at 8:35 am., revealed the residents in the ITU were restricted to the unit, but the residents in the Dillon building had their own Chapel. They further stated their philosophy involved allowing individual worship, but no group worship. Administrative staff continued to explain, residents were provided this information in the Handbook for that unit. Further interview failed to evidence staff provided the handbook to the residents in the ITU.

Even though review of the Care Team meeting revealed the ability for the facility to provide for some religious and/or recreational activities during the free time for the patient in the ITU, in 5/06, the facility failed to follow up on this and 6 months later during this survey, the facility still had not provided for time and availability for this approved request.

H 011 — KAR 28-34--3b.,(b) Patient Complaints — H 011

The facility's policies and procedures shall establish a mechanism for responding to patient complaints.
This RULE: is not met as evidenced by:

The hospital census on the state licensed buildings was 319 at the time of entrance on 10/30/06. Based on record review and staff interview the hospital failed to follow through and address resident/patient complaints and failed to follow their own complaint process policy.

Findings included:

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H 011	Continued From Page 6 - Review of 41 random sampled patient/resident complaint/grievance reports between May 1st and October 31, 2006 and e-mail communication revealed multiple patient/resident complaints that failed to be reconciled and continued to present problems on the units. Concerning the complaints on Dillon Building. 1. On 7/18/06, an e-mail from the consumer relations department to a engineering department supervisor revealed "....on a side note, I commonly hear about not having hot water on Dillon." On 7/19/06 response from the engineering department supervisor "We have a recirculating system for the hot water in the patient restrooms and other select areas of the building, but to return to the original hot water system in patient rooms to its original condition we would need further funding that is just not available. We have a lot of other areas that the money could be better utilized. Since this is not an infection control issue and it is such a small volume of water to each patient sink I thought this was a dead issue. I also understand that it is not a requirement hot water to every s/s (stool/sink) combi. (combination) so we should simply tell the residents no you cannot have hot water and it is not available at this time." 2. On 8/7/06, an e-mail from the consumer relations department to an engineering department supervisor revealed "I have received some complaints about the plumbing on E1. Anytime that water has been shut off to fix something, it apparently affects the hot water supply. Resident claims they went for days with cold water showers. There is a sink in the	H 011	H 011 Dillon Bldg 1 (page 7): <u>How correction has been, or will be, accomplished</u>: LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water temperature at the showers was increased to 105 degrees on or around November 3, 2006. <u>How others potentially affected by the same deficiency have been, or will be, identified</u>: Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees. <u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>: This will be a component of the preventative maintenance program, for staff to use during their monthly inspections. <u>How performance will be monitored to ensure improvement is sustained</u>: Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends. <u>How substantial compliance will be measured</u>: Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist. <u>Position responsible for correction</u>: Physical Plant Supervisor Specialist	

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H 011	Continued From Page 7 bathroom that does not have any cold water. They have had to put a straw in the faucet of the sink to allow the water to come directly out instead of running down the backside of the sink. The handicapped toilet has been out of working order for months." The answering e-mail from the engineering department supervisor on 8/7/06 revealed " (staff members names), can you please look in the work-order program and tell me if we have had any previous work-orders on these items." Answering e-mail from the engineering department staff to the consumer relations department stated "I found 3 tickets made concerning this room, and specifically plumbing issues." On 8/10/06, the consumer relations department sent an e-mail to several engineering supervisory department staff stating, "I have reviewed your job tickets but we still have problems that need fixed... Here is a list of problems/concerns as of 8-9-06 for that bathroom on Dillon E-1. This comes from a staff member that I requested to actually go to the bathroom and check the showers, sinks, and toilets. Here is what the staff found." The staff members findings included: "All shower water in the east 1 shower room is cold or cool. One shower that I felt was a little warmer, but almost all of them are cool to cold. I wouldn't take a shower in here, it's too cold for me. The handicap toilet has been out of order since 6-15-06. It has a sign on the door with this date on it. No cold water in the second sink form the door in the restroom, and not much water pressure either. Thre is hardly any water pressure in the first sink from the door, a straw has been put in the whole (hole) where the water is supposed to come out so the water will come	H 011		

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H 011	Continued From Page 8 out over the drain so that a person can get water on there (their) hands without touching the sink itself. The water is barely coming out. I was told by a resident that the hot water will work for a little while, then it goes too cold. I think this will become a problem when winter gets here. I myself, couldn't take a shower in here, it's too cold for me. Even during the summer, I have my water at home a lot warmer than what it's putting out here. Another thing I noticed is that there are no hot or cold water buttons on any of the showers. There is just one button on each shower, and you have no control over how you want the water to feel. You hit the button, and the water starts to come out, and have no way of controlling the temp. A resident just came up to me and said that it's supposed to be pre-mixed hot and cold, and for him to get any hot water out is to turn all the showers on at the same time. That's the first time I've been in the shower room, and I was surprised. I don't know if this will help you, but I'm sure there have been many different complaints about the showers and restroom problems on our unit. I have also heard residents say that, the showers get too hot, so I've heard both sides." Observation on 10/31/06, at 7:47 am, of Dillon building West 2, by a state licensure surveyor and hospital staff (Director of Environment Services, Director of Customer Services, Engineering Supervisor, Vocational Training Supervisor, Safety officer plus other unit supervisory staff) the shower temperature started at 88 degrees and after 4 minutes of pushing the button to recycle, the temperature did reach 102 degrees. Staff member "Y" during that tour, stated one of the patients had complained at 7:50 am, that they had to take a cold shower that am.	H 011		

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H 011	Continued From Page 9 Observation on 10/31/06 in bathroom E-1 by a state licensure surveyor and hospital staff (Director of Environment Services, Director of Customer Services, Engineering Supervisor, Vocational Training Supervisor, Safety officer plus other unit supervisory staff) revealed the water temperature at 9:47 am to be 95 degrees after 3 cycles of pushing the button (3 minutes total). It took several more pushing of the button to cycle up to 102 degrees. This temperature would have been after the residents morning showers. During the environmental tours on 10/31/06 the water temperatures ran 72 to 77 degrees in the handwashing sink in the basement of Dillon building. Engineering staff member "E" at 12:40 pm verified the temperature in the sink only got up to 77 degrees after several times of pushing the button. Staff member "E" further stated that the buttons cycles are 60 seconds long. 3. On 10/02/06, one resident stated the restroom had one sink that "did not work period" and the second sink had hot water only, no cold water. This same complainant stated they had filed other grievances since 4/29/06 and nothing happened to fix the problems. On 10/10/06 the consumer relations department sent an e-mail to the engineering department supervisor as follows: "I have received another grievance for the East 1 Bathroom. Please let me know where we are at with this bathroom." An answer from the engineering department supervisor on 10/11/06 stated "To my knowledge we have not had any requests for repair, (name of employee) can you make a work-order for the plumbers to repair this."	H 011	H 011 Dillon Bldg 3 (page 10): <u>How correction has been, or will be, accomplished</u>: Hot water is not provided on Dillon building patient areas; tempered water and cold water are provided. LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The cold water valve to the hand-washing sink was repaired on or around November 3, 2006. LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water pressure to the hand-washing sink was repaired on or around November 3, 2006. <u>How others potentially affected by the same deficiency have been, or will be, identified</u>: Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to inspect water valve operation and increase water pressure in all other patient areas. <u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>: This will be a component of the preventative maintenance program, for staff to use during their monthly inspections. <u>How performance will be monitored to ensure improvement is sustained</u>: Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-orders to ensure corrective actions occur as indicated, and to monitor for any trends. <u>How substantial compliance will be measured</u>: Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist. <u>Position responsible for correction</u>: Physical Plant Supervisor Specialist	

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H 011	Continued From Page 10 Observation by the state surveyor and facility staff on 10/31/06 revealed one of the bathroom sinks with packaging tape on two sides of the water spigot and a straw to direct the flow. Interview with staff member "E" stated on 10/31/06 at 9:07 am that the hand washing sinks were supposed to spray out 2 inches into the bowl and verified these sinks only sprayed out 1/4 to 1/2 inches from the rim of the sink underneath the spignet. Interview with patient #97 on 10/31/06 2:20 pm verified without the straw the water barely came out of the spigot and ran onto the sink ledge and onto the floor. Resident #93 on 10/31/06 at 10 am revealed that engineering had worked on the sinks but they have a pressure problem. 4. Review of the consumer relations records revealed complaints from 8/7/06 and 9/8/06 concerning a handicap toilet not working with e-mails from consumer relations to engineering supervisor each time. Review of consumer relations records revealed a memo sent by the remodeling contracting company on 11/10/06 with message of "Returned warranty request from 5-23-06. E-11, R #115 Toilet Leaking." The 2nd page of the fax contained a copy of "Warranty Request No. 3" dated 5/23/06 which stated "Description of Defect: E1, R#115 - handicapped stall - toilet leaking. No pressure in sink. (Resubmitted 10/31/6)"and "Corrective Action: was leaking at the connection from the flush valve to the fixture. Installed bracing to the piping. I talked with (staff member E) & (staff member E) was satisfied w/ (with) the connections." Observation by the state surveyor and facility staff on 10/31/06 revealed the handicap toilet	H 011	H 011 Dillon Bldg 4 (page 11): Plan of Correction as noted on H 011 Dillon Bldg 2 (page 7)	

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H 011	Continued From Page 11 with a sign which stated "This toilet is out of order since 6/15/06". Interview with staff member "E" on 10/31/06 at 10:45 am, verified that the toilet failed to function and did not have any water to it. Interview with staff members "S" and "R" on 10/31/06 at 10:58 am verified they knew of the problem and had reported the problem multiple times but quit when a female staff in the engineering department said maintenance knew about it and to stop reporting. After more than 6 months of complaints concerning the broken handicap toilet and the water temperature on Dillon building, the hospital continued to fail to meet the patients rights at KAR 28-34-3b (1) "Each patient has the right to respectful care given by competent personnel." Interview with staff member A on 11/15/06 at 10:30 am, confirmed the complaints had been ongoing and not been reconciled leaving the patient care staff frustrated. Concerns noted throughout the hospital. 1. Interview with patient/resident #88 at 3:07 pm on 10/31/06 revealed the hospital failed to provide privacy for residents while using the phone and stated they had put in complaints concerning this problem. Observation on 10/31/06 with the surveyor and facility staff confirmed the telephones for patient/resident use failed to allow for private conversations throughout the hospital. Review of the consumer relations records revealed complaints concerning the lack of privacy when using the phone. Review of the facility policy, Patient/Resident's Rights & Responsibility revised 04/05 states "Every patient/resident being treated in any treatment	H 011	H 011 Noted throughout Hospital 1 (page 12): How correction has been, or will be, accomplished: Regarding phone privacy, Administrative Program Directors on each of the three Programs have assessed patient-access phone arrangements to determine what changes may be warranted, in order to ensure such arrangements meet or exceed industry standards in similar facilities. --The Sexual Predator Treatment Program will install dividers that meet or exceed industry standards, with sound absorbing materials between phones to provide increased privacy on Meyer, ITU, and Dillon units. Completion date on or before February 14, 2007. --The Psychiatric Services Program will take measures to enhance existing encasements around the phones to meet or exceed industry standards. Grievance processes will be monitored to ensure improvements are maintained. Completion date on or before January 30, 2007. --On the State Security program, two pay telephones are provided for patient use on each unit. Each telephone has an approximate 12-inch-deep wooden privacy box surrounding the telephone with a wooden door attached. On or about 12-14-06, it was verified that all privacy boxes are in place on all SSP units. No changes will be made in this Program. How others potentially affected by the same deficiency have been, or will be, identified: All three Programs have assessed such privacy arrangements, with increased awareness hospital-wide regarding phone privacy issues. Processes that have been, or will be, established to ensure the deficiency does not reoccur: Measures, as identified above, will be taken to enhance privacy encasements to meet or exceed industry standards. How performance will be monitored to ensure improvement is sustained: Grievance management and resolution processes will ensure such improvements are maintained across Programs. How substantial compliance will be measured: Compliance will be evidenced by installation of and/or enhancements to partitions. Ongoing compliance will be measured through Grievance Resolution Committee reports and Customer Services Dept reports. Position responsible for correction: SPTP VTP Work Director and SSP/PSP Administrative Program Directors	

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H 011	Continued From Page 12	H 011		

facility, in addition to all other rights preserved by the care and Treatment Act for Mentally Inn Persons, has the following right: 2) To communicate by all reasonable means with a reasonable number of persons at reasonable hours of the day and night, including both to make and receive confidential telephone calls..."

Review of an e-mail dated 8/8/06 from consumer relations to a administrative director revealed some complaints about the phones being too close together on the units (no privacy) and asking the possibility of getting some kind of divider put between the phones. The administrative director immediately e-mailed a request to the wood shop supervisor asking if they could build a divider and stating they felt the "residents would be happy to make it a project in one of their classes since it is their issue." Same day e-mail from the wood shop supervisor to the administrative director stated, ...gave me some good ideas and I'll get with (name of person in wood shop) on this. Will request the LSH engineering guys to do the installation work once the phone boxes completed.

Interview with the consumer relations staff on 11/15/06 at 10:30 am, revealed they had received multiple complaints concerning the lack of privacy when using the phone. They stated they had not received any communication from the wood shop concerning this issue since the 8/8/06 e-mails but knew the problem still existed.

After at least 3 months of complaints concerning privacy while using the telephone, the hospital continued to fail in providing the patients/residents the right to private phone communication with others.

- On 10/31/06 at 9:36 am, while discussing

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H 011	Continued From Page 13 multiple environmental issues, staff member "Q" stated that their experience in this hospital "is you just have to live with it." - Review of Consumer Relations reports revealed complaints concerning the lack of activities outside the patient area for the patients on the ITU (Intensive Treatment Unit). Review of the October 19th Sexual Predator Treatment Program Leadership Meeting minutes revealed staff discussion concerning this request for activities in the gym and swimming pool with follow up documentation "approved if it can be worked out and if the van is secure." Interview with staff member B revealed acknowledgement of the lack of ITU time at the gym or swimming pool for quite some time and verified that the van would be secure but the problem involved finding the time as ITU has to be isolated from the rest of the programs. At the time of the interview they stated that the activities department lacked the time for an individual group. This staff member further stated that the swimming pool and gym schedule includes Meyer building from 8am to 10 am Monday and Wednesday and Dillon building 10 am to 12 noon Monday, Wednesday and Friday and again Thursday from 8 am to 10 am. When asked about evening or weekend activities for this group in the gym or swimming pool, the staff member stated that they reserved the weekends for the youth. The activities department offers yard activities and pottery during the week and then arts on Saturday but this is on the unit and also stated "at this time, these patients don't get to leave their units". In addition, this staff member stated they are trying to get a 9 to 10 am time approval for these patients to go to the gym but due to lack of drivers and activity staff this has not been worked out.	H 011	H 011 Noted throughout Hospital bullet (page 14): How correction has been, or will be, accomplished: The Jung Bldg weight room will be open for Phase 9 and 10 residents for Monday privilege nights. Completion date 12/14/06. How others potentially affected by the same deficiency have been, or will be, identified: This issue is specific to residents on this unit (ITU). Processes that have been, or will be, established to ensure the deficiency does not reoccur: The Resident Handbook and ITU Handbook will be updated to reflect opportunity for residents on Phase 9 and 10 to take part in this activity. How performance will be monitored to ensure improvement is sustained: The SPTP Grievance Resolution processes will help ensure such improvements are monitored and maintained. How substantial compliance will be measured: The Grievance Resolution Committee reports will reflect evidence of compliance. Additionally, Activity Therapy personnel will record participation time for Phase 9 and 10 residents on their progress reports. Position responsible for correction: SPTP Administrative Program Director and SPTP Activity Therapy Director	

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H 014	Continued From Page 14	H 014		
H 014	KAR 28-34-5a Governing Body Authority Governing body. Each hospital shall have an organized governing body. The governing body shall be the ultimate authority in the hospital responsible for its organization and administration in a manner which is consistent with appropriate standards of patient care, environmental safety and institutional management. This RULE: is not met as evidenced by: The hospital had a census of 319 at the time of entrance on 10/31/06. Based on observation, record review and staff interview, the governing body failed to assure a clean, safe, and comfortable environment throughout the patient care areas and failed to assure that the facilities provided patients with an area that would assure the privacy of phone conversations. Findings included: - Review of consumer relations department records revealed multiple complaints from patients and staff on Dillon Building concerning the lack of temperature control for the water used by patients with the water usually too cold for showering comfortably, one sink in the bathroom that does not have any cold water, patient's having to put a straw in the faucet to allow the water to come directly out instead of running down the backside of the sink, the handicapped toilet being out of working order since at least 6/15/06, no warm water in the sinks in their rooms and no privacy for patients making phone calls. Review of an e-mail sent from the consumer relations department to the engineering department on 8/10/06 revealed, "I have	H 014	H 014 Governing Body Authority bullet 1 (page 15): Plan of Correction as noted on H 011 Dillon Bldg 2 (page 7)	

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Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: M073001	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/16/2006
NAME OF PROVIDER OR SUPPLIER: **LARNED STATE HOSPITAL**		STREET A... ESS, CITY, STATE, ZIP CODE: **ROUTE ... BOX 89 LARNE... KS 67550**	

(X4) ID PREFIX TAG	SUMMARY ST... MENT OF DEFICIENCIES (EACH DEFICIENCY MUST ... PRECEEDED BY FULL REGULATORY OR LSC ID... YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 014	Continued From P... 15	H 014		

reviewed your jo... ts but we still have problem... that need fixed... H... is a list of problems/concern... of 8-9-06 for that bathroom on Dillon E-1. Thi... nes from a staff member th... I requested to act... go to the bathroom and check the shower... ks, and toilets. Here is wha... the staff found." T... taff members findings included: "All sho... water in the east 1 shower room is cold or co... ne shower that I felt was a little warmer, but a... t all of them are cool to col... I wouldn't take a s... er in here, it's too cold for me. The handicap... et has been out of order since 6-15-06. It h... sign on the door with this date on it. No cold... ter in the second sink from the door in the rest... m, and not much water pressure either. T... s hardly any water pressure in the first sink from... door, a straw has been pu... in the whole (hole)... re the water is supposed to come out so the w... will come out over the drain so that a person c... et water on there (their) hands without touc... the sink itself. The water i... barely coming out. ... as told by a resident that the hot water will work... a little while, then it goes to cold. I think this w... ecome a problem when winter gets here. ... self, couldn't take a shower in here, it's too co... me. Even during the summer, I have m... ter at home a lot warmer than what it's putt... ut here. Another thing I noticed is that the... e no hot or cold water buttons on any of ... showers. There is just one button on each sh... r, and you have no control over how you wan... water to feel. You hit the button, and the w... starts to come out, and have no way of controll... he temp. A resident just came up to me an... id that it's supposed to be pre-mixed hot and... d, and for him to get any hot water out is to turn... the showers on at the same time. That's the fi... me I've been in the shower room, and I was s... ised. I don't know if this

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING ______ B. WING ______	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 014	Continued From Page 16 will help you, but I'm sure there have been many different complaints about the showers and restroom problems on our unit. I have also heard residents say that, the showers get too hot, so I've heard both sides." Observations on 10/31/06, beginning at 7:47 am, during the Dillon building environmental rounds by a state licensure surveyor and hospital staff (Director of Environment Services, Director of Customer Services, Engineering Supervisor, Vocational Training Supervisor, Safety officer plus other unit supervisory staff) revealed: 1. The shower temperature started at 88 degrees Fahrenheit (F) and after 4 minutes of pushing the button to recycle, the temperature did reach 102 degrees F. Staff member "Y" stated one of the patients had complained at 7:50 am, that they had to take a cold shower that am. 2. In bathroom E-1 the water temperature at 9:47 am measured 95 degrees F after 3 cycles of pushing the button (3 minutes total). It took several more times pushing the button to reach 102 degrees F. This temperature would have been after the residents morning showers. 3. The water temperatures ranged from 72 to 77 degrees F in the handwashing sink in the basement of Dillon building. Engineering staff member "E" 12:40 pm verified the temperature in the sink would only reach 77 degrees F after several times of pushing the button. Staff member "E" further explained the buttons cycles are 60 seconds long. 4. One of the bathroom sinks with packaging tape on two sides of the water spigot and a straw to direct the flow. Interview with staff member	H 014	H 014 Governing Body Authority 1 (page 17): <u>How correction has been, or will be, accomplished</u>: Showers arrangements were designed for group showering. When several patients actuate the shower valves at the same time, water is hot within one minute and remains hot. However, when individual showers are taken throughout the day, it will take up to five minutes for the water to reach 105 degrees. LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The Water Temperature at the showers was increased from 102 to 105 degrees on or around November 3, 2006. <u>How others potentially affected by the same deficiency have been, or will be, identified</u>: Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees. <u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>: This will be a component of the preventative maintenance program, for staff to use during their monthly inspections. <u>How performance will be monitored to ensure improvement is sustained</u>: Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends. <u>How substantial compliance will be measured</u>: Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist. <u>Position responsible for correction</u>: Physical Plant Supervisor Specialist	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING ______ B. WING ______	11/16/2006

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LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

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H 014	Continued From Page 17 "E" on 10/31/06 at 9:07 am revealed the hand washing sinks were supposed to spray out 2 inches into the bowl and verified these sinks only sprayed out 1/4 to 1/2 inches from the rim of the sink underneath the spigot. Interview with patient #97 on 10/31/06 2:20 pm verified without the straw the water barely came out of the spigot and ran onto the sink ledge and onto the floor. Resident #93 on 10/31/06 at 10 am revealed that engineering had worked on the sinks but they have a pressure problem. 5. The handicap toilet with a sign which stated **"This toilet is out of order since 6/16/06".** Interview with staff member "E" on 10/31/06 at 10:45 am, verified the toilet failed to function and did not have any water to it. Interview with staff members "H" and "R" on 10/31/06 at 10:58 am verified both knew of the problem and had reported it multiple times but quit reporting when a staff member in the engineering department said maintenance knew about it and to stop reporting. After approximately 6 months of complaints concerning the plumbing problems in Dillon, the hospital continued to fail to meet the patients rights at KAR 28-34-3b (1) "Each patient has the right to respectful care given by competent personnel." Interview with staff member A on 11/15/06 at 10:30 am, confirmed the complaints have been ongoing and the fact they have not been reconciled is frustrating for the consumer relations department and patient care staff working directly with these patients.. - Tour of the ATC (Acute Treatment Center) and the CSU (Crisis Stabilization Unit) between 10/30/06 and 11/15/06, evidenced multiple areas	H 014	H 014 Governing Body Authority 5 (page 18): Refer to H011 Dillon Bldg 2 (page 7)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: M073001	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 11/16/2006
NAME OF PROVIDER OR SUPPLIER: **LARNED STATE HOSPITAL**	STREET ADDRESS, CITY, STATE, ZIP CODE: **ROUTE #3 BOX 89 LARNED, KS 67550**		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 014	Continued From Page 18 where the facility failed to provide shower curtains or locking doors for privacy when toileting or showering, and hot water for washing hands and showering. Examples included: 1. The men's bathroom in the Activity room contained a bathroom stall with a shower curtain held up with only 2 curtain rings, causing the privacy curtain to fall away and continually expose residents using this shower. Another toilet failed to have a working lock on the door. 2. The women's bathroom in the Activity room contained 3 toilet stalls, with 2 of the 3 door locks non-functioning. The handwashing sinks failed to have any hot water. After running the water for several minutes, facility staff member E, verified the sinks should have had hot water by then. 3. The handwashing sink in the central bathroom beside the Comfort Room in Acute Treatment Center (ATC) South, on 11/1/06 at 3:05 pm., contained only 71 degree Fahrenheit (F) water. Facility staff member Z, at that time verified the hot water capped off to this sink. 4. The Shower in the central bathroom beside the Comfort room, in ATC south, on 11/1/06 at 3:11 pm., failed to reach over 85 degrees Fahrenheit, 13 degrees below average body temperature. Interview with facility staff member #II, at that time verified some residents used that shower. 5. The shower in the resident room #81, on 11/1/06 only reached 83 degrees Fahrenheit, 15 degrees below average body temperature. - Tour of the buildings in ATC (Acute Treatment Center) and CSU (Crisis Stabilization Unit),	H 014	H 014 Governing Body Authority 5.1 (page 19): <ins>How correction has been, or will be, accomplished</ins>: Larned State Hospital has been unable to locate this specific deficiency. H 014 Governing Body Authority 5.2 (page 19): <ins>How correction has been, or will be, accomplished</ins>: Larned State Hospital has been unable to locate this specific deficiency.	

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Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: M073001	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFI10CIENCY)	(X5) COMPLETE DATE
H 014	Continued From Page 19 between 10/30/06 and 11/15/06, evidenced multiple unsafe, unclean, and unsanitary areas, a sampling of which included: ATC Building: 1. Raised areas in the tile floor creating trip hazards. 2. Multiple microwaves with dried food particles hanging from the interior. 3. Multiple tables with the formica missing, creating splintery and uncleanable wood areas. 4. Two anti-fatigue mats in the beauty shop with large missing areas of the mats creating very sharp, raised areas. 5. Multiple non working drinking fountains. 6. Multiple drinking fountains which lacked enough water pressure to prevent resident from having to put their mouths on the water spigot. 7. The triage room contained a suction catheter, already opened and hooked to the suction machine. Staff member #GG, on 11/1/06 at 4:10 pm., verified they could not assure this suction catheter remained clean. Cafeteria Building: 1. Men's restroom contained missing tile pieces, and the edge of the door to this room contained nicked, splintery areas. 2. The door to the Ladies restroom contained broken splintery edges. 3. The west entryway contained a build up of	H 014	H 014 ATC Bldg 1 (page 20): How correction has been, or will be, accomplished: LSH Engineering Dept issued a job ticket to the Carpentry Dept staff on December 15, 2006 to repair the tile flooring. Completion date on or before January 20, 2007. How others potentially affected by the same deficiency have been, or will be, identified: Notification will be sent to Program Directors to instruct line level supervisors to identify loose carpet tiles and trip hazards on other patient units. Corrections will be made as identified. Processes that have been, or will be, established to ensure the deficiency does not reoccur: This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections. How performance will be monitored to ensure improvement is sustained: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Physical Plant Supervisor Specialist	

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H 014	Continued From Page 20 dust and dirt, black/brown substance, varying from between 1 inch and 3 inches around the edge. 4. Multiple window sills, very dusty and dirty. 5. Multiple areas of splattered food on the walls and ceiling, yellow, orange, and light brown, in varying sizes. 6. Multiple Dining room tables with formica missing creating sharp and splintery areas, as well as exposed wood. 7. Missing ceiling tiles in the Dining room. 8. A build up of white deposits on the Ice and Water dispenser spouts. 9. Cracked tile at the base of the serving line. 10. Black scuff marks, 2-3 feet up the wall, along 20 feet of the wall. Hospital Building: 1. Multiple grates on the windows with a large build up of brown/black substance, and dirt and dust. 2. A stopped up sink in the women's restroom. Facility staff member #Z, on 11/1/06 at 2:20 pm., verified if the sink ran more than 30 seconds, it would overflow. 3. The sink in resident room #87 only trickled water out, and the sink in resident room #86 failed to work at all. The walls in resident rooms #86 and #85 contained multiple areas of missing paint, exposing bare wall.	H 014	H 014 Cafeteria Bldg 4 (page 21): How correction has been, or will be, accomplished: Window sills were cleaned on December 13, 2006. How others potentially affected by the same deficiency have been, or will be, identified: Custodial Manager has assigned the custodial supervisors to inspect all areas of campus for cleanliness of window sills, and ensure cleaning occurs as necessary. Processes that have been, or will be, established to ensure the deficiency does not reoccur: This deficiency will be identified through weekly inspections. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished. These items will also be identified in the monthly safety tours. How performance will be monitored to ensure improvement is sustained: Monitoring will occur through weekly inspections and monthly safety tours. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Custodial Supervisor	

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H 014	Continued From Page 21 4. The men's restroom shower revealed a build up of dirt, and needed much cleaning. 5. The divider wall between the 2 toilet areas contained satanic symbols, sexual body parts, and vulgar words, carved into the paint. 6. The wall beside the pay phones contained an area of missing paint 1 and 1/2 feet in diameter, exposing bare wall. 7. The treatment room contained a torn vinyl examination table, exposing the foam underneath. Activity Therapy Building: 1. Multiple windows, window ledges, and cabinet tops with a build up of dust, dirt, and cobwebs. 2. The hallway leading to the Gym contained a ledge, 4 inches wide, with a build up of dust and dead bugs. 3. The pool area contained 24 each large windows with a white filmy build up on them, preventing residents from seeing outside. Staff member #HH, on 10/30/06 at 5:03 pm., verified the facility only cleans these windows 1 time per year. The ceiling to the pool area contained multiple cobwebs hanging 3 to 5 feet long from the ceiling. The ceiling area also contained 8 large light fixtures with multiple cobwebs, spiders (both alive and dead), and dust. 4. Fans with a build up of dust on the grates and blades. 5. A seam down the middle of the carpet in the Music room, 30 feet long and with a 1 inch to 1 and 1/2 inch frayed edge, which created a trip	H 014	H 014 Hospital Bldg 4 (page 22): How correction has been, or will be, accomplished: The restroom shower was cleaned on or before December 15, 2006. How others potentially affected by the same deficiency have been, or will be, identified: Custodial Manager has assigned the custodial supervisors to inspect all areas of campus to be sure the showers are clean, and to ensure cleaning occurs as necessary. Processes that have been, or will be, established to ensure the deficiency does not reoccur: This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished. How performance will be monitored to ensure improvement is sustained: Monitoring will occur through weekly inspections and monthly safety tours. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Custodial Supervisor	

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H 014	Continued From Page 22 hazard down the middle of this room. 6. Dirty carpeted areas, needing vacuumed. 7. Boxes stored directly on the floors. 8. Base cabinets with gaps between the cabinets and the wall 1/2 inch wide by 6 foot long an 12 foot long, where the caulking dried up and separated, causing the cabinets to pull away from the wall. 9. A Microwave with dried food on the interior, a stove with a dirty oven, and a build up of dust and grease on top of the refrigerator in the Home Living room. 10. Ten 1 inch diameter missing paint areas on the inside of the door of patient room #84. Four holes in floor (through the tile and into the cement) 1/2 inch in diameter and 1/2 to 1 inch deep, which created trip hazards in room #84. The ventilation system in this room also failed to work. 11. A central bathroom on ATC South contained one toiled which did not flush well and a sink which produced a loud screaming noise when turned on. 12. A carpeted area with a missing piece of carpet square, in a triangular section, creating a trip hazard. 13. Multiple missing pieces of formica on the nursing station countertops creating sharp edges. 14. Multiple vinyl chair cushions with tears in the vinyl, various sizes, exposing the foam underneath.	H 014	H 014 Activity Therapy Bldg 6 (page 23): How correction has been, or will be, accomplished: Plan of Correction as noted on H 014 Activity Therapy Bldg 1 (page 22)	

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H 014	Continued From Page 23 15. The room of resident #81 contained a 4 inch long crack in the mirror on the medicine chest. 16. The private shower in the room of resident's #82 and #83 contained a build up of mold in the grout, a rusted shower water controller knob, and a rusted soap holder. 17. Visitor restroom light fixture contained more than 30 dead bugs. 18. A water fountain failed to work. 19. The light in the bathroom of resident #80 failed to work. Jung Building 1. Hallway leading to the Cafeteria with multiple 4 inch diameter dust balls, a build up of dust, dirt, cobwebs, crumbled up papers, and dead bugs throughout this halfway. Interview with Resident 396, on 10/31/06 at 4:07 pm. verified the hospital never cleaned this area. 2. Dining Hall, a build up of dust and dirt on all window sills, along with spilled salt and pepper pieces on a 20 foot long area. eight vents under windows with such a build up of dust, dirt and debris, that either no or very little fresh air could get through the vents into the room. The walls were streaked with food stains and had gouges. Several tables had a buildup of greasy substance thick enough to scrape up with a fingernail. An area on the ceiling, 7 inches long by 3/4 inch wide,with a dark brown, orange substance partially dried and flaking from the ceiling. Build up on perimeter of the floor of dark sticky substance, 1-2 inches around the perimeter of the room, along the baseboard. Multiple yellow,	H 014	H 014 Activity Therapy Bldg 15 (page 24): How correction has been, or will be, accomplished: LSH Engineering Dept issued a job ticket to the Paint Dept. staff on December 18, 2006 to repair the mirror. Completion date on or before January 20, 2007. How others potentially affected by the same deficiency have been, or will be, identified: Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues in other patient areas. Corrections will be made as identified. Processes that have been, or will be, established to ensure the deficiency does not reoccur: This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections. How performance will be monitored to ensure improvement is sustained: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Physical Plant Supervisor Specialist	

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H 014	Continued From Page 24 orange, and red stains on the walls. 3. Kitchen tray line serving area contained exhaust fans with a build up of dust, multiple streaks of food down the wall of the serving line and a build up of dark brown food substance in the grout. The floor beneath this area contained a buildup of brown/black substance. The ice water dispensing machine contained a a build up of reddish, white, green substance on the plastic spouts. The wall behind the ice machine contained a dead, splattered bug. Interview with resident # 98 stated the splattered bug had been there for over 3 weeks. 4. The walls in the room of Resident #92 contained multiple yellow orange streaks and multiple areas of dried white substance. 5. The walls of room 142, currently without a resident, contained multiple orange brown streaks as well as dark orange brown ring in the toilet bowl. 6. Water fountains did not function. Resident # 2 on 10/31/06 at 3:10 pm verified the fountain had not worked for at least 2 weeks and maintenance had turned the water off. 7. A wooden chair in the television room with a broken arm rest. 8. Multiple light fixtures and cage covers over smoke detectors with a build up of dust. 9. Multiple vinyl chair cushions with tears in the vinyl exposing the foam underneath. 10. An air circulation unit in the small television group meeting room contained a non-functioning circulator. The air in the room was warm and the	H 014	H 014 Jung Bldg 3 (page 25): Plan of Correction as noted on H 014 Jung Bldg 2 (page 24)	

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LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

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H 014	Continued From Page 25 room felt stuffy. Resident #98 verified on 10/31/06 at 3:40 pm the room got stuffy and the circulator did not work. 11. Tear in the vinyl on the examination table pad, exposing the foam underneath. 12. The walls int he room of resident # 97 contained multiple brown and yellow streaks and spots. The curtain for this residents room consisted of a folded bedspread which was held up by multiple paper clips and tape. The patient further stated they scrubbed on their walls, but could not get the stains off. 13. The window curtains in the room of resident # 96 revealed multiple curtain panels, facing different directions, and all failed to cover the bottom 6 inches of the residents window failing to allow privacy for this resident. The resident stated on 10/31/06 at 2;40 pm they had to put up a drawing board to attempt to cover the rest of the window. 14. The central shower room did not have shower curtains covering all of the shower stalls to allow privacy for residents when showering. One shower curtain was to long for the shower and had been folded up and stapled but this created staples sticking out of the shower curtain. 15. Multiple pay phones without the means for resident privacy during use. Meyer Building: 1. Dining Hall contained 24 tables with a build up of sticky substance, able to be scraped with a fingernail. Vents under 8 windows clogged with a buildup of dust and dirt, not allowing any fresh air	H 014	H 014 Jung Bldg 11 (page 26): <u>How correction has been, or will be, accomplished</u>: Vinyl cover will be ordered through Central Supply, with accompanying work orders, to repair the table. Completion date June 1, 2007. <u>How others potentially affected by the same deficiency have been, or will be, identified</u>: Building tours will identify other examination tables in need of repair. <u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>: This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections. <u>How performance will be monitored to ensure improvement is sustained</u>: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. <u>How substantial compliance will be measured</u>: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. <u>Position responsible for correction</u>: Administrative Program Director	

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	M073001	A. BUILDING ____ B. WING ____	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARNED STATE HOSPITAL	**ROUTE #3 BOX 89** **LARNED, KS 67550**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 014	Continued From Page 26 into the room. Window and door ledges all contained buildup of dust and dirt. Two salad bar tables contained a build up of dust, dirt, and debris. A fan with a build up of dust on the grate and blades. The doorway from the dining hall to the garden/activity area contained a build up of black sticky substance. 2. Hallway to Meyer floor contained multiple Kleenex, wadded up napkins and papers. The exit foyer contained cups, cotton balls, leaves and a pile of dust and debris. 3. Day hall contained a fan blowing air in the room with a build up of dust and dirt on the grate and blades. 4. Shower room with a non functioning air return. Interview with staff member X, on 11/1/06 at 10:06 am verified the staff had completed a work order and told engineering. This shower room also failed to have shower curtains to allow privacy while showering in 1 of 3 shower stalls. Interview with Staff W, on 11/1/06 at 10:06 am, verified the missing shower curtain became moldy and they threw it away, and had not replaced it. 5. Multiple vinyl cushions had various sized tears in the vinyl exposing the foam underneath. 6. A fan with dusty dirty grate and blades, tuning the blades almost black form the build up. 7. A common restroom contained a broken toilet paper holder. 8. A wooden framed couch contained multiple areas of graffiti and vulgar pictures dug into the wood frame.	H 014	H 014 Meyer Bldg 2 (page 27): Plan of Correction as noted on H 014 Meyer Bldg 1 (page 26) H 014 Meyer Bldg 3 (page 27): Plan of Correction as noted on H 014 Meyer Bldg 1 (page 26)	

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H 014	Continued From Page 27 9 The vent int he mop room made a loud noise, but failed to work. The very warm air in this room contained a foul odor. 10. The supply room window screen contained a build up of dust and cobwebs, not allowing visibility to the outside. 11. The sink in patient room # 162, which did not have a patient at the time of survey, contained a torn mattress and a non-functioning hand washing sink. Staff member U, on 11/1/06 at 10:07 am verified engineering shut the water off to this sink due to their inability to fix the sink. 12. The toilet in patient #100's room leaked and formed a 10 inch diameter puddle of water on the floor and the hand washing sink did not work at all. Staff member U, on 11/16/06 at 10:11 am, verified this was reported. The patient stated the problem had been going on for "2 months or so". 13. Pay phones without the means for patients to have a private conversation. Isaac Ray: 1. A television room with 15 feet of missing baseboard. 2. Multiple common rooms with a build up of dust and dirt on the window ledges. 3. Multiple common television/day rooms with multiple chairs snuggled up against each other and lining the entire wall area of the rooms. These lines of chairs contained a build up of food particles, trash, dust and dirt between each other as well as between them and the walls. 4. The patient laundry room washing machine	H 014	H 014 Meyer Bldg 9 (page 28): How correction has been, or will be, accomplished: LSH Engineering Dept issued a job ticket to the Electric Dept. staff on December 19, 2006. The exhaust fan will be inspected and repaired if necessary. Completion date on or before December 30, 2006. How others potentially affected by the same deficiency have been, or will be, identified: Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified. Processes that have been, or will be, established to ensure the deficiency does not reoccur: This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections. How performance will be monitored to ensure improvement is sustained: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Position responsible for correction: Physical Plant Supervisor Specialist	

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H 014	Continued From Page 28	H 014		

failed to work.

5. A central shower room with 4 shower stalls with no shower curtains on any of the stalls.

6. Multiple list fixtures with numerous dead bugs visible in the lights.

7. Fans with dusty and dirty grates and blades.

8. Examination room and hallway with dried alcohol wipes on the floor as well as a buildup of dust on the tops of flat surfaces such as the multiple X-Ray lights, floor lamp, scale, and the wall mounted blood pressure machine.

9. Multiple pay phones without the means for resident to have a a private conversation.

10. Restroom floor in the storm shelter/computer room contained many dead bugs.

11. Multiple bathroom stools with extensive corrosion and rust.

Dillon Building:

1. The basement and woodshop restrooms contained no door or curtain for privacy for the toilet areas, within a room that failed to allow residents to lock the door.

2. Multiple marred walls and chairs with missing areas of vinyl exposing the foam underneath.

3. Multiple boxes stored on the floors int he Library.

4. Seventy seven fabric covered theater chairs with multiple large stains and worn fabric showing the foam underneath.

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H 014	Continued From Page 29 5. Activity room contained an 18 inch diameter round cut out in the tile floor,with a black plastic seal placed around the perimeter, with 3 inch wide clear plastic tape over the edges of the cover, attempting to seal the cover. When staff member E, stepped on the circle, a very strong sewer gases smell permeated the room. The restrooms failed to have a means to allow privacy for the toilet areas. 6. The Home Living Room contained multiple very dusty shelves. 7. A leaking base in the utility room water draw area with a floor drain created a strong ammonia odor. The residents's washing machine drained into this base and caused the water to stream out onto the floor of the room. Resident #94 stated on 10/31/06 at 11:12 am the resident's had to keep using this washing machine to wash their personal laundry and they stood in water to do so. They further stated they reported the problem several times since 4/06 and maintenance tried to fix it once, but the fix failed to hold and maintenance failed to come back. 8. Multiple living room areas with most or all of the chair cushions containing multiple torn areas in the vinyl exposing the foam underneath, some areas measuring greater than 8 inches. 9. Multiple microwave ovens and crock pots unclean with food particles remaining in them. 10. Multiple chair cushions with dark ink print on them in the residents's living room. Staff member Q stated the resident workers tried to get the print off of the cushions, but couldn't. This staff member further stated their experience with the hospital was "just live with it".	H 014	H 014 Dillon Bldg 5 (page 30): <u>How correction has been, or will be, accomplished</u>: Plan of Correction as noted on H 009 Dillon Bldg 3 (page 3): H 014 Dillon Bldg 6 (page 30): <u>How correction has been, or will be, accomplished</u>: VTP resident workers will dust shelves as part of routine duties. Completion date December 14, 2006. <u>How others potentially affected by the same deficiency have been, or will be, identified</u>: Monthly inspections will identify others potentially affected. <u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>: This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections. <u>How performance will be monitored to ensure improvement is sustained</u>: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. <u>How substantial compliance will be measured</u>: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. <u>Position responsible for correction</u>: VTP Supervisor	

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H 014	Continued From Page 30 11. One handicapped shower failed to have the sprayer hose attached to allow the shower to be used for handicapped patients. A search of the shower room revealed the shower attachment failed to work. 12 Pay phones without means for residents to have a private conversation. Dietary: 1. Tour of the dry food storage area, on 11/14/06 at 12:17 pm., revealed the facility stored patient bed mattresses in multiple areas surrounded by dried food storage. Interview with facility staff member #DD, on 11/14/07 at 12:22 pm, verified they were unaware of a requirement to store food separately. 2. Tour of the Dining room for the facility , on 11/1/06 at 1:00 pm., revealed each of 3 dining areas contained greater than 50 ceiling tiles with large (2-3 inch diameter) greasy areas. Most of these greasy, discolored tiles also contained dried, flaking butter, some areas handing down from the ceiling tile 3/4 inch long over the tables where the residents eat. One of the tiles also contained white paper backing from the pat of butter handing down from the tile. - Review of the consumer relations records on 11/15/06, revealed multiple complaints from several different patients concerning the lack of privacy when using the phone throughout the hospital. Review of the facility policy, Patient/Resident's Rights & Responsibility revised 04/05 states "Every patient/resident being treated in any treatment facility, in addition to all other rights preserved by the care and Treatment Act for Mentally Inn Persons, has the	H 014	H 014 Dillon Bldg 11 (page 31): How correction has been, or will be, accomplished: Shower hose is of the quick-coupling nature The unit keeps the hose locked in the nurses station as a safety precaution. When used correctly, the shower attachment operates as specified. Completion date December 20, 2006. How others potentially affected by the same deficiency have been, or will be, identified: Same procedure for all handicapped showers. Processes that have been, or will be, established to ensure the deficiency does not reoccur: Instruction will be provided to unit staff. How performance will be monitored to ensure improvement is sustained: Monitoring will occur through Grievance processes and monthly inspections. How substantial compliance will be measured: Unit Leader review, on a case-by-case basis. Position responsible for correction: Unit Leaders	

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H 014	Continued From Page 31	H 014		

following right: 2) To communicate by all reasonable means with a reasonable number of persons at reasonable hours of the day and night, including both to make and receive confidential telephone calls..."

Review of a 8/8/06 e-mail from consumer relations to a administrative director revealed some complaints about the phones being too close together on the units (no privacy) and asking the possibility of getting some kind of divider put between the phones. The administrative director immediately e-mailed a request to the wood shop supervisor asking if they could build a divider and stating they felt the "residents would be happy to make it a project in one of their classes since it is their issue." Same day e-mail from the wood shop supervisor to the administrative director stated, ...gave me some good ideas and I'll get with (name of person in wood shop) on this. Will request the LSH engineering guys to do the installation work once the phone boxes completed.

Interview with patient/resident #88 at 3:07 pm on 10/31/06 confirmed that the facility failed to provide privacy for residents while using the phone and stated they had put in complaints concerning this problem. Observation on 10/31/06 environmental tour with the surveyor and facility staff confirmed that the telephones for patient/resident use failed to allow for private conversations throughout the facility.

Interview with the consumer relations staff on 11/15/06 at 10:30 am, confirmed they had received multiple complaints concerning the lack of privacy when using the phone throughout the facility. They stated they had not received any communication from the wood shop concerning this issue since the 8/8/06 e-mails but knew the

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H 014	Continued From Page 32 problem still existed. After at least 3 months of complaints concerning privacy while using the telephone, the facility continues to fail in providing the patients/residents the right to private phone communication with others. In summary, throughout the hospital the governing body failed to assure that the patients received care in a safe, clean and comfortable environment. The facility staff have voiced frustration and discouragement when they try to correct the situation. As voiced by one staff member during environmental rounds on 10/31/06 at 9:36 am, while discussing multiple environmental issues, staff member "Q" stated that their experience in this hospital "is you just have to live with it."	H 014		
H 031	KAR 28-34-7(e) Nursing RN Supervision All licensed practical nurses and nursing staff shall be under the supervision of a registered nurse. This RULE: is not met as evidenced by: The hospital had a census of 319 at the time of entrance on 10/31/06. Based on record review and staff interview the facility lacked adequate care planning and supervision of staff to prevent respiratory arrest for one of two (#6) death records reviewed. Findings included: - Review of the medical record for patient #6 identified the patient as admitted to this facility on July 21, 2005 with several diagnoses which included: Hypertension, Morbid Obesity, Osteoporosis, Gait Unsteadiness, Constipation,	H 031		

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H 031	Continued From Page 33 GI reflux disease, Edentulous, Anemia, Seizure Disorder, Post Cerebrovascular Accident, rule out Sleep Apnea, Foot Ulcer. The diet order in the record dated February 22, 2006 included a Level III Dysphagia- Diabetic ADA 1800 calorie - no salt. An additional part of the record stated, "Please grind all meat, scrambled eggs only." On 3/1/06, documentation revealed the patient using fingers to eat every particle of food. On 3/23/06 documentation revealed patient digging in the trash and hoarding food. On 3/24/06 the staff documented that patient complained of "something in my throat". Patient coughed up 2 medium sized pieces of ham. Special Dysphagia III diet ordered again on 3/31/06. Review of the plan of care revealed a lack of any plan for this patient who had a history of choking on food and difficulty swallowing and with a special order for the Dysphagia III diet. Review of the NDDTF's (National Dysphagia Diet Task Force) article "Promoting an Easier Swallow" revealed the Dysphagia level III diet should consist of food that is soft-solid and requires more chewing ability. Meats, fruits, and vegetables are served in easy-to-cut, soft, bite-sized pieces. No hard, chunky, crunchy, sticky, or very dry foods are allowed. This eliminates most breads, dry cereals, crackers, dry baked potatoes, fried potatoes, seeds, nuts, or items with multiple textures such as soups and stews. On 4/1/06, nursing documentation revealed patient found unresponsive with food matter in the mouth at 7:05 am. The staff tried to remove the matter without success. Staff identified the mass as pancakes. Breakfast that morning consisted of pancakes with syrup. The facility called an ambulance at 7:07 am and after many	H 031		

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H 031	Continued From Page 34 attempts failed to successfully clear the airway. According to the ambulance report, the EMT (Emergency Medical Technician) intubated (opened the airway) the patient at 8:05 am. The hospital documented the cause of death as Anoxic Brain Damage, Respiratory Arrest. In summary, the RN (Registered Nurse) failed to document a plan of care for this patient's tendency for choking, failed to supervise nursing staff to assure the close observation during meal time, and failed to assure that this patient received their food in small bite size pieces as the diet required and with ground meat as ordered by the physician.	H 031		
H 033	KAR 28-34-7(g) Nursing Policies/Procedures Nursing care policies and procedures shall be in writing and consistent with generally accepted practice and shall be reviewed and revised as necessary. This RULE: is not met as evidenced by: The facility identified a census of 319 patients. Based on record review, staff and alert resident interview, the facility failed to assure nursing staff followed physician's written orders for needed medical supplies required for a documented medical condition for one alert resident. Findings included: - Review of the medical record for an alert resident revealed a physician's order, dated 4/24/06 and brought forward as a continued and current order for-"...May use Fan as long as it abides by the fire code regulation -due to Bronchial Asthma..." Further review of the medical record revealed	H 033	H 033 Nursing Policies/Procedures (page 35): How correction has been, or will be, accomplished: Physician will review this resident's medical order for medical necessity. If determined a fan is medically necessary, electricity will be provided in the resident's room or the resident will be moved to a room with electricity. Completion date January 1, 2007. How others potentially affected by the same deficiency have been, or will be, identified: Review of patient Grievances. Processes that have been, or will be, established to ensure the deficiency does not reoccur: Enhanced nursing supervisory structure in this Program, to provide closer oversight to staff practices. How performance will be monitored to ensure improvement is sustained: Nurse Leader on the unit will monitor compliance regarding physician orders. How substantial compliance will be measured: Compliance monitored through routine chart checks. Position responsible for correction: Clinical Director and Unit Leader	

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H 033	Continued From Page 35	H 033		

documentation of the resident using the fan when on a different unit, for the last several months, prior to being moved to their present living quarters on the Intensive Treatment Unit.

The alert resident, on 10/31/06 at 8:35 pm., verified they had a physician's order for the fan, and used the fan until the facility moved them to this unit. They stated the windows in this unit won't let enough air in, and it is hard to breathe. They further stated this unit has no electricity in patient rooms, and that is why they can't use their fan anymore.

Observation in this unit, on 10/31/06, verified the individual resident rooms did not have electrical outlets, and further more the facility only had 3 individual electrical outlets available for resident use in the unit, 1 on 2 sides of the nurses station, and 1 towards the ceiling above the wall mounted television and 2 of those were occupied by multi outlet plugs owned by other residents.

Interview with facility staff member #T, on 11/15/06 at 12:05 pm. verified they knew the reason the fan denial involved the lack of electrical outlets. Staff further verified the medical record lacked documentation of physician notification of staff not following the physician's order.

Interview with facility staff member #FF, on 11/15/06 at 12:50 pm., verified the patient owned their own fan, and had the fan on their current unit, but cannot use it due to no electricity in the building the facility moved this resident to.

Review of the medical record revealed the facility moved this resident to the current unit in the Jung Building on 9/5/06, knowing the resident needed the fan, knowing the resident previously

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H 033	Continued From Page 36 used the fan for their medical condition, knowing the resident had a physician's order for the fan, and further knowing the building did not have the electrical outlets for the required equipment to support this resident's medical condition. The ITU treatment team documented meeting on 10/11/06 and discussed this resident's medical issues and physician's order for a fan. The meeting minutes documented that staff discussed the possibility of putting electricity in a couple of resident rooms to accommodate these types of needs and documented a work order would be filled out. As of 11/16/06, the facility failed to accommodate this resident's medical needs.	H 033		
H 054	KAR 28-34-9a(d)(5) MR, Confidentiality Each record shall be treated as confidential. Only persons authorized by the governing body shall have access to the records. These persons shall include individuals designated by the licensing agency for the purpose of verifying compliance with state or federal statutes or regulations and for disease control investigations of public health concern. This RULE: is not met as evidenced by: The facility identified a census of 319 residents. Based on observation and staff interview, the facility failed to prevent unauthorized access to medical records. Findings included: - During tour of the Isaac Ray building, on 11/2/06 at 8:55 am. a counter in the the Dental Clinic contained a box with greater than 150 patient medical records. Interview with Staff member #BB, at that time verified the records	H 054	H 054 MR, Confidentiality (page 37): How correction has been, or will be, accomplished: A box in the dental clinic area containing patient dental records was sitting on the counter, in the process of being filed. The box was removed on November 9, 2006, and the medical records filed in the appropriate area for files not currently in use. How others potentially affected by the same deficiency have been, or will be, identified: All patient medical records maintained by the clinic will be maintained in locked file cabinets. The rooms in which these file cabinets are kept, are also locked. All keys are kept by clinic staff only and patient records may only be accessed with a key maintained by clinic staff. Processes that have been, or will be, established to ensure the deficiency does not reoccur: Dental clinic files are secured in locked filing cabinets, and in a locked room. No dental records are maintained in any unlocked file cabinet. How performance will be monitored to ensure improvement is sustained: A monitoring log has been created and will be kept in the main clinic office area. At the end of each day's Clinics, the log will be checked to ensure that all file cabinets are locked. The monitor will be reviewed for compliance each month by the clinic's Sr. Administrative Assistant. Any non-compliance will be reported to the Clinic Director for appropriate follow up. How substantial compliance will be monitored The monitor will be assessed for compliance by the Sr. Administrative Assistant. Any non-compliance will be reported to the Clinic Director for follow up. The compliance rate will be targeted at 100%, with an expectation of no less than 95%. Position responsible for correction: Clinic Director/Manager	

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	M073001	A. BUILDING ______ B. WING ______	11/16/2006

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LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

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H 054	Continued From Page 37 should not have been there. Further observation in this area revealed 2 unlocked file cabinets with greater than 1000 patient medical records in each. Further more 1 of these file cabinets lacked the capability to be locked. Interview with staff member #CC, at that time, verified that when housekeeping needs to clean the area, the staff with keys let them into the area, but do not always stay with them.	H 054		
H9999	Final Comments KAR 28-34-14(f). Dietary Department. Adequate administrative, working, and storage space and facilities shall be provided. There shall be a separate storage area above floor level for food. This requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a separate storage area for food. Findings included: - Tour of the dry food storage area, on 11/14/06 at 12:17 pm., revealed the facility stored patient bed mattresses in multiple areas surrounded by dried food storage. Interview with facility staff member #DD, on 11/14/07 at 12:22 pm, verified they were unaware of a requirement to store food separately. KAR 28-34-15(i) Laundry. The washing and rinsing process shall be adequate to provide	H9999	H 9999 Final Comments – Dietary Dept (page 38): Plan of Correction as noted on H 014 Dietary (page 31)	

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H9999	Continued From Page 38	H9999		

protection to patients and personnel. The temperature of water during the washing process shall be controlled to provide minimum temperature of 165 degrees Fahrenheit for 25 minutes.

This requirement is not met as evidenced by:

The facility identified a census of 319 residents. Based on observation and staff interview, the facility failed to properly wash laundry.

Findings included:

- Tour in the Isaac Ray building, on 11/2/06 at 10:02 am., revealed a Living Skills room with a washer and dryer identified for resident use. The maximum water temperature, on the hot setting, only reached 100 degrees Fahrenheit. Facility staff member #BB, at that time, verified the facility washed hand towels used in their cooking classes. The washing machine, at the time of the tour, contained hand towels, wash rags, and multiple t-shirts, with the washing machine set on the warm setting, which tested at 82 degrees Fahrenheit on that setting.

KAR 28-34-21(b). Psychiatric department. In hospitals where an organized psychiatric department is established, the following shall apply: Adequate facilities, equipment, and personnel shall be provided commensurate with the hospital's psychiatric program. There shall be a written description of the program.

This requirement is not met as evidenced by:

The facility identified a census of 319 residents of which 22 were located on the intensive treatment unit (ITU). Based on record review

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H9999	Continued From Page 39 and staff interview, the facility failed to follow the inpatient sexual predator treatment program (SPTP) plan for 2 of 4 patients sampled in the ITU. (#1 and #4) Findings included: - Review of the facility " Sexual Predator Treatment Program of Kansas-Intensive Treatment Unit Handbook " revealed a 10-step program for patients admitted to the ITU which takes a minimum of 12 weeks to complete. Each step advanced (one to ten) is based on a weekly behavioral assessment. Record review of patient # 1 revealed an admission to the intensive treatment unit (ITU) on 7/10/06 at step level one. On 10/18/06 the patient advanced to step 8 and on 10/26/06 dropped back to level 1. Records revealed on 11/8/06 the treatment team reconsidered and advanced the patient back up to step 8. On 10/30/06 at 6:50 pm patient #97 stated " patients make the same mistakes over and over because they get no direction from here " . Interview with staff T on 11/15/06 at 3:45 pm verified the facility did not follow the SPTP when dropping patient #1 from step 8 back to step 1 indicating the policy needed to be changed for clarification. - Review of the weekly points earned as well as the step assignment for resident #4 revealed the resident earned points enough to allow advancement to step 8 on 10/6/06-10/12/06, and this was done. The following week this resident earned points totaling 36.8, which still earned the patient step 8 status, but facility staff dropped the resident to step 7. Further review of the medical	H9999		

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H9999	Continued From Page 40 record failed to evidence documentation to support this decision to drop the resident's status. Interview with facility staff member #T, on 11/15/06 at 12:02 pm. verified the medical record failed to document the thought process for this decision. This staff member stated they use clinical judgement to round up or down in the points system, and verified staff failed to thoroughly explain the variance in the points and steps assignment to the residents and further the staff failed to apply it consistently. KAR 28-34-31(c) General sanitation and housekeeping. The premises shall be kept neat, clean, and free of rubbish. This requirement is not met as evidenced by: The facility identified a census of 319 residents. Based on observation, staff and patient interview, the facility failed to keep patient areas neat, clean, and free of rubbish. Findings included: - Tours of the multiple State licensed patient areas, between 10/30/06 and 11/15/06, revealed all licensed patient areas with multiple unkept and unclean areas, as well as multiple non to partially functioning equipment, a sampling of which included the following: Jung Building- (1) Hallway leading to the Cafeteria with multiple 4 inch diameter dust balls, and a build up of dust, dirt, cobwebs, crumbled up papers, and dead bugs throughout this hallway. Interview with Resident #98, on 10/31/06 at 4:07 pm. verified the facility never cleaned this area.	H9999	H 9999 Final Comments – General Sanitation – Jung Bldg 1 (page 41): Plan of Correction as noted on H 014 Noted Jung Bldg 1 (page 24)	

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H9999	Continued From Page 41	H9999		
	(2) Dining Hall, a build up of dust and dirt on all window sills, along with spilled salt and paper pieces on a 20 foot long area. Eight vents under windows with such a build up on dust, dirt and debris, that either no or very little fresh air can get through the vents and into the room. Walls streaked with food stains and gouges in the walls. Seven tables with a build up of greasy substance, which can be scraped up with a fingernail. An area on the ceiling, 7 inches long by 3/4 inches wide, with a dark brown, orange substance, partially dried up, and flaking from the ceiling. Build up on perimeter of the floor of dark sticky substance, 1-2 inches around the perimeter of the room, along the baseboard. Multiple yellow, orange, and red stains on the walls.		H 9999 Final Comments – General Sanitation – Jung Bldg 2 (page 42): Plan of Correction as noted on H 014 Noted Jung Bldg 2(page 24)	
	(3) Kitchen tray line serving area contained exhaust fans with a build up of dust, multiple streaks of food down the wall of the serving line, and a build up of dark brown food substance in the grout. The floor beneath this area contained a build up of brown/black substance. The ice/water dispensing machine contained a build up of reddish/white/green substance on the plastic spouts. The wall behind the ice machine contained a dead/splattered bug. Interview with resident #98, at that time, verified the splattered dead bug on this wall for greater than 3 weeks.		H 9999 Final Comments – General Sanitation – Jung Bldg 3 (page 42): Plan of Correction as noted on H 014 Noted Jung Bldg 3 (page 25)	
	(4) The walls in the room of Resident #92 contained multiple yellow/orange streaks down the walls and multiple areas of dried white substance.		H 9999 Final Comments – General Sanitation – Jung Bldg 4 (page 42): Plan of Correction as noted on H 014 Noted Jung Bldg 4 (page 25)	
	(5) The walls of room 142, currently without a resident, contained multiple orange/brown streaks down the walls, as well as a dark orange/brown ring in the toilet bowl.		H 9999 Final Comments – General Sanitation – Jung Bldg 5 (page 42): Plan of Correction as noted on H 014 Noted Jung Bldg 5 (page 25)	

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H9999	Continued From Page 42 (6) Water fountains which did not function. Resident #2, on 10/31/06 at 3:10 pm., stated the fountain has not worked for at least 2 weeks, and Maintenance turned the water off the to drinking fountain. (7) A wooden chair in the television room with a broken arm rest. (8) Multiple light fixtures and cage covers over smoke detectors with a build of dust. (9) Multiple vinyl chair cushions with tears in the vinyl exposing the foam underneath. (10) An air circulation unit in the small television/group meeting room contained a non-functioning circulator. The air in the room was warm, and the room felt stuffy. Resident #98, on 10/31/06 at 3:40 pm., verified the room gets stuffy and that the circulator did not work. (11) Tear in the vinyl on the examination table pad, exposing the foam underneath. (12) The walls in the room of resident #97 contained multiple brown and yellow streaks and spots. The curtain for this residents room consisted of a folded up bedspread which was held up by multiple paper clips and tape. The patient further stated they scrubbed on their walls, but could not get the stains off of the walls. (13) The window curtains in the room of resident #96 revealed multiple curtain panels, facing different directions, and all failed to cover the bottom 6 inches of the resident's window allowing for privacy. The patient stated, on 10/31/06 at 2:40 pm. they had to put up a drawing board to attempt to cover the rest of the	H9999	H 9999 Final Comments – General Sanitation – Jung Bldg 6 (page 43): Plan of Correction as noted on H 014 Jung Bldg 6 (page 25) H 9999 Final Comments – General Sanitation – Jung Bldg 7 (page 43): Plan of Correction as noted on H 014 Jung Bldg 6 (page 25) H 9999 Final Comments – General Sanitation – Jung Bldg 8 (page 43): Plan of Correction as noted on H 014 Jung Bldg 8 (page 25) H 9999 Final Comments – General Sanitation – Jung Bldg 9 (page 43): Plan of Correction as noted on H 014 Noted Jung Bldg 9 (page 25) H 9999 Final Comments – General Sanitation – Jung Bldg 10 (page 43): Plan of Correction as noted on H 014 Jung Bldg 10 (page 25) H 9999 Final Comments – General Sanitation – Jung Bldg 11 (page 43): Plan of Correction as noted on H 014 Noted Jung Bldg 11 (page 26) H 9999 Final Comments – General Sanitation – Jung Bldg 12 (page 43): Plan of Correction as noted on H 014 Jung Bldg 12 (page 26) H 9999 Final Comments – General Sanitation – Jung Bldg 13 (page 43): Plan of Correction as noted on H 014 Noted Jung Bldg 13 (page 26)	

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H9999	Continued From Page 43	H9999		
	window.			
	(14) The central shower room did not have shower curtains covering all of the shower stalls to allow privacy for residents when showering. One shower curtain was too long for the shower and was folded up and stapled to the right length, but this created staples sticking out of the shower curtain.		H 9999 Final Comments – General Sanitation – Jung Bldg 14 (page 44): Plan of Correction as noted on H 014 Noted Jung Bldg 14 (page 26)	
	(15) Multiple pay phones without the means for the residents to have a private conversation .		H 9999 Final Comments – General Sanitation – Jung Bldg 15 (page 44): Plan of Correction as noted on H 014 Noted Jung Bldg 15 (page 26)	
	Meyer Building:			
	(1) Dining Hall contained 24 tables with a build up of sticky substance, able to be scraped up with a fingernail. Vents under 8 windows clogged with a build up of dust and dirt, not allowing any fresh into the room. Window and door ledges all contained a build up of dust and dirt. Two salad bar tables contained a build up of dust, dirt, and debris. A fan with a build up to dust on the grate and blades. The doorway from the dining hall to the garden/activity area, contained a build up of black sticky substance.		H 9999 Final Comments, Meyer Bldg 1 (page 44): Plan of Correction as noted on H 014 Noted Meyer Bldg 1 (page 26)	
	(2) Hallway to Meyer floor contained multiple Kleenexes, wadded up napkins and papers. Foyer to exit to Meyer contained cups, cotton balls, leaves and a pile of dust and debris.		H 9999 Final Comments, Meyer Bldg 2 (page 44): Plan of Correction as noted on H 014 Noted Meyer Bldg 2(page 27)	
	(3) Day hall contained a fan blowing air in the room with a build up on dust and dirt on the grate and blades.		H 9999 Final Comments, Meyer Bldg 3 (page 44): Plan of Correction as noted on H 014 Noted Meyer Bldg 3(page 27)	
	(4) Shower room with a non functioning air return. Interview with staff member X, on 11/1/06 at 10:06 am. verified the staff told engineering and put in a work order, but was not sure what happened with that. This shower room also failed		H 9999 Final Comments, Meyer Bldg 4 (page 44): Plan of Correction as noted on H 014 Meyer Bldg 4 (page 27)	

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H9999	Continued From Page 44 to have shower curtain to allow privacy while showering in 1 of 3 shower stalls. Interview with Resident W, on 11/1/06 at 10:06 am., verified the missing shower curtain became moldy and they threw it away, and had not replaced it. (5) Multiple vinyl cushions with tears in the vinyl exposing the foam underneath, in various sizes. (6) A fan with dusty dirty grate and blades, turning the blades almost black from the build up. (7) A common restroom contained a broken toilet paper holder. (8) A wooden framed couch contained multiple areas of graffiti and vulgar pictures dug into the wood frame. (9) The vent in the mop room made a loud noise, but failed to work. The very warm air in this room contained a foul odor. (10) The supply room window screen contained a build up of dust and cobwebs, making the window unable to be seen out of. (11) The sink in patient room #162, which did not have a patient at the time of the tour, contained a torn mattress and a non-functioning hand washing sink. Staff member U, on 11/1/06 at 10:07 am. verified Engineering shut the water off to this sink due to their inability to fix the sink. (12) The toilet in the room of patient #100 leaked and formed a 10 inch diameter puddle of water on the floor of the patient's room and the hand washing sink did not work at all. Staff member U, on 11/1/06 at 10:11 am., verified this was reported. The patient stated this has been	H9999	H 9999 Final Comments, Meyer Bldg 5 (page 45): Plan of Correction as noted on H 014 Noted Meyer Bldg 5 (page 27) H 9999 Final Comments, Meyer Bldg 6 (page 45): Plan of Correction as noted on H 014 Noted Meyer Bldg 6 (page 27) H 9999 Final Comments, Meyer Bldg 7 (page 45): Plan of Correction as noted on H 014 Noted Meyer Bldg 7 (page 27) H 9999 Final Comments, Meyer Bldg 8 (page 45): Plan of Correction as noted on H 014 Meyer Bldg 8 (page 27) H 9999 Final Comments, Meyer Bldg 9 (page 45): Plan of Correction as noted on H 014 Meyer Bldg 8 (page 27) H 9999 Final Comments, Meyer Bldg 10 (page 45): Plan of Correction as noted on H 014 Noted Meyer Bldg 10 (page 28) H 9999 Final Comments, Meyer Bldg 11 (page 45): Plan of Correction as noted on H 014 Meyer Bldg 8 (page 27) H 9999 Final Comments, Meyer Bldg 12 (page 45): Plan of Correction as noted on H 014 Meyer 12 (page 28)	

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H9999	Continued From Page 45 ongoing for "2 months or so." (13) Pay phones without the means for residents to have a private conversation. Isaac Ray: (1) A television room with 15 feet of missing baseboard. (2) Multiple common rooms with a build up of dust and dirt on the window ledges. (3) Multiple common television/day rooms with multiple chairs snuggled up against each other and lining the entire wall area of the rooms. These lines of chairs contained a build up of food particles, trash, dust and dirt, between each other, as well as between them and the walls. (4) The patient laundry room washing machine failed to work. (5) A central shower room with 4 shower stalls with no shower curtains on any of the stalls. (6) Multiple light fixtures with numerous dead bugs visible in the lights. (7) Fans with dusty and dirty grates and blades. (8) Examination room and hallway with dried alcohol wipe on the floor as well as a build up of dust on the tops of flat surfaces such as the multiple X-Ray lights, floor lamp, Scale, and the blood pressure machine wall unit. (9) Pay phones without the means for residents to have a private conversation. Dillon Building:	H9999	H 9999 Final Comments, Meyer Bldg 13 (page 46): Plan of Correction as noted on H 014 Noted Meyer Bldg 13 (page 28) H 9999 Final Comments, Isaac Ray Bldg 1 (page 46): Plan of Correction as noted on H 014 Isaac Ray Bldg 1 (page 28) H 9999 Final Comments, Isaac Ray Bldg 2 (page 46): Plan of Correction as noted on H 014 Noted Isaac Ray Bldg 2 (page 28) H 9999 Final Comments, Isaac Ray Bldg 3 (page 46): Plan of Correction as noted on H 014 Noted Isaac Ray Bldg 3 (page 28) H 9999 Final Comments, Isaac Ray Bldg 4 (page 46): Plan of Correction as noted on H 014 Isaac Ray Bldg 4 (page 28) H 9999 Final Comments, Isaac Ray Bldg 5 (page 46): Plan of Correction as noted on H 014 Noted Isaac Ray Bldg 5 (page 29) H 9999 Final Comments, Isaac Ray Bldg 6 (page 46): Plan of Correction as noted on H 014 Isaac Ray Bldg 6 (page 29)	

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LARNED STATE HOSPITAL	**ROUTE #3 BOX 89** **LARNED, KS 67550**

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H9999	Continued From Page 46 (1) The basement and woodshop restrooms contained no door or curtain for privacy for the toilet areas, within a room that failed to allow residents to lock the door. (2) Multiple marred walls and chairs with missing areas of vinyl exposing the foam underneath. (3) Multiple boxes stored on the floors in the Library. (4) Theatre fabric chairs, 77 each, with multiple large stains and fabric worn showing the foam underneath. (5) Activity room contained an 18 inch diameter round cut out in the tile floor, with a black plastic seal placed around the perimeter, with 3 inch wide clear plastic tape over the edges of the cover, attempting to seal the cover. When staff member E, stepped on this circle, a very strong sewer gas smell permeated the room. The restrooms failed to have a means to allow privacy for the toilet areas. (6) The Home Living room contained multiple very dusty shelves. (7) A leaking base in a utility room water draw area with a floor drain created a strong ammonia odor. The resident's washing machine drained into this base and caused the water to stream out onto the floor of the room. Resident #94 stated on 10/31/06 at 11:12 am. that the resident's had to keep using this washing machine to wash their personal laundry, and they stood in water to do so. They further stated they reported the problem several times since 4/06, and Maintenance tried to fix it once, but the fix failed to hold, and started leaking again within 24	H9999	H 9999 Final Comments, Dillon Bldg 1 (page 47): Plan of Correction as noted on H 014 Noted Dillon Bldg 1 (page 29) H 9999 Final Comments, Dillon Bldg 2 (page 47): Plan of Correction as noted on H 014 Noted Dillon Bldg 2 (page 29) H 9999 Final Comments, Dillon Bldg 3 (page 47): Plan of Correction as noted on H 014 Noted Dillon Bldg 3 (page 29) H 9999 Final Comments, Dillon Bldg 4 (page 47): Plan of Correction as noted on H 014 Noted Dillon Bldg 4 (page 29) H 9999 Final Comments, Dillon Bldg 5 (page 47): Plan of Correction as noted on H 014 Dillon 5 (page 30) H 9999 Final Comments, Dillon Bldg 6 (page 47): Plan of Correction as noted on H 014 Dillon Bldg 7 (page 30) H 9999 Final Comments, Dillon Bldg 7 (page 47): Plan of Correction as noted on H 014 Noted Dillon Bldg 7 (page 30)	

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING ______ B. WING ______	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H9999	Continued From Page 47 hours, and Maintenance failed to come back to fix it again. (8) Multiple living room areas with most or all of the chair cushions containing multiple torn areas is the vinyl exposing the foam underneath, some areas measured greater than 8 inches in diameter. (9) Multiple microwave ovens and a crock pot, unclean, with food particles remaining in them. (10) Multiple chair cushions with dark ink print on them in the resident's living room. Staff member Q stated the resident workers tried to get the print off of the cushions, but couldn't. This staff member further stated that their experience with the hospital was they "just had to live with it." (11) One handicapped shower failed to have the sprayer hose attached to allow the shower to be used for handicapped patients. A search of the shower room revealed the shower attachment failed to work. (12) Pay phones without the means for residents to have a private conversation. KAR 28-34-31(d) General sanitation and housekeeping. Housekeeping procedures shall be written. This requirement is not met as evidenced by: The facility identified a census of 319 residents. Based on staff interview, the facility failed to have written housekeeping procedures. Findings included:	H9999	H 9999 Final Comments, Dillon Bldg 8 (page 48): Plan of Correction as noted on H 014 Noted Dillon Bldg 8 (page 30) H 9999 Final Comments, Dillon Bldg 9 (page 48): Plan of Correction as noted on H 014 Noted Dillon Bldg 9 (page 30) H 9999 Final Comments, Dillon Bldg 10 (page 48): Plan of Correction as noted on H 014 Noted Dillon Bldg 10 (page 30) H 9999 Final Comments, Dillon Bldg 11 (page 48): Plan of Correction as noted on H 014 Dillon Bldg 7 (page 30) H 9999 Final Comments, Dillon Bldg 12 (page 48): Plan of Correction as noted on H 014 Noted Dillon Bldg 12 (page 31)	

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING ____ B. WING ____	11/16/2006

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H9999	Continued From Page 48 - Interview on 11/1/06 at 9:30 am. with staff member X, verified the facility did not have any housekeeping policies they were aware of. Staff member V, on 11/1/06 at 9:32 am., further verified they were unaware of any written housekeeping policies for the facility. KAR 28-34-31(h). General sanitation and housekeeping. There shall be adequate hand washing facilities conveniently located. This requirement is not met as evidenced by: The facility identified a census of 319 residents. Based on observation, staff and patient interview, the facility failed to have adequate working hand washing facilities. Findings included: - Tours of the multiple State licensed patient areas, between 10/30/06 and 11/15/06, revealed all licensed buildings with non working or inadequately working hand washing facilities, a sampling of which included: - (a) In the Jung Building, the sink in the patient #97's room contained a cut off straw in the spigot to cause the stream to direct the water into the bowl of the sink, instead of onto the floor. This patient, on 10/31/06 at 2:20 pm., verified without the straw the water barely came out of the spigot and then ran onto the sink ledge and onto the floor. (b) In the Meyer building, a central restroom contained a very slow draining sink. Staff member V, on 11/1/06 at 9:02 am., verified facility engineering aware of this situation, have looked it over several times in the last year, but	H9999	H 9999 Final Comments, General Sanitation/Housekeeping 1 (page 49): How correction has been, or will be, accomplished: All VTP workers have position descriptions telling them what areas and tasks need to be cleaned and are their responsibilities. The Environmental Services department has a policy and procedure manual which is available to all areas of campus. The Custodial Manager will ensure all program directors have access to this manual. Completion date on or before December 22, 2006. How others potentially affected by the same deficiency have been, or will be, identified: Custodial Manager will check with all program directors to be sure they have access to the manual. Processes that have been, or will be, established to ensure the deficiency does not reoccur: Custodial Manager will provide any updates or changes to the manual are delivered to the program directors. Monthly inspections will ensure corrections are in place. How performance will be monitored to ensure improvement is sustained: Custodial Manager will check annually with Program Directors as to the status of the manual. Monthly safety tours will monitor for sustained improvements. How substantial compliance will be measured: Custodial Manager will check annually with Program Directors as to the status of the manual. Director of Safety and Environment will collect and aggregate safety tour data, and follow-up as indicated. Position responsible for correction: Custodial Manager and VTP Supervisors	

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING ______ B. WING ______	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H9999	Continued From Page 49 failed to fix the problem. They further verified that in the time it took to get a water temp, the sink almost ran over. They stated Engineering last looked at this sink about 1 month ago. (c) In the Isaac Ray building, a hand washing sink in the patient laundry room failed to work. (d) The Dillon Building contained Multiple rooms where the water flow to the hand washing sinks stopped as soon as the residents left pressure off of the button, not allowing the residents to use friction to wash their hands. Interview with facility staff member E, on 10/31/06 at 11:45 am., verified all of the hand washing sinks in this unit were set up to only stay on as long as the resident held in the button, and the water stopped as soon as they left off the button. Resident #95, at that time further verified they had to use their knee to hold in on the button in order to be able to rub their hands together to wash them. The Dillon Building further contained multiple central bathrooms with non-functioning hand washing sinks, as well as sinks which functioned but the stream of water failed to allow for proper hand washing and furthermore trickled out onto the sink ledges and onto the floor. Resident #94 stated that most sinks on their unit, with 32 patients, failed to work. A central restroom contained 2 handwashing sinks with clean plastic tape partially over the spigot. Resident #93 stated on 10/31/06 at 10:00 am. that Engineering had worked on the sinks, but they have a pressure problem. A central restroom contained cut off straws which resident stuck into the water spigots of the hand washing sinks. Facility staff member E,	H9999	H 9999 Final Comments, General Sanitation/Housekeeping 2.c (page 50): How correction has been, or will be, accomplished: Larned State Hospital has been unable to locate this specific deficiency. H 9999 Final Comments, General Sanitation/Housekeeping 2.d (page 50): Plan of Correction as noted on H 011 Dillon Bldg 3 (page 10)	

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: M073001	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARNED STATE HOSPITAL	**ROUTE #3 BOX 89 LARNED, KS 67550**

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H9999	Continued From Page 50 stated on 10/31/06 at 9:07 am. that the hand washing sinks were supposed to spray out 2 inches into the bowl, and verified these sinks only sprayed out 1/4 to 1/2 inch from the rim of the sink underneath the spigot. KAR 28-34-31(i) General sanitation and housekeeping. Common drinking cups shall be prohibited. This requirement is not met as evidenced by: The facility identified a census of 319 residents. Based on observation, staff and patient interview, the facility failed to maintain common drinking fountains with adequate flow to prevent the fountain from becoming a common drinking apparatus. Findings included: Tours of State licensed patient areas, between 10/30/06 and 11/15/06, revealed multiple drinking fountains in the Dillon and Isaac Ray buildings, with the water flow so low, residents could not get a drink of water without placing their mouths on the spigot, creating a common drinking apparatus. Resident #91, on 11/2/06 at 12:14 pm. verified the facility had multiple drinking fountains with flow so low the residents could not avoid putting their mouth on the spigots. Facility staff member Z, on 11/2/06 at 11:50 am., verified the water fountains failed to have enough water pressure to prevent residents from putting their mouths on the spigots.	H9999	H 9999 Final Comments, KAR 28-34-31 (i) General Sanitation/Housekeeping (page 51): Plan of Correction as noted on H 011 Dillon Bldg 3 (page 10)	

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M073001	A. BUILDING B. WING	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H9999	Continued From Page 51 KAR 28-34-31(k) General sanitation and housekeeping. Adequate and conveniently located toilet facilities shall be provided. This requirement is not met as evidenced by: The facility identified a census of 319 residents. Based on observation and staff interview, the facility failed to maintain a handicapped central toilet in the Dillon East 1 bathroom. Findings included: - On 10/31/06 at 10:50 am., the Dillon East 1 resident central bathroom contained a sign on the Handicapped toiled which stated-"This toilet is out of order since 6/15/06." Facility staff member E, on 10/31/06 at 10:45 am. verified this toilet failed to function, and did not have any water to it at all. Interview with staff members S and R, on 10/31/06 at 10:58 am., verified both knew of the problem, had reported the problem multiple times and both quit reporting the continued loss of the toilet function when a female staff member in the Engineering department said Maintenance staff knew of the problem, and told them to stop reporting it. KAR 28-34-31(l) General sanitation and housekeeping. Periodic checks shall be made throughout the buildings and premises to enforce sanitation procedures. The times and results of such checks shall be recorded. This requirement is not met as evidenced by: The facility identified a census of 319 residents. Based on observation, staff and patient interview, the facility failed to perform adequate checks of the buildings maintenance and	H9999	H 9999 Final Comments, KAR 28-34-31 (k) General Sanitation/Housekeeping (page 52): Plan of Correction as noted on H 011 Dillon Bldg 2 (page 7) H 9999 Final Comments, KAR 28-34-31 (l) General Sanitation/Housekeeping (page 52): <u>How correction has been, or will be, accomplished</u>: Supervisors of the Environmental Services department will perform weekly inspections of all areas cleaned by the environmental services staff. Completion date on or before January 1, 2007. <u>How others potentially affected by the same deficiency have been, or will be, identified</u>: The supervisors of the Environmental Services department will perform weekly inspections of all areas cleaned by the environmental services staff. <u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>: Weekly inspections will occur in all areas. <u>How performance will be monitored to ensure improvement is sustained</u>: This will be a component of the preventative maintenance program as well as the monthly safety tour check-list, for staff to use during their monthly inspections. <u>How substantial compliance will be measured</u>: Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends <u>Position responsible for correction</u>: Custodial Manager	

Bureau of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: M073001	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 11/16/2006

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H9999	Continued From Page 52 sanitation. Findings included: - Review of the deficiencies written under KAR 28-34-31(c),(d),(h),(i),and (k) revealed multiple areas with unclean and unkept patient areas as well as multiple non functioning equipment. Interview with staff member #AA, on 11/13/06 at 4:20 pm. revealed a team of personnel go room by room and check for problems, needed cleaning, and life safety code issues, as well as needed repairs. They further stated they do these checks every 6 months (where patient's sleep and do activities). Interview with staff member Z, on 11/15/06 at 10:12 am. verified they do the housekeeping and maintenance rounds every 6 months for patient areas, but further verified the documentation is poor regarding when and if repairs were made.	H9999		

4.53

<u>**Attachment to Page 2 of 53**</u>

H 009 Jung Bldg 2 (page 2):
<u>How correction has been, or will be, accomplished</u>:
LSH Engineering Dept issued a job ticket to Grounds Dept. to remove and repair bench and table. Work was completed on or about November 17, 2006.
<u>How others potentially affected by the same deficiency have been, or will be, identified</u>:
Notification will be sent to Grounds Dept Supervisor to instruct Grounds Dept personnel to look for damaged benches and tables in other areas. Corrections will be made as identified.
<u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
<u>How performance will be monitored to ensure improvement is sustained</u>:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
<u>How substantial compliance will be measured</u>:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
<u>Position responsible for correction</u>:
Physical Plant Supervisor Specialist

H 009 Jung Bldg 3 (page 2):
<u>How correction has been, or will be, accomplished</u>:
LSH Engineering Dept issued a job ticket to Grounds Dept. to remove and repair bench. Work was completed on or about November 17, 2006.
<u>How others potentially affected by the same deficiency have been, or will be, identified</u>:
Notification will be sent to Grounds Dept Supervisor to instruct Grounds Dept personnel to look for damaged benches in other areas. Corrections will be made as identified.
<u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
<u>How performance will be monitored to ensure improvement is sustained</u>:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
<u>How substantial compliance will be measured</u>:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
<u>Position responsible for correction</u>:
Physical Plant Supervisor Specialist

H 009 Jung Bldg 4 (page 2):
<u>How correction has been, or will be, accomplished</u>:
LSH Engineering Dept issued a job ticket to the Electric Dept. to install a padlock on the disconnect. Work was completed on or about December 12, 2006.
<u>How others potentially affected by the same deficiency have been, or will be, identified</u>:
Notification will be sent to Electric Dept Supervisor to instruct Electric Dept personnel to look for missing locks on disconnect boxes in all areas. Corrections will be made as identified.
<u>Processes that have been, or will be, established to ensure the deficiency does not reoccur</u>:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly or quarterly inspections.
<u>How performance will be monitored to ensure improvement is sustained</u>:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
<u>How substantial compliance will be measured</u>:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of

Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Jung Bldg 5 (page 2):
How correction has been, or will be, accomplished:
Personal protective equipment was delivered to Jung on December 15, 2006. A GFCI receptacle was installed in the janitor closet on December 8, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned supervisors to inspect all closets in all buildings to ensure the necessary personal protective equipment is available. Notification will be sent to the Electric Dept Supervisor to instruct Electric Dept personnel to assess areas requiring GFCI Receptacles. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur
Monthly or quarterly safety tours will ensure presence of GFCI Receptacles and personal protective equipment in relevant closets. When personal protective equipment is used or otherwise removed, the custodial supervisor of the identified building will order replacements through the Supply Dept.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for corrections:
Environmental Service Manager; Physical Plant Supervisor Specialist

H 009 Jung Bldg 6 (page 2):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 14, 2006. The water temperature at the hand-sink was increased to 105 degrees on or around November 20, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the Preventative Maintenance Program Documentation, to be compiled and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Jung Bldg 7 (page 2):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept on December 18, 2006 to repair the tables. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.

Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Jung Bldg 8 (page 2):
How correction has been, or will be, accomplished:
Regarding multi-plug outlets, SPTP will provide a power strip for Jung Bldg residents to use, within code. Completion date February 2007.

Regarding lack of outlets in resident rooms, LSH has submitted a request to Engineering to have electrical outlets installed in all resident rooms. This will likely take some time to accomplish due to availability of capital improvement money. Completion date 2009.
How others potentially affected by the same deficiency have been, or will be, identified:
This issue is relevant only to patients on this unit in the Jung Bldg.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
SPTP policy will identify ongoing availability of power strips, as code allows. Installation of outlets, when funding is available for such, will be a permanent correction.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends. Additionally, Grievance Resolution processes will ensure this improvement is maintained.
How substantial compliance will be measured: Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment. Additionally, Grievance Resolution Committee reports will reflect evidence of compliance.
Position responsible for correction:
Unit Leader

Attachment to Page 3 of 53

H 009 Jung Bldg 10 (page 3):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept staff on December 14, 2006 to repair the countertop. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Dillon Bldg 1 (page 3):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 14, 2006. The water temperature at the hand-sink was increased to 105 degrees on or around November 20, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, and part of the monthly safety tour check-list for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Dillon Bldg 2 (page 3):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept on December 18, 2006 to repair the tables. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:

Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Dillon Bldg 3 (page 3):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The sewer lid and gasket was replaced on or around November 20, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Plumbing Dept Supervisor to instruct Plumbing Dept personnel to look for possible trip hazards as they conduct their day-to-day duties. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

Attachment to Page 4 of 53

H 009 Dillon Bldg 5 (page 4):
How correction has been, or will be, accomplished:
LSH SPTP Program repaired all pine furniture throughout Dillon Building. Work was completed on or before November 20, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Meyer Bldg 1 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept staff on December 14, 2006 to repair the foyer door. Completion date on or before January 20, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged doors on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Meyer Bldg 2 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 14, 2006 to establish the hot water temperature at Meyer Building at 120 degrees. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to establish hot water temperatures in all other patient areas at 120 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, and part of the monthly safety tour check-list for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:

Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Meyer Bldg 3 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on December 18, 2006 to repair the tables. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Meyer Bldg 4 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 14, 2006 to decrease the hot water temperature at Meyer Building to 120 degrees. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to decrease all hot water temperatures in other patient areas to 120 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Meyer Bldg 5 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 14, 2006. The hot water temperature at Meyer Building will be decreased to 120 degrees. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to decrease all hot water temperatures in other patient areas to 120 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their

monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Meyer Bldg 6 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 14, 2006. The hot water temperature at Meyer Building will be decreased to 120 degrees. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to decrease all hot water temperatures in other patient areas to 120 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Isaac Ray Bldg 1 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water temperature at the showers was increased to 105 degrees on or around November 3, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 009 Isaac Ray Bldg 2 (page 4):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water temperature at the showers and sinks were increased to 105 degrees on or around November 3, 2006.

How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 009 Isaac Ray Bldg 3, first bullet (page 5):
How correction has been, or will be, accomplished:
Regarding religious worship practices, residents on this unit (ITU) continue to have the right to individual worship. To accommodate group worship requests, residents on Steps 9 and 10 will be permitted group worship. The Resident Handbook will be updated to inform residents of their access to group worship for when on Steps 9 and 10, and to emphasize their right to individual worship. Completion date on or before August 2007.

Regarding access to activities in other buildings, residents on this unit (ITU) who are on Steps 9 and 10 will be included with Phase 4 and 5 residents from Jung North unit when taken to Gym and Swim. Completion date on or before August 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Each Program has activities identified and specifically tailored for their respective patient populations, with access dependent on patient safety considerations.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
The Resident Handbook will be updated to reflect group religious services for residents on Steps 9 and 10, as well as to reinforce the right to individual worship on any Step. Program policy will note inclusion of identified ITU residents in the Gym and Swim activity. The Handbook and policy will be routinely reviewed for accuracy, with modifications made as needed. Additionally, a facility-wide policy will be developed to establish guidelines for patients practicing a recognized religion within the limitations imposed by hospital physical structures, consistent with security and custody considerations, operational needs, rehabilitation goals and the mission of the Agency.
How performance will be monitored to ensure improvement is sustained:
Grievance Resolution processes will help ensure such improvements are monitored and maintained.
How substantial compliance will be measured:
The SPTP Grievance Resolution Committee reports will reflect evidence of compliance.
Position responsible for correction:
Treatment Team Leader (ITU) and Hospital Attorney

H 009 Isaac Ray Bldg 3, first bullet (page 5):
How correction has been, or will be, accomplished:
Regarding religious worship practices, residents on this unit (ITU) continue to have the right to individual worship. To accommodate group worship requests, residents on Steps 9 and 10 will be permitted group worship. The Resident Handbook will be updated to inform residents of their access to group worship for when on Steps 9 and 10, and to emphasize their right to individual worship. Completion date on or before August 2007.

Regarding access to activities in other buildings, residents on this unit (ITU) who are on Steps 9 and 10 will be included with Phase 4 and 5 residents from Jung North unit when taken to Gym and Swim. Completion date on or before August 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Each Program has activities identified and specifically tailored for their respective patient populations, with access dependent on patient safety considerations.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
The Resident Handbook will be updated to reflect group religious services for residents on Steps 9 and 10, as well as to reinforce the right to individual worship on any Step. Program policy will note inclusion of identified ITU residents in the Gym and Swim activity. The Handbook and policy will be routinely reviewed for accuracy, with modifications made as needed. Additionally, a facility-wide policy will be developed to establish guidelines for patients practicing a recognized religion within the limitations imposed by hospital physical structures, consistent with security and custody considerations, operational needs, rehabilitation goals and the mission of the Agency.
How performance will be monitored to ensure improvement is sustained:
Grievance Resolution processes will help ensure such improvements are monitored and

maintained.
How substantial compliance will be measured:
The SPTP Grievance Resolution Committee reports will reflect evidence of compliance.
Position responsible for correction:
Treatment Team Leader (ITU) and Hospital Attorney

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H 011 Dillon Bldg 2 (page 7):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water Temperature at the showers was increased to 105 degrees on or around November 3, 2006. The pressure at the hand washing sinks was increased on or around November 3, 2006. The LSH Engineering Department completed a warranty request to repair the ADA toilet; the general contractor sent a completion certificate to the LSH Engineering Department but the toilet failed shortly after. The general contractor was contacted to return to repair the toilet a second time, but it failed within one week. The LSH Engineering Department initiated a job ticket for the Plumbing Department and a warranty request to the general contractor, the ADA Toilet was repaired on or before November 3, 2006. Other ADA toilets were available throughout the program space.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification has been sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees and increase pressure to all hand-washing sinks. LSH Engineering Department reviews all outstanding warranty requests for progress.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 014 Governing Body Authority 2 (page 17):
Refer to H014 Governing Body Authority 1 (page 17)

H 014 Governing Body Authority 3 (page 17):
Refer to H011 Dillon Bldg 2 (page 7)

H 014 Governing Body Authority 4 (page 17):
Refer to H011 Dillon Bldg 3 (page 10)

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H 014 Governing Body Authority 5.3 (page 19):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water temperature at the showers was increased to 105 degrees on or around November 3, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Governing Body Authority 5.4 (page 19):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water temperature at the showers was increased to 105 degrees on or around November 3, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Governing Body Authority 5.5 (page 19):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on November 3, 2006. The water temperature at the showers was increased to 105 degrees on or around November 3, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all water temperatures on other patient areas to 105 degrees.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the preventative maintenance program, for staff to use during their monthly inspections.

How performance will be monitored to ensure improvement is sustained:
Physical Plant Supervisor Specialist will initiate Preventative Maintenance Work-Orders to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Preventative Maintenance Program Documentation will be compiled, aggregated and maintained by the Physical Plant Supervisor Specialist.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 014 ATC Bldg 2 (page 20):
How correction has been, or will be, accomplished:
Housekeeping Dept will perform initial cleaning. Unit Leaders will identify the expectation of weekly cleaning of patient care area microwaves on their Unit's 3-11 Shift Assignment Sheet, and will be accountable for ensuring the microwaves are clean and free of debris.
Completion date December 30, 2006
How others potentially affected by the same deficiency have been, or will be, identified:
Cleaning and monitoring expectations are uniform across all LSH Units.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Unit Nursing staff will conduct weekly spot-checks of microwaves located in patient care areas of Units, with follow-up by the 3-11 shift leader if there is lack of compliance.
How performance will be monitored to ensure improvement is sustained:
This item will be incorporated into the comprehensive, monthly Unit Safety Tours.
How substantial compliance will be measured:
Monthly Unit Safety Tours data, aggregated by Director of Safety and Environment, will monitor compliance.
Position responsible for correction:
Unit Leaders

H 014 ATC Bldg 3 (page 20):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on December 18, 2006 to repair the tables. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 ATC Bldg 4 (page 20):
How correction has been, or will be, accomplished:
New anti-fatigue mats will be ordered to replace the damaged mats. Completion date January 31, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial supervisors will inspect all areas that use ergonomic mats to be sure they are found to be safe and in good repair.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Monthly safety tours will look for damage to mats, with replacements ordered through supply as necessary.
How performance will be monitored to ensure improvement is sustained:
Monitoring will occur during these monthly safety tours.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.

Position responsible for correction:
Chief Operating Officer

H 014 ATC Bldg 5 (page 20):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 15, 2006 to increase drinking fountain pressure. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to increase all drinking fountain water pressures on other patient areas.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 ATC Bldg 6 (page 20):
Plan of Correction as noted on H 014 ATC Bldg 5 (page 20):

H 014 ATC Bldg 7 (page 20): Kim Brennan
How correction has been, or will be, accomplished:
The Unit Leader and Shift Leader responsible for the Triage Unit will be notified of this deficiency and instructed that that suction catheters are not to be hooked to the suction machine until ready or needed for use. This practice will assure that these emergency supplies are maintained as sterile. This is applicable directly to Triage but notice of this practice will be sent to all Unit Leaders across the facility. Completion date January 15, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
This notification will be conveyed to all Unit Leaders at LSH.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Unit Nursing staff check emergency carts weekly, and document accordingly if any outdated or opened items are found. Opened items are to be discarded.
How performance will be monitored to ensure improvement is sustained:
This item will be incorporated into the comprehensive, monthly Unit Safety Tours.
How substantial compliance will be measured:
Monthly Unit Safety Tours data, aggregated by Director of Safety & Environment, will monitor compliance.
Position responsible for correction:
Unit Leaders

H 014 Cafeteria Bldg 1 (page 20):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept on December 15, 2006 to repair the door and replace the tiles. Completion date or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Dietary Manager to instruct line level supervisors to identify and report other damaged areas within the Cafeteria. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:

This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Cafeteria Bldg 2 (page 20):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on December 15, 2006 to repair the door. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Dietary Manager to instruct line level supervisors to identify and report other damaged areas within the Cafeteria. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Cafeteria Bldg 3 (page 20):
How correction has been, or will be, accomplished:
The problem was identified as dirt build-up, with floor finish covering the dirt. To correct the condition, the floor is scheduled to be stripped of floor finish and new floor finish applied.
Completion date December 21, 2006
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned custodial supervisors to inspect all areas of campus to be sure there is no dirt build-up on floors. If areas of build-up are found, instructions to resolve these issues are provided.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Weekly inspections, as well as monthly safety tours, will identify concerns. Areas in need of refinishing will occur as identified.
How performance will be monitored to ensure improvement is sustained:
Monitoring will occur through weekly inspections and monthly safety tours.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Custodial Supervisor

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H 014 Cafeteria Bldg 5 (page 21):
Plan of Correction as noted on H 014 Cafeteria Bldg 4 (page 21)

H 014 Cafeteria Bldg 6 (page 21):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on November 8, 2006. Over 90 percent of the tables have been repaired, as of December 21, 2006. Completion date for remaining items on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
LSH Carpentry Department received a job ticket to inspect and repair all dining tables as needed. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Cafeteria Bldg 7 (page 21):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept on December 7, 2006. All missing ceiling tiles were replaced on or before December 12, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to the Carpentry Department to identify any other missing tiles in other patient areas. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety & Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Cafeteria Bldg 8 (page 21):
How correction has been, or will be, accomplished:
The Food Services Director will ensure dept staff clean the machine, and will generate a work order to have the machine repaired and painted.
Completion date for cleaning and work order January 31, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Food Services Director will instruct Food Services supervisors to inspect ice machines in all other kitchens across campus and report any deficiencies.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Monthly safety tours will monitor this deficiency, to ensure improvement is sustained.
How performance will be monitored to ensure improvement is sustained:

Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Director of Dietary Services

H 014 Cafeteria Bldg 9 (page 21):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on December 15, 2006 to repair the door and replace the tile. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Dietary Manager to instruct line level supervisors to identify and report other damaged areas within the Cafeteria. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Cafeteria Bldg 10 (page 21):
Plan of Correction as noted on H 014 Cafeteria Bldg 4 (page 21)

H 014 Hospital Bldg 1 (page 21):
How correction has been, or will be, accomplished:
Window grates were cleaned on December 8, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned the custodial supervisors to inspect all areas of campus to be sure the windows are clean, and to ensure cleaning occurs as needed.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished.
How performance will be monitored to ensure improvement is sustained:
Monitoring will occur through weekly inspections and monthly safety tours.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Custodial Supervisor

H 014 Hospital Bldg 2 (page 21):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 15, 2006 to repair the sink drain. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar deficiencies on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:

This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Hospital Bldg 3 (page 21):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 15, 2006 to increase the water pressure to the sink, and a job ticket to the Paint Dept staff on December 15, 2006. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar deficiencies on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 014 Hospital Bldg 5 (page 22):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Paint Dept staff on December 15, 2006. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Hospital Bldg 6 (page 22):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Paint Dept staff on December 15, 2006. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Hospital Bldg 7 (page 22):
How correction has been, or will be, accomplished:
The table will be sent to Supply for repair.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be issued campus-wide indicating the procedure to have exam tables refinished.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
To be monitored through monthly safety tours, and daily rounds by Program Director.
How performance will be monitored to ensure improvement is sustained:
To be monitored through monthly safety tours, and daily rounds by Program Director.
How substantial compliance will be measured:
Monthly Unit Safety Tours data, aggregated by Director of Safety and Environmental will monitor compliance.
Position responsible for correction:
Unit Leaders and Administrative Program Director
H 014 Activity Therapy Bldg 1 (page 22):

How correction has been, or will be, accomplished:
Cleaning of these areas was addressed on or before November 21, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned the custodial supervisors to inspect all areas of the AT building ensuring it is cleaned, vacuumed regularly, dusted and any boxes removed from the floor.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished. Also, a process changes will involve enhanced attention to high maintenance areas in this building, on a quarterly basis.
How performance will be monitored to ensure improvement is sustained:
Monitored through weekly inspections and monthly safety tours.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Custodial Manager

H 014 Activity Therapy Bldg 2 (page 22):
Plan of Correction as noted on H 014 Activity Therapy Bldg 1 (page 22)

H 014 Activity Therapy Bldg 3 (page 22):
Plan of Correction as noted on H 014 Activity Therapy Bldg 1 (page 22)

H 014 Activity Therapy Bldg 4 (page 22):
Plan of Correction as noted on H 014 Activity Therapy Bldg 1 (page 22)

H 014 Activity Therapy Bldg 5 (page 22):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Carpentry Dept staff on December 15, 2006. An estimate for new carpet will be sent to Support Services Executive Committee for consideration. To eliminate the immediate trip hazard, the carpet will be trimmed and patched. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 014 Activity Therapy Bldg 7 (page 23):
How correction has been, or will be, accomplished:
Boxes were removed from the floor on or before December 15, 2006
How others potentially affected by the same deficiency have been, or will be, identified:
Other AT areas will be advised of the expectation of not having boxes stored on the floor, with compliance assessed through monthly Safety Tours.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This item will be incorporated into the monthly Safety Tour checklist, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs and buildings, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
AT Department Head and Custodial Manager

H 014 Activity Therapy Bldg 8 (page 23):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Carpentry Dept staff on December 15, 2006 to caulk between base cabinets and wall. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to the Activity Therapy Director to instruct Activity Therapist supervisors to identify similar issues on other patient areas. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Activity Therapy Bldg 9 (page 23):
How correction has been, or will be, accomplished:
Microwave, oven, and refrigerator tops in the AT Bldg will be cleaned. Completion date on or before January 1, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notices will be sent to all AT kitchen areas to perform this cleaning this as part of their routine cleaning processes.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
These items will be incorporated into the monthly safety tour checklist, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs and buildings, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:

Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
AT Department Director

H 014 Activity Therapy Bldg 10 (page 23):
How correction has been, or will be, accomplished:
The thermostat in the patient room was adjusted. LSH Engineering Department issued a job ticket to the Carpentry Dept staff on December 15, 2006. The penetrations will be sealed on or before December 30, 2006. LSH Engineering Department issued a job ticket to the Electric Dept staff on December 15, 2006. This will be completed on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar deficiencies on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Activity Therapy Bldg 11 (page 23):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 15, 2006 to repair the toilet. Completion date on or before December 30, 2006
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar deficiencies on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Activity Therapy Bldg 12 (page 23):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Carpentry Dept staff on December 15, 2006. The Carpet will be repaired to eliminate trip hazards. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues in other patient areas. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:

This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Activity Therapy Bldg 13 (page 23):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. staff on December 14, 2006 to repair the countertop. Completion date on or before January 20, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to the Activity Therapy Director to instruct the activity therapist supervisors to identify damaged furniture in other patient areas. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Activity Therapy Bldg 14 (page 23):
How correction has been, or will be, accomplished:
All chairs with tears in the vinyl have been placed into a repair rotation, with seats to be recovered. Completion date June 1, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be issued campus wide indicating the procedure to have chairs refinished.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
To be monitored through monthly safety tours, and daily rounds by Program Director.
How performance will be monitored to ensure improvement is sustained:
To be monitored through monthly safety tours, and daily rounds by Program Director.
How substantial compliance will be measured:
Monthly Unit Safety Tours data, aggregated by Director of Safety and Environmental will monitor compliance.
Position responsible for correction:
Unit Leaders and Administrative Program Director

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H 014 Activity Therapy Bldg 16 (page 24):

How correction has been, or will be, accomplished:
A work order has been generated to have the area cleaned, and new silicone applied. Completion date on or before January 31, 2007.

How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned the custodial supervisors to inspect all areas of campus to be sure the showers are clean, and to initiate actions as necessary to resolve any issues found.

Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished.

How performance will be monitored to ensure improvement is sustained:
Monitored through weekly inspections, as well as monthly safety tours.

How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.

Position responsible for correction:
Custodial Manager

H 014 Activity Therapy Bldg 17 (page 24):

How correction has been, or will be, accomplished:
The light fixture was cleaned November 20, 2006.

How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned the custodial supervisors to inspect all areas of campus to be sure the light fixtures are clean and free of bugs, and to initiate actions as necessary to resolve any issues found.

Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished.

How performance will be monitored to ensure improvement is sustained:
Monitored through weekly inspections, as well as monthly safety tours.

How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.

Position responsible for correction:
Custodial Manager

H 014 Activity Therapy Bldg 18 (page 24):

How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 15, 2006 to repair the drinking fountain. Completion date on or before December 30, 2006.

How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to check and repair all drinking fountains if necessary, in other patient areas.

Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.

How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.

How substantial compliance will be measured:

Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Activity Therapy Bldg 19 (page 24):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Electric Dept. staff on December 18, 2006 to repair the light. Completion date on or before December 20, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues in other patient areas. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Jung Bldg 1 (page 24):
How correction has been, or will be, accomplished:
A VTP resident worker will be assigned to clean the identified area, and include it as a part of the routine weekly inspection. Completion date 12/14/06.
How others potentially affected by the same deficiency have been, or will be, identified:
Monthly Unit inspections will identify any similar issues or concerns.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Monthly Unit inspections will identify any similar issues or concerns.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
VTP Supervisor

H 014 Jung Bldg 2 (page 24):
How correction has been, or will be, accomplished:
VTP resident work crew will clean area. Completion date January 15, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Monthly Unit inspections will identify similar concerns.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
VTP supervisor will address each item, as identified, and follow-up with monthly unit inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.

Position responsible for correction:
VTP Supervisor

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H 014 Jung Bldg 4 (page 25):
How correction has been, or will be, accomplished:
Staff will inform residents that they will be provided with a strong cleaner to clean problem areas. ITU will designate a "deep cleaning day", for resident rooms, at which time the cleaning materials will be provided to all residents. Deep cleaning day will be scheduled routinely for 2 hours every week. These new cleaning processes will be initiated, with follow up monthly unit inspections per policy. Completion date January 1, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Monthly Unit inspections will identify similar concerns.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Shift supervisors will address each item, as identified, and follow-up with monthly unit inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
ITU Shift Supervisors

H 014 Jung Bldg 5 (page 25):
How correction has been, or will be, accomplished:
Empty rooms will be assigned to VTP/resident workers to clean, twice per week, as part of their job assignments. Completion date December 14, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Monthly Unit inspections will identify similar concerns.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Shift supervisors will address each item, as identified, and follow-up with monthly unit inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
VTP Supervisor

H 014 Jung Bldg 6 (page 25):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Electric Dept. staff on December 19, 2006. The drinking fountain was demolished by an angry patient. LSH Engineering Dept is awaiting treatment team approval to replace the drinking fountain. Until such time, residents receive water from staff in the control center per request. Completion date on or before April 1, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
This is an isolated incident; impact is limited to ITU Unit. .
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
Monthly Unit inspections will identify similar concerns.
How performance will be monitored to ensure improvement is sustained:
Director of Safety & Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.

Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Jung Bldg 7 (page 25):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on December 18, 2006 to repair the chair. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Jung Bldg 8 (page 25):
LSH Engineering Dept contacted the contracting fire alarm inspectors on December 18, 2006. The guards over the smoke detectors will be cleaned during Jung South Unit's routine fire alarm system inspection. Repairs will be completed during the week of December 18, 2006. Completion date on or before December 22, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Contracting fire alarm inspection personnel will clean smoke alarm guards while cleaning smoke alarms.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Jung Bldg 9 (page 25):
How correction has been, or will be, accomplished:
Vinyl covers will be ordered through Central Supply, with accompanying work orders, to repair the chairs. Completion date June 1, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Other chairs have been identified for repair.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.

How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
SPTP Administrative Program Director

H 014 Jung Bldg 10 (page 25):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Electric Dept staff on December 19, 2006. The air handling unit will be inspected, and repaired if necessary. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify and report air handling unit issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 014 Jung Bldg 12 (page 26):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Paint Dept staff on December 18, 2006 to paint the walls. Completion date on or before January 30, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Jung Bldg 13 (page 26):
How correction has been, or will be, accomplished:
Curtains will be ordered through supply, and installed upon receipt. Completion date April 15, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Routine monthly tours across units will allow for identification.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
SPTP Administrative Program Director

H 014 Jung Bldg 14 (page 26):
How correction has been, or will be, accomplished:
Shower curtains have been ordered; to be hung upon receipt. Completion date: 02/14/07.
How others potentially affected by the same deficiency have been, or will be, identified:
Routine monthly tours across units will allow for identification.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:

SPTP Administrative Program Director

H 014 Jung Bldg 15 (page 26):
Plan of Correction as noted on H 011 Noted throughout Hospital 1 (page 12)

H 014 Meyer Bldg 1 (page 26):
How correction has been, or will be, accomplished:
Targeted cleaning duties will be added to VTP job descriptions. Completion date January 15, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
No others areas are affected.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
VTP Supervisor

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H 014 Meyer Bldg 4, bullet 1 (page 27):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Electric Dept staff on December 19, 2006. The return air or exhaust fan will be inspected, and repaired if necessary. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Meyer Bldg 4, bullet 1 (page 27):
How correction has been, or will be, accomplished:
Shower curtains have been ordered; to be hung upon receipt. Completion date 02/14/07.
How others potentially affected by the same deficiency have been, or will be, identified:
Routine monthly tours across units.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
SPTP Administrative Program Director/Designee

H 014 Meyer Bldg 5 (page 27):
Plan of Correction as noted on H 014 Jung Bldg 9 (page 25):

H 014 Meyer Bldg 6 (page 27):
Plan of Correction as noted on H 014 Meyer Bldg 1 (page 26)

H 014 Meyer Bldg 7 (page 27):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on December 19, 2006 to replace the toilet paper holder. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged bathroom hardware on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:

This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Meyer Bldg 8 (page 27):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept on December 14, 2006. Spare furniture has been refinished and will replace the damaged furniture while it is being repaired. Completion date on or before January 31, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged furniture on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 014 Meyer Bldg 10 (page 28):
Plan of Correction as noted on H 014 Meyer Bldg 1 (page 26)

H 014 Meyer Bldg 11 (page 28):
How correction has been, or will be, accomplished:
VTP workers will incorporate the cleaning of vacant rooms into their routine work processes. Completion date December 14, 2006.
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 19, 2006 to repair the hand-washing sink. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Meyer Bldg 12 (page 28):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Plumbing Dept staff on December 21, 2006. The toilet will be repaired on or before December 30, 2006.

How others potentially affected by the same deficiency have been, or will be, identified:
Notification was sent to the Plumbing Dept Supervisor to instruct Plumbing Dept personnel to check and repair all toilets if necessary, in other patient areas.

Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.

How performance will be monitored to ensure improvement is sustained:
Director of Safety & Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.

How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.

Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Meyer Bldg 13 (page 28):
Plan of Correction as noted on H 011 Noted throughout Hospital 1 (page 12)

H 014 Isaac Ray Bldg 1 (page 28):

How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Carpentry Dept. on December 19, 2006 to install the base-mold. Completion date on or before December 30, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify damaged base-mold in other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Isaac Ray Bldg 2 (page 28):
How correction has been, or will be, accomplished:
Cleaning was performed on or before December 15, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned the custodial supervisors to inspect all areas of campus to ensure cleanliness of window ledges, and to initiate actions as necessary to resolve any issues found.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished.
How performance will be monitored to ensure improvement is sustained:
Monitoring will occur through weekly inspections as well as monthly safety tours. Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Custodial Manager

H 014 Isaac Ray Bldg 3 (page 28):
How correction has been, or will be, accomplished:
Cleaning was performed on or before December 15, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned the custodial supervisors to inspect other similar areas to ensure food particles, trash, etc., are cleaned up.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished.
How performance will be monitored to ensure improvement is sustained:
Weekly inspections, as well as monthly safety tours. Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:

Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Custodial Manager

H 014 Isaac Ray Bldg 4 (page 28):
How correction has been, or will be, accomplished:
LSH Engineering Dept issued a job ticket to the Electric Dept. staff on November 8, 2006. The laundry appliance was replaced on November 8, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

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H 014 Isaac Ray Bldg 5 (page 29):
How correction has been, or will be, accomplished:
The missing shower curtains will be located, and Environmental Services will re-hang them. Completion date on or before December 21, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Instruction was sent to Environmental Services personnel to look for missing shower curtains as they conduct their day-to-day duties, with corrections made as identified. Additionally the Chief Operating Officer will request that the Laundry Dept return any shower curtains they receive to the Environmental Services supervisor of the building the curtains come from, so they can be re-hung as soon as possible. Notification was sent to the Activity Therapy Director to instruct Vocational Training Program Supervisors to instruct Vocational Training Program workers who clean shower areas, to look for missing shower curtains as they conduct their day-to-day duties. Corrections will be made as identified.

Notification was sent to the State Security Program (Isaac Ray Building) Unit Leaders instructing them to instruct Nursing Services personnel to look for missing shower curtains as they conduct their day-to-day supervision of showers and report any missing shower curtains to Environmental Services personnel to request they be re-hung.

The Administrative Program Directors of the Psychiatric Services Program and Sexual Predator Treatment Program were asked to advise their Unit Leaders to instruct nursing personnel in the same manner.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety & Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Environmental Services Director and Chief Operating Officer

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H 014 Dillon Bldg 7 (page 30):
How correction has been, or will be, accomplished:
LSH Engineering Department issued a job ticket to the Carpentry Dept staff on November 8, 2006. The mop sink base was sealed on or around November 10, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Notification will be sent to Program Directors to instruct line level supervisors to identify similar issues on other patient units. Corrections will be made as identified.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Physical Plant Supervisor Specialist

H 014 Dillon Bldg 8 (page 30):
Plan of Correction as noted on H 014 Jung Bldg 9 (page 25)

H 014 Dillon Bldg 9 (page 30):
How correction has been, or will be, accomplished:
Staff on the 3-11 shift have been assigned to clean microwave ovens and crock pots.
Completion date December 14, 2006.
How others potentially affected by the same deficiency have been, or will be, identified:
Monthly inspections will identify others potentially affected.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Unit Leaders

H 014 Dillon Bldg 10 (page 30):
How correction has been, or will be, accomplished:
VTP resident workers will check, clean, repair and replace cushions.
Completion date February 14, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Monthly inspections will identify others potentially affected.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This will be a component of the monthly safety tour check-list, for staff to use during their monthly inspections.
How performance will be monitored to ensure improvement is sustained:
Director of Safety and Environment will aggregate monthly safety tour data, across all programs, to ensure corrective actions occur as indicated, and to monitor for any trends.

How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
VTP Supervisor

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H 014 Dillon Bldg 12 (page 31):
Plan of Correction as noted on H 011 Noted throughout Hospital 1 (page 12)

H 014 Dietary 1 (page 31):
How correction has been, or will be, accomplished:
Mattresses were moved to a different location, away from dry food storage, on December 14, 2006. .
How others potentially affected by the same deficiency have been, or will be, identified:
LSH only has one central warehouse therefore; this will not affect other areas.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
LSH did not comply with the requirement due to lack of knowledge of the requirement. Relevant personnel were educated about the regulations.
How performance will be monitored to ensure improvement is sustained:
Monitoring will occur through environmental rounds.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Storekeeper III

H 014 Dietary 2 (page 31):
How correction has been, or will be, accomplished:
Custodial staff will remove butter residue from the ceiling tiles by January 31, 2007.
How others potentially affected by the same deficiency have been, or will be, identified:
Custodial Manager has assigned the custodial supervisors to inspect all dining areas of campus to ensure other cafeterias do not have butter residue on the ceilings.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
This deficiency will be identified in the future through weekly inspections, as well as monthly safety tours. When areas are identified as needing additional cleaning, the custodial supervisor will initiate a work crew to get this accomplished.
How performance will be monitored to ensure improvement is sustained:
Monitoring will occur through weekly inspections, as well as monthly safety tours.
How substantial compliance will be measured:
Refer to the attached Safety Tour spreadsheet, to be compiled and maintained by the Director of Safety and Environment.
Position responsible for correction:
Custodial manager

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H 031 Nursing RN Supervision (page 33):

How correction has been, or will be, accomplished:

Regarding care plan documentation, identification of interventions unique to a patient's condition or treatment need is made in the Comprehensive Integrated Treatment Plan (CITP). Development of the patient's CITP requires collective discussion and agreement by each unit's core Treatment Team Members. To ensure choking concerns are adequately considered by the Treatment Team, "Dysphagia" is a risk factor that has been included in the hospital's Comprehensive Risk Assessment. This Comprehensive Risk Assessment establishes a formal structure for collaborative Team discussion across 15 possible risk areas, to identify the most salient areas of treatment focus. To further support clinical discussion at the Treatment Team meetings, various Task Teams have been established and charged with: refining processes to allow for more-expeditious receipt of patient information from the outside facilities and consultants, and implementing new processes to help secure timely consent from patients for releases of information. Additionally, the Nursing Care Plan task team is giving particular emphasis to Axis-III diagnoses in its work on refining and individualizing nursing interventions.

Still under development, implementation of the Dysphagia component of the Comprehensive Risk Assessment is planned for April 1, 2007.

Regarding supervision of nursing staff and patients during meal time, in the on-unit dining areas of this Program nursing personnel are present during meal times and circulate throughout the dining area. Observations are made to ensure that patient meal trays are labeled according to current diet orders, to identify amount of the meal consumed, and to watch for any difficulties with swallowing or chewing. A listing of patients receiving on-unit meals will be posted in the nursing stations, along with the patients' specific diet orders, and updated on a daily basis as necessary to ensure a current listing. Patients identified with a diagnosis of dysphagia will have their meals provided on their unit, versus the campus cafeteria, to allow for even closer observation and identification of any difficulties with chewing and swallowing. The hospital has purchased horseshoe shaped meal tables to be used in this Program so improve observation of patients with special dietary needs such as being at risk for choking. Relevant Nursing policies will be modified to clarify current procedures and to reflect new expectations, as identified above. Nursing department education to assist in recognizing signs of choking is being provided through New Nursing Employee orientation; education for existing nursing personnel will be provided on-line. Completion date for policy modification is March 1, 2007.

Regarding ensuring provision of the physician-ordered diet, as noted above, this Program will maintain a current listing of patients receiving on-unit meals, along with specific diet orders. A number of Task Teams have been working in support of this effort, as well. One Task Team is exploring improvement opportunities within the clinical and production areas of dietary practices. Considerations under review include: clarifying special diets, establishing uniform dietary manuals, refining processes for completing Focused Nutritional Assessments, identifying education needs and opportunities for relevant personnel regarding special dietary issues, and securing provision of such training. Another Task Team is charged with refining evaluation and competency-assessment processes as related to this and other clinical areas, as well as refining processes involved in the documentation of training provided to personnel. A third Task Team is evaluating patient meal supervision processes across the hospital's three Programs. Recommendations will be made regarding optimal locations for meals served on the unit, with regards to staffing levels and room availability, and identification of reasonable expectations for supervision during meal times. Processes will be established to ensure these Task Teams provide progress reports to the hospital's Quality Management Department on a monthly basis, effective January 2007. Completion date February 31, 2007.

How others potentially affected by the same deficiency have been, or will be, identified:

The hospital's Medical Executive Committee (MEC) has discussed the need for outside consultative services to support identification of appropriate clinical interventions for patients with a diagnosis of dysphagia, and secured a Speech Pathology consult/contract with a local medical facility. A sub-committee has been established to review and approve requests for requested consults.

Additionally, to aid in identification and provision of necessary interventions, the hospital's Clinical Dietitian has provided an educational, information-review session with members of the Medical Staff on Mechanical Diet Protocol. On-line documentation processes have also been implemented, hospital-wide, to support identification and treatment of patients with dysphasia and other diet or medical concerns, including: Clinical Consult Order, Outside Medical Consult Order, Physical and Neurological Examination, Treatment Team Notes, Team to Team Transfer Form, Medical Staff Admission Intake Assessment, Nursing Admission Intake Assessment, Physician's Diet Order, Clinic Progress Notes, and Dietary Progress Notes.

Procedural changes made within the Psychiatric Services Program (regarding listing patients receiving on-unit meals, and their diet orders, in nursing stations, and having patients diagnosed with dysphagia take meals on their unit) will be presented by the Director of Nursing to the Clinical Executive Committee to discuss the merits and feasibility of implementation on the other Programs. Completion date March 1, 2007.

Processes that have been, or will be, established to ensure the deficiency does not reoccur:
All consult requests, aside from emergencies, are sent to the Clinical Director. A committee reviews and approves requests, with the Sr. Administrative Assistant to the Clinical Director monitoring these approvals.

As identified above, a consult/contract has been established with a local Speech Pathologist, along with processes for securing such services as needed. In addition to direct clinical services, the Speech Pathologist will be considered for provision of training to LSH personnel on relevant issues (e.g., diagnoses, what behaviors to watch for, what to consider when positioning patients, etc.).

In June 2006, the hospital hired a Registered Dietitian Consultant to provide guidance and counsel to the hospital's Clinical Dietitian and other agency leaders regarding practices within the Nutritional Services Department. Focus of the consultative services has included: education to patients and staff in aspects of nutrition and disease, involving patients in setting goals regarding nutrition and disease-prevention/management, maintaining proper documentation in patient records to assure continuity of care, and advising dietary services department in communication, food service practice and structure.

New processes and roles recently established within the Quality Management Department will provide for the oversight and support needed to help guide Task Teams toward quality, timely completion of assignments.

How performance will be monitored to ensure improvement is sustained:
Task Teams will be expected to identify areas of improvement, processes to achieve improvement, and timelines for project completion, and to report to Quality Management Department per identified schedule. Quality Management Department will oversee reporting processes, and present resulting work products to the Clinical Executive Committee, as necessary.

How substantial compliance will be measured:
Quality Management Department will oversee Task Team reporting processes, and identify concerns to the Clinical Executive Committee as warranted.

Position responsible for correction:
Clinical Director

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H 9999 Final Comments - Laundry (page 39):
How correction has been, or will be, accomplished:
A policy currently exists in the State Security Program's policy book regarding washers and dryers for patient use, and addresses education regarding usage. The policy also states that the washers and dryers on units and living skill classroom areas are intended for laundering only patient's personal clothing. A supplemental draft policy draft was completed on 12-14-06, which pertains to the patient use of washers and dryers for the entire LSH campus. The draft policy specifies that towels, linens, rags, dishtowels and other non-patient personal laundry will not be laundered on a unit or in living skill classroom laundry facilities. Such items must be sent to the hospital's Laundry Dept for proper disinfection, approved temperature control and monitoring. Policy will be implemented upon approval.

Policy to be approved by the hospital's Clinical Director, and implemented campus-wide by February 1, 2007. Completion date February 1, 2007.

How others potentially affected by the same deficiency have been, or will be, identified:
New policy will be applicable hospital-wide. The Infection Control Nurse reviewed areas in other Programs with patient washers and dryers. Presently, the Psychiatric Services Program does not have patient personal laundry facilities, so no policy or training will need to be implemented. The Sexual Predator Treatment program has been identified as an additional area in which the residents do their personal laundry on the unit.
Processes that have been, or will be, established to ensure the deficiency does not reoccur:
The Administrative Program Director of the SPTP program has assigned the Unit Leaders to write a policy similar to the SSP policy (Policy S2-39A). Activity Therapy personnel will properly train and perform competency-assessments on the residents on the use of the washers and dryers. Training and competencies (by Activity Therapy as well as unit staff) for those residents using the washers and dryer will be performed on an as needed basis on all units with a patient washer and dryer. Those competencies will be documented. The Infection Control Nurse will assist in educating the staff on the Infection Control aspects of the patient washers and dryers.
How performance will be monitored to ensure improvement is sustained:
Infection Control Nurse will perform a periodic spot check of patient washers and dryers and document such checks. Periodic spot checks on the documentation of training and competencies for residents will also be performed by the Infection Control Nurse. Safety tours will also assist in monitoring.
How substantial compliance will be measured:
The Infection Control Nurse will measure compliance at a 90%. The data will be obtained during the periodic spot checks. The compliance will be measured from the expected training verses the actual residents trained, as well as the number of spot checks performed observing correct cleaning techniques versus total stop checks performed.
Position responsible for correction:
Infection Control Nurse

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H 9999 Final Comments – Psychiatric Dept (page 40):

How correction has been, or will be, accomplished:

Resident Handbook will be modified to clarify resident promotion and demotion based on their behavior. On a weekly basis a designated Treatment Team member will document, in the hospital's Electronic Progress Note (EPN) system, a resident's movement in the Program. Justification will also be provided as evidenced by the weekly behavioral observation sheet. Processes are identified in the ITU Handbook, and ITU staff receive tutorial training/assistance to enhance their understanding of the processes and the consistency of the resulting information. Completion date December 14, 2006.

How others potentially affected by the same deficiency have been, or will be, identified:

This is unique to ITU patients.

Processes that have been, or will be, established to ensure the deficiency does not reoccur:

Processes have been established for weekly documentation, in the hospital's Electronic Progress Note (EPN) system, a resident's movement in the Program, with accompanying justification for such movement.

How performance will be monitored to ensure improvement is sustained:

On a weekly basis a designated Treatment Team member will document, in the hospital's Electronic Progress Note (EPN) system, a resident's movement in the Program. Justification will also be provided as evidenced by the weekly behavioral observation sheet. Treatment Team members will provide oversight.

How substantial compliance will be measured:

Resident perceptions of compliance with identified approaches will be evidenced through Resident Grievances and/or other expressions of concern to clinical staff or the Grievance Resolution Committee.

Position responsible for correction:

SPTP Administrative Program Director

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H 9999 Final Comments, Isaac Ray Bldg 7 (page 46):
Plan of Correction as noted on H 014 Noted throughout Isaac Ray 7 (page 29)

H 9999 Final Comments, Isaac Ray Bldg 8 (page 46):
Plan of Correction as noted on H 014 Isaac Ray Bldg 8 (page 29)

H 9999 Final Comments, Isaac Ray Bldg 9 (page 46):
Plan of Correction as noted on H 014 Noted Isaac Ray Bldg 9 (page 29)

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H 9999 Final Comments, General Sanitation/Housekeeping 2.a (page 49):
Plan of Correction as noted on H 014 Dillon Bldg 7 (page 30)

H 9999 Final Comments, General Sanitation/Housekeeping 2.b (page 49):
Plan of Correction as noted on H 011 Meyer Bldg 11 (page 28)