CORE ISSUES

Facility	License #	Physical Address	Phone Number
Shodair Residential Treatment Center	12851	2755 Colonial Drive	406-444-7500
Administrator	City	Zip Code	Survey Date
Craig Aasved	Helena	59604-	05/19/2021
Survey Team Leader	Survey Type		Response Due
Taylor, Jasmine	Complaint Inspection		05/29/2021

Item #	Rule ()	Description
1	50-5-111-2 Prohibited activities	The surveyor's onsite inspection on 06/01/2021 and interview with the Accreditation and Credentialing Coordinator. FINDINGS: 1) The facility did not preserve all evidence related to the sentinel event that occurred on May 19, 2021. The facility destroyed the staff communication form completed by the Night Shift Registered Nurse the morning of the sentinel event on May 19, 2021. This form documented pertinent information into the investigation and root cause of the event.
2	53-21-107-7 Abuse and neglect of persons admitted to	The surveyor's review of the email notification of the event dated 05/20/2021 and subsequent information submitted to the department, and the facility's 'Child Abuse/Neglect Reporting Policy.' FINDINGS: 1) The report provided to the Licensure Bureau on 05/20/2021 and subsequent correspondence from the facility did not

		include complete details of the allegation, including the names of any facility staff against whom the allegation is made; a description of the rationale for conducting the investigation with either in-house or outside personnel; details of the process of the investigation of each allegation of abuse or neglect; details of the conclusions of the investigation; and details of corrective action taken. The report did not include the nature and extent of the child's injuries as specified in the facility's own Child Abuse/Neglect Reporting Policy' 2) On 10/21/2021 the facility was cited for failure to appropriately report Child Abuse/Neglect and follow the facility's own Child Abuse/Neglect Reporting policy. The facility's Plan of Correction dated 11/03/2020 states, "Shodair has updated our process for reporting child abuse and neglect to ensure all incidents get reported appropriately and on time to DPHHS." The facility has not followed its Plan of Correction as evidenced by its failure to appropriately report all required information for the sentinel event on 05/19/2021.
2	53-21-107-7 Abuse & neglect at mental health facilities prohibited reporting investigations	The surveyor's review of the email notification of the event dated 05/20/2021 and subsequent information submitted to the department, and the facility's 'Child Abuse/Neglect Reporting Policy.' FINDINGS: 1) The report provided to the Licensure Bureau on 05/20/2021 and subsequent correspondence from the facility did not include complete details of the allegation, including the names of any facility staff against whom the allegation is made; a description of the rationale for conducting the investigation with either in-house or outside personnel; details of the process of the investigation of each allegation of abuse or neglect; details of the conclusions of the investigation; and

		details of corrective action taken. The report did not include the nature and extent of the child's injuries as specified in the facility's own Child Abuse/Neglect Reporting Policy' 2) On 10/21/2021 the facility was cited for failure to appropriately report Child Abuse/Neglect and follow the facility's own Child Abuse/Neglect Reporting policy. The facility's Plan of Correction dated 11/03/2020 states, "Shodair has updated our process for reporting child abuse and neglect to ensure all incidents get reported appropriately and on time to DPHHS." The facility has not followed its Plan of Correction as evidenced by its failure to appropriately report all required information for the sentinel event on 05/19/2021.
3	53-21-142-13 Rights of person admitted to facility	The surveyor's review of the incident report dated 05/19/2021, review of video footage, the facility's 'Monitoring Patients Policy,' interviews with 25 staff on 06/01/2021, 06/02/2021, 06/03/2021, and 06/04/2021 and the Root Cause Analysis submitted to the department on 06/10/2021. FINDINGS: 1.The facility is not providing a humane psychological and physical environment. The facility has failed to ensure patient safety as evidenced by repeat occurrences of inadequate supervision resulting in a sentinel event on May 19, 2021. During interviews with 25 staff on 06/01/2021, 06/02/2021, 06/03/2021, and 06/04/2021, Staff noted a lack of adequate staff to supervise patients, maintain a safe environment and complete all required patient visual checks in real-time. Staff expressed extreme concern for both staff and patient safety. Staff indicated the ratio of 1 staff to 8 patients during the day and evening creates unsafe conditions. Staff stated that registered nurses are included in the staff ratio but are not able to continuously provide direct client supervision due to

		their other duties. Staffing recommendations implemented by the facility on April 24, 2021 continue to include nurses in the staffing ratio. The staffing changes implemented on April 24, 2021 were not added to the provider policy and are not consistently followed. The night of the sentinel event, one mental health technician had called off from their shift and was not replaced. The staffing was not at the new recommended level. Staff do not continuously monitor patients. Facility policy requires staff to visually see patients every 15 minutes. Prior to the event, 15-minute checks were not always completed at regular intervals. Staff stated that insufficient staffing numbers also resulted in bathroom alarm lights remaining on for several minutes at a time. The night shift staffing ratios can often be 1 staff to 12 patients. Staff have stated that it is impossible to safely supervise patients at this staffing level. Staff stated they are not provided additional staff members when multiple patients are on suicide precautions that require 1:1 monitoring. Staff report there have been up to 6 patients on suicide precautions sleeping on the milieu due to lack of staffing. Multiple staff reported bringing these concerns to management, explicitly asking for more staff in order to follow the facility's policies and procedures. Staff report their requests for increased staffing were denied. The Root Cause Analysis submitted to the department on 06/10/2021 does not include a plan for addressing the inadequate staffing numbers.
4	37.106.2202(1) Residential Treatment Facility: Licensure Standards	The surveyor's onsite inspection on 06/01/2021, interview with the Chief Engineer, interviews with 25 staff on 06/01/2021, 06/02/2021, 06/03/2021, and 06/04/2021, review of video footage, the Incident Report Form dated 05/24/2021, and review of Root Cause Analysis reported submitted to the department on 6/10/2021. FINDINGS for EC.02.01.01

		1) Prior to the event, several staff noticed the bathroom alert light was not functioning properly. A piece of tape was placed near the light notifying staff of the malfunction. There was no documentation of a work order being entered to fix the light, and there is no documentation of any steps taken prior to the event in response to this malfunction. 2) After the event, the facility did not replace the bathroom vents with breakaway vents. Vents on the Glacier unit were covered with another structure to prevent being used as ligature point. However, these covers contain small holes which do not negate the existing safety risks. 3) On 05/24/2021, Resident #2 reported attempting to replicate the sentinel event by wrapping a shower curtain around her neck three times. This event was not reported to the department and was discovered during interviews. Shower curtains have not been removed from the bathrooms, and there have been no efforts to minimize the risk posed by the shower curtain. FINDINGS FOR EC.03.01.01 1) Prior to the event, several staff stated they did not receive training on the functioning of the motion sensors and the bathroom light timers. Several staff did not know how often the timer triggered, or how to manually reset the timer. Since the event, staff have not received any training specific to the motion sensor and how it functions. Several staff could not identify where the motion sensor was located. Several staff could not explain how to re-set the timer for the bathroom light. Staff stated that an email had been sent out after the event and the process is discussed during shift-change meetings. Staff have not received hands-on training demonstrating how to ensure the light is set and stated their

		training was not sufficient for staff to feel comfortable with the light-reset process. Many staff are not aware that the motion sensor was covered during the sentinel event, and staff have not received any training on how to minimize that risk. 2) The bathroom is identified as a high-risk area, with doors remaining locked at all times. When staff allow residents in the bathroom, residents are to enter the bathroom and close the door behind them. On 05/19/2021, the resident entered the bathroom, then exited to shut the exterior bedroom door completely. The resident twice exited the bathroom, grabbed items from the bedroom, and re-entered the bathroom. Staff could not identify any steps to assure residents do not exit and re-enter the bathroom. The facility did not identify this risk in their initial mitigation plan or provide any plans to address this risk. 3) During the surveyor's onsite observations on 06/03/2021 and 06/04/2021, the surveyor witnessed multiple staff struggle to re-set the bathroom alarm lights. In interviews with staff, multiple staff noted issues with the keys used to reset the lights, describing the mechanism as "gummy" and noting having to turn the key several times before the light resets. 4) The Root Cause Analysis report provided to the department on June 10, 2021 cited human factors contributing to the patient suicide on May 19, 2021 including the facility's staffing shortages for over 1 month and therapist burnout. The facility has not implemented a mitigation plan to address either of these contributing factors. In addition, the facility has not provided additional education or training to staff regarding suicide prevention, signs and risk factors of suicide and monitoring patients when a distressing event or therapy session increases safety concerns.

4	37.106.2202(1) Residential Treatment Facility: Licensure Standards	The surveyor's onsite inspection on 06/01/2021, interview with the Chief Engineer, interviews with 25 staff on 06/01/2021, 06/02/2021, 06/03/2021, and 06/04/2021, review of video footage, the Incident Report Form dated 05/24/2021, and review of Root Cause Analysis reported submitted to the department on 6/10/2021. FINDINGS for EC.02.01.01 1) Prior to the event, several staff noticed the bathroom alert light was not functioning properly. A piece of tape was placed near the light notifying staff of the malfunction. There was no documentation of a work order being entered to fix the light, and there is no documentation of any steps taken prior to the event in response to this malfunction. 2) After the event, the facility did not replace the bathroom vents with breakaway vents. Vents on the Glacier unit were covered with another structure to prevent being used as ligature point. However, these covers contain small holes which do not negate the existing safety risks. 3) On 05/24/2021, Resident #2 reported attempting to replicate the sentinel event by wrapping a shower curtain around her neck three times. This event was not reported to the department and was discovered during interviews. Shower curtains have not been removed from the bathrooms, and there have been no efforts to minimize the risk posed by the shower curtain. FINDINGS FOR EC.03.01.01 1) Prior to the event, several staff stated they did not receive training on the functioning of the motion sensors and the bathroom light timers. Several staff did not know how often the timer triggered, or how to manually reset the timer. Since

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		minutes passed without staff completing a verbal check with the resident, and approximately 49 minutes passed without staff completing a visual check of the resident. When the Resident failed to respond to the final verbal check, the Staff entered the bathroom. The Resident was found hanging from the shower curtain, having used the ceiling vent as a ligature point. Staff got the Resident down and called the Registered Nurses on the unit for help. The resident was not able to be revived. 2) Since the event, the facility has not created any internal measures to ensure adherence to the 15-minute check policy and the process for re-setting bathroom motion sensor timers. There is no policy or procedure in place to review the completed checks and ensure the policy is being followed. Staff have not been required to demonstrate competency of the re-training regarding the bathroom procedures, including demonstrating competency on manually re-setting the motion sensor timer. FINDINGS FOR LD.04.04.05 1) Staff interviewed stated that leadership had not educated staff on lessons learned from the system and process failures that led to the sentinel event. Staff were not aware of how the event occurred, the system failures with the motion sensors and bathroom light timers, and the results of the risk assessment created as a result of this event.