

**The Competitive and Quality Impact of the Proposed Acquisition of
Adventist Health Vallejo by Acadia Healthcare**

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Richard M. Scheffler, PhD
Neal Adams, MD, MPH
Daniel R. Arnold, PhD

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1. Introduction

This report provides an assessment of the potential impact on price and quality of the proposed acquisition of Adventist Health Vallejo (hereafter, AHV) – a 61-bed acute psychiatric hospital in Northern California¹ – by Acadia Healthcare (hereafter, Acadia). Acadia is a private equity backed for-profit corporation. Nationally it operates 227 behavioral health facilities with 29 in California. Its California facilities are primarily opioid maintenance or residential substance use treatment centers located in the greater Los Angeles, San Diego, and San Francisco metropolitan areas. Acadia currently owns two acute psychiatric hospitals in the state – San Jose Behavioral Health (80 beds, hereafter SJBH) and Pacific Grove Hospital in Riverside, CA (68 beds). AHV is in Vallejo, CA (Solano County) while SJBH is in San Jose, CA (Santa Clara County). The two facilities are 76 miles apart with a drive time of about 1 hour and 20 minutes. The focus of this report is to assess how AHV and SJBH being under common ownership would impact the market for acute psychiatric services in Northern California.²

The report proceeds as follows: We describe our qualifications for assessing the competitive impact of the proposed acquisition in Section 2. Section 3 describes the data used in our analysis while Section 4 presents an overview of the market for acute psychiatric services in Northern California. In Section 5, we discuss why we conclude the acquisition is unlikely to significantly increase the horizontal market power of AHV and SJBH. However, in Section 6 we present evidence that supports our concerns that the acquisition creates the potential for significant “cross-market” price effects. Our evaluation and conclusions on the quality impacts

¹ <https://oshpd.ca.gov/facility/adventist-health-vallejo/>

² When mentioning “acute psychiatric services” we are referring to inpatient psychiatric care at acute psychiatric hospitals or in the psychiatric units of general acute care hospitals. We detail our reasoning for including care at both types of facilities in Section 4.2.

associated with the acquisition are in Section 7. Section 8 details our recommendations for the conditions that should be placed on the acquisition.

2. Qualifications

Professor Richard Scheffler is the lead consultant for this analysis. He is responsible for the overall design of the report and review of the data and supporting documents. He wrote various sections of the report in collaboration with Dr. Daniel Arnold. Dr. Neal Adams was the lead author of Section 6. All three members of the consulting team jointly discussed all aspects of the report and support its recommendations.

Professor Scheffler is a Distinguished Professor of Health Economics and Public Policy in the Graduate School of Public Health and the Goldman School of Public Policy at the University of California, Berkeley. Professor Scheffler also directs the Petris Center on Health Care Markets and Consumer Welfare (petris.org) at UC Berkeley. He received his PhD in economics from New York University and has taught health economics at the undergraduate, Master's, and PhD levels. For over three decades his research has focused on how health care markets function and the impact of consolidation on health care prices and the affordability of health care coverage. Professor Scheffler has also published extensively on mental health and received the Carl A. Taube Award (honoring distinguished contributions to the field of mental health services research) from the American Public Health Association's Mental Health Section and the Gold Medal from Charles University in Prague. He has consulted on a number of health

care mergers and acquisitions. Most recently he testified on the CVS-Aetna, Anthem-Cigna, and Centene-Health Net proposed acquisitions.³

Dr. Neal Adams is a psychiatrist with an MD from Northwestern and an MPH from Harvard. He is also a graduate of the California Health Care Foundation Leadership Program. Dr. Adams has been a part-time psychiatric consultant for the Petris Center since 2004 where he has provided clinical, research, teaching and administrative psychiatric expertise to a wide range of the Center's activities in mental health services research in both California and international project sites. Dr. Adams is a Distinguished Life Fellow of the American Psychiatric Association and has served as president of the American College of Mental Health Administration, medical director for mental health departments in California and New Mexico, medical director at the California Institute of Mental Health, associate medical director for Magellan and Optum Health Care, and as a consultant for the Federal Substance Abuse and Mental Health Administration (SAMHSA). His professional expertise as a medical director of mental health departments and a practicing psychiatrist was called on many times to inform many sections of the report.

Dr. Daniel Arnold is research economist at the UC Berkeley School of Public Health and research director of the Petris Center. Dr. Arnold obtained his PhD in economics from the University of California, Santa Barbara and specializes in modeling big data. His recent paper, which found hospital mergers lead to lower wages for non-health care workers, was chosen to be

³ Scheffler RM. 2018. Testimony Regarding CVS Health Corporation's Proposed Acquisition of Aetna Inc. <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Scheffler-CVS-Aetna-Testimony-06-19-18.pdf>; Fulton BD, Scheffler RM, Arnold DR. 2016. Testimony Regarding Anthem, Inc.'s Proposed Acquisition of Cigna Corporation. <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/CDI-Testimony-re-Anthem-and-Cigna-Fulton-Scheffler-and-Arnold-032916-final.pdf>; Scheffler RM, Fulton BD. 2016. Testimony Regarding Centene Corporation's Proposed Acquisition of Health Net, Inc. <http://www.insurance.ca.gov/0250-insurers/0500-legal-info/upload/FinalExhibitBinderHealthNetCenteneHearingPart-1.pdf>.

one of eight papers presented at the FTC’s Thirteenth Annual Microeconomics Conference.⁴ Dr. Arnold conducted the data analysis in the report under the supervision of Professor Scheffler, worked with Professor Scheffler on the research design used in the report, and assisted in the writing of the report.

3. Data Analyzed and Documents Reviewed

This section describes the data analyzed and documents reviewed for this report. The 2018-2019 Patient Discharge Data (PDD) from California’s Office of Statewide Health Planning and Development (OSHPD) served as the data source for the market structure and prices sections of the report (Section 3.1). Several documents and data sources were used to conduct our quality analysis (Section 3.2). We also reviewed two letters from Acadia’s lawyers that detailed their view of the competitive impact of the proposed acquisition (Section 3.3).

3.1 OSHPD Data

We obtained 2018-2019 OSHPD Patient Discharge Data for this report.⁵ For each discharge we knew (1) the hospital where the patient was treated (2) patient demographics (zip code and county of residence, age group, and sex), and (3) the discharge’s length of stay, Diagnosis Related Group (DRG), primary payer (e.g., Medi-Cal), charge, and status (e.g., discharged to home). The dataset extract we received contained 2.5 million discharges, of which 127,547 (or 5%) were psychiatric discharges. We excluded psychiatric discharges from patients residing in

⁴ <https://www.ftc.gov/news-events/events-calendar/thirteenth-annual-federal-trade-commission-microeconomics-conference>

⁵ <https://oshpd.ca.gov/data-and-reports/request-data/data-documentation/>

counties south of San Luis Obispo.⁶ This left us with 117,969 psychiatric discharges (58,665 in 2018 and 59,304 in 2019).

3.2 Quality Data

We reviewed several documents and data sources to analyze the impact of the proposed acquisition on quality of care. Only limited information about each facility’s operations and quality of care were available. The three key data sources we analyzed were:

- Rate of seclusion and restraint incidents from publicly available CMS/Medicare data.
- A Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) survey conducted at SJBH on 1/5/2018⁷
- A Compliance Validation Survey conducted at SJBH by the California Department of Public health on 7/19/19 for Federal “Conditions for Coverage” (42CFR482.23)

The documents reviewed are discussed in more detail in Section 7 of the report. We have attached them as appendix material to this report.

3.3 Letters from McDermott Will & Emery

We reviewed the July 30, 2021 “Re: Acadia Healthcare’s acquisition of Adventist Health Vallejo” letter, the September 3, 2021 “Re: Proposed Sale of the Assets of Adventist Health Vallejo” letter, and the September 21, 2021 “Re: Proposed Sale of the Assets of Adventist Health

⁶ That is, 10 of California’s 58 counties are excluded from our analysis. The 10 counties are Imperial, Kern, Los Angeles, Orange County, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura.

⁷ We have included both this survey and the survey mentioned in the following bullet point as appendix material to this report.

Vallejo” letter sent to the staff at the California Office of the Attorney General by McDermott Will & Emery. Nothing in the letters changed our views of the competitive or quality impact of the proposed acquisition.

4. Market Overview

The purpose of this section is to present an overview of the market for acute psychiatric services in Northern California (defined hereafter as counties north of San Luis Obispo) and discuss the relevant product and geographic markets for the acquisition.⁸ Section 4.1 outlines how the health plans we interviewed view the market. In section 4.2 we discuss the relevant product market for the proposed acquisition. Section 4.3 lists the top 10 hospitals by number of psychiatric discharges in Northern California. Section 4.4 concludes our market overview by presenting data on both the patient age and payer distributions at AHV and SJBH.

4.1 Health Plan Interviews

We start our market overview with the health plans’ perspective. We interviewed six health plans (payers) in the course of our investigation. All the health plans indicated that the market for inpatient psychiatric services is a “seller’s market” and that inpatient psychiatric services are a critical part of the insurance products they offer. The six health plans we interviewed were:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

⁸ Specifically, all of California’s 58 counties except Imperial, Kern, Los Angeles, Orange County, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura.

[REDACTED]
[REDACTED]

With the respect to the market being a “seller’s market,” the health plans generally said they wanted to contract with every acute psychiatric hospital in their coverage areas. They did not feel like they could selectively contract with acute psychiatric hospitals. This was due to there being so few acute psychiatric hospitals – and more generally, psychiatric beds – in Northern California. Additionally, each of the health plans we interviewed is bound by the Department of Managed Health Care’s “timely access to care” standards⁹ which require health plans to have hospitals available within specific geographic and time-elapsed standards. The health plans communicated to us that these standards make it even more difficult to selectively contract with acute psychiatric hospitals.

When asked specifically if they would agree to a 5% price increase at AHV or SJBH to keep them “in-network,” the health plans generally said yes. When asked about a 10% increase most plans said they would, but a few wavered. The collection of statements from the health plans outlined in this section support the notion that AHV and SJBH have market power.

4.2 Product Market

Age and insurance coverage play an important role in understanding the nature and organization of inpatient psychiatric care. From a clinical and licensure perspective, children under 18 may not be treated on the same inpatient unit of a hospital as adults. Thus, there must be a distinct physical unit for children and adolescents that is separate from the adult unit(s). In addition,

⁹ <https://www.dmhc.ca.gov/healthcareincalifornia/yourhealthcarerights/timelyaccesstocare.aspx>

clinical staffing and services for each age group are also unique. Hospitals providing services for children under the age of 12 will typically have a distinct unit/program for this cohort as well.

Medi-Cal also has age-related policies that impact where and how inpatient psychiatric services are provided. Because of what is called the “IMD (Institution for Mental Diseases) exclusion,” inpatient psychiatric care for Medi-Cal beneficiaries between the ages of 18 and 64 can only be provided in facilities of less than 17 beds, or in the psychiatric unit of a general hospital. Medi-Cal will not pay for inpatient psychiatric care for adults in acute psychiatric hospitals.

These rules do not apply to Medicare which provides coverage for both older adults as well as disabled younger adults.

Accordingly, we proceeded with our analysis based on dividing the entirety of inpatient psychiatric services into three “products” by age:

1. Children 17 and under
2. Adults 18-64
3. Adults 65 and older

The needs of children and adolescents requiring inpatient psychiatric care are different and separate from those of adults in multiple respects--from licensure and physical plant to laws governing civil commitment as well as staffing and programming. These distinctions are well

established over decades of practice and codified in California law and regulations.^{10,11,12,13,14}

Accordingly, inpatient psychiatric services for children and adolescents are a separate product.

Additionally, we concluded that inpatient psychiatric services at acute psychiatric hospitals and general acute care hospitals *are* the same “product.” That is, the inpatient psychiatric care provided in an acute psychiatric hospital is generally the same care provided in the psychiatric unit of a general acute care hospital.

¹⁰ Persons under the age of 18 can be held for 72 hours for evaluation and treatment if they are a danger to themselves or others, pursuant to The California’s Children’s Civil Commitment and Mental Health Treatment Act of 1988 (W&IC Section 5585 et. seq.). Persons age 18 and over are held for evaluation and treatment under the Lanterman-Petris-Short Act (W&IC Section 5150 et. seq.).

¹¹ Section 5751.7 of the California Welfare and Institutions Code states: (a) For the purposes of this part and the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000)), the State Department of Health Care Services and the State Department of State Hospitals shall ensure that, whenever feasible, minors shall not be admitted into psychiatric treatment with adults if the health facility has no specific separate housing arrangements, treatment staff, and treatment programs designed to serve children or adolescents. The Director of Health Care Services shall provide waivers to counties, upon their request, if this policy creates undue hardship in any county due to inadequate or unavailable alternative resources. In granting the waivers, the Director of Health Care Services shall require the county to establish specific treatment protocols and administrative procedures for identifying and providing appropriate treatment to minors admitted with adults. (b) However, notwithstanding any other provision of law, no minor may be admitted for psychiatric treatment into the same treatment ward as any adult receiving treatment who is in the custody of any jailor for a violent crime, is a known registered sex offender, or has a known history of, or exhibits inappropriate, sexual, or other violent behavior which would present a threat to the physical safety of minors.

¹² In several policy briefs dating as far back as 1989, the American Academy of Child and Adolescent Psychiatry provided guidance on the unique programmatic needs of children and adolescents receiving inpatient psychiatric care. These documents are available at:

- (a) https://www.aacap.org/aacap/Policy_Statements/1989/Inpatient_Hospital_Treatment_of_Children_and_Adolescents.aspx
- (b) https://www.aacap.org/AACAP/Policy_Statements/1990/Model_for_Minimum_Staffing_Patterns_for_Hospitals_Providing_Acute_Inpatient_Treatment.aspx

¹³ Inpatient psychiatric services for children and adolescents are distinct from services provided to adults. In their British Medical Journal (April 10, 2004, v.328(7444)) entitled *Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards*, Worrall, A. et al state: Child and adolescent psychiatric inpatient wards were established because young people with mental illness are often poorly served by admission to general psychiatric wards owing to needs that differ from those adults, different skills needed by staff, and difficulty ensuring young people's safety.

¹⁴ California Children’s Hospital Association: *Improving Behavioral Health Care For Children In California: A Call to Action*. December 2019. www.ccha.org

The OSPHD data also includes psychiatric discharges from psychiatric health facilities (PHFs). We excluded these discharges from our analysis based on Dr. Adams' opinion that at these facilities (and the patients served) are not the same as those found in acute psychiatric hospitals or general acute care hospitals—they are smaller, are largely publicly funded and focused on the care of people with chronic and severe mental health conditions. Our sample of psychiatric discharges dropped from 117,969 to 98,311 after excluding PHF psychiatric discharges.¹⁵ Of these remaining 98,311 psychiatric discharges, the vast majority (83,090 or 85%) had a diagnosis related group (DRG) of 885 (psychoses)¹⁶; psychiatric discharges with a DRG other than 885 were not included in our analysis. This left us with an analytic sample of 83,090 psychiatric discharges in Northern California (defined as counties north of San Luis Obispo).¹⁷

4.3 Psychiatric Discharges in Northern California

Table 1 shows how the 83,090 psychiatric discharges in our analytic sample break out across Northern California acute psychiatric and general acute care hospitals in Northern California. Table 1 lists only the top 10 hospitals in terms of number of psychiatric discharges in 2018-2019. The top three hospitals are all owned by Universal Health Services and have a combined 27% share of all discharges in Northern California. AHV and SJBH rank 8th and 10th, respectively.

¹⁵ In their 2019 report, *The California Model for Behavioral Health: A Standard of Care for All*, Behavioral Health Action (a coalition of more than 50 statewide organizations united to raise awareness about behavioral health issues in California), classifies Psychiatric Health Facilities (PHFs) as “crisis care and alternatives to hospitalization” and not equivalent to care provided in free-standing acute psychiatric hospitals or the psychiatric units in general medical hospitals.

¹⁶ The full list of principal diagnoses included in DRG 885 is available at https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P0335.html.

¹⁷ That is, 48 of California’s 58 counties. The 10 counties excluded are Imperial, Kern, Los Angeles, Orange County, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura.

They both had a 5% share of Northern California psychiatric discharges in 2018-2019. The top 10 hospitals accounted for 66% of Northern California psychiatric discharges in 2018-2019.

Table 1. Top 10 Hospitals in Northern California (by Number of Psychiatric Discharges), 2018-

Facility	City	System	Number of Discharges	Share of discharges	Cumulative Share
SIERRA VISTA HOSPITAL	SACRAMENTO	UNIVERSAL HEALTH SERVICES	9,226	11%	11%
HERITAGE OAKS HOSPITAL	SACRAMENTO	UNIVERSAL HEALTH SERVICES	7,977	10%	21%
FREMONT HOSPITAL	FREMONT	UNIVERSAL HEALTH SERVICES	5,310	6%	27%
AURORA BEHAVIORAL HEALTHCARE-SANTA ROSA, LLC	SANTA ROSA	SIGNATURE HEALTHCARE SERVICES	5,245	6%	33%
COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	FRESNO	COMMUNITY MEDICAL CENTERS	5,242	6%	40%
DOCTORS MEDICAL CENTER	MODESTO	TENET HEALTHCARE	5,076	6%	46%
SUTTER CENTER FOR PSYCHIATRY	SACRAMENTO	SUTTER HEALTH	4,625	6%	51%
SAN JOSE BEHAVIORAL HEALTH	SAN JOSE	ACADIA HEALTHCARE	4,406	5%	57%
KAWeah DELTA MEDICAL CENTER	VISALIA	KAWeah DELTA HEALTH CARE DISTRICT	3,795	5%	61%
ADVENTIST HEALTH VALLEJO	VALLEJO	ADVENTIST HEALTH	3,762	5%	66%
Total in Northern California			83,090		

Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: Only acute psychiatric hospitals and general acute care hospitals in counties north of San Luis Obispo are included.

4.4 Populations Served by AHV and SJBH

Next, we examine the characteristics of the patient populations served by AHV and SJBH. Table 2 shows the number and percent of discharges at AHV and SJBH across four age groups: 12 & under, 13-17, 18-64, and 65+. The 18-64 age group accounts for the majority of discharges at both AHV (67%) and SJBH (79%). AHV's patient population is slightly younger than SJBH's with 28% of AHV's discharges being for patients 17 and under versus 16% for SJBH. Notably,

SJBH does not treat patients 12 and under whereas 8% of AHV's discharges are for patients 12 and under. AHV's 300 discharges for patients 12 and under accounted for 20% of all 12 and under psychiatric discharges in Northern California in 2018-2019.

Table 2. AHV and SJBH Patient Age Distributions, 2018-2019

	Number of AHV Psychiatric Discharges	Number of SJBH Psychiatric Discharges	% of AHV Psychiatric Discharges	% of SJBH Psychiatric Discharges
12 & under (children)	300*	0	8%	0%
13 - 17 (adolescents)	753	704	20%	16%
18 - 64 (adults)	2,505	3,474	67%	79%
65+ (older adults)	204	228	5%	5%
TOTAL	3,762	4,406	100%	100%

Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: AHV = Adventist Health Vallejo. SJBH = San Jose Behavioral Health. * Accounts for 20% of the under 12 psychiatric discharges in Northern California.

We now look at the mix of payers in the product markets we have defined. Table 3 shows the percent of discharges by payer across the same four age groups in Table 2. Commercial enrollees accounted for the majority of discharges at both AHV (50%) and SJBH (43%). Notably, the share of Medi-Cal patients is higher for patients 17 and under. Medi-Cal generally reimburses at lower rates than commercial insurers meaning hospitals have a financial incentive to increase their share of commercially insured patients. This financial incentive, coupled with the fact that SJBH does not currently treat children 12 and under, gives us concern that SJBH will not actively attempt to maintain the same level of services for 12 and under patients at AHV following its acquisition.

Table 3. AHV and SJBH Payer Distributions by Age, 2018-2019

AHV Payer Distribution by Age				
	Commercial	Medi-Cal	Medicare	Other*
12 & under (children)	69%	31%	0%	0%
13 - 17 (adolescents)	51%	47%	0%	2%
18 - 64 (adults)	51%	8%	39%	3%
65+ (older adults)	6%	1%	91%	1%
OVERALL	50%	17%	31%	2%
SJBH Payer Distribution by Age				
	Commercial	Medi-Cal	Medicare	Other*
12 & under (children)	N/A	N/A	N/A	N/A
13 - 17 (adolescents)	56%	36%	0%	8%
18 - 64 (adults)	43%	1%	31%	25%
65+ (older adults)	8%	0%	89%	2%
OVERALL	43%	7%	29%	21%

Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: AHV = Adventist Health Vallejo. SJBH = San Jose Behavioral Health. *Other includes payment from county indigent programs, California Children Services (CCS), the Civilian Health and Medical Program of Uniformed Services (TRICARE), the Veterans Administration, or for patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy.

5. Horizontal Market Analysis

In this section, we analyze the competitive impact of the acquisition by focusing on whether the merging firms are “direct competitors” engaged in what is known as “horizontal competition.” Direct competition exists when firms compete in the same market and are viewed as potential substitutes to each other. We conduct three analyses which screen for potential horizontal competition concerns: overlapping primary service areas (Section 5.1), differences in pre- vs. post-merger HHIs (Section 5.2), and a diversion analysis (Section 5.3). In Section 5.4 we detail our conclusion on what the results from these three analyses mean for the level of horizontal concern created by the proposed acquisition.

5.1 AHV and SJBH Primary Service Areas

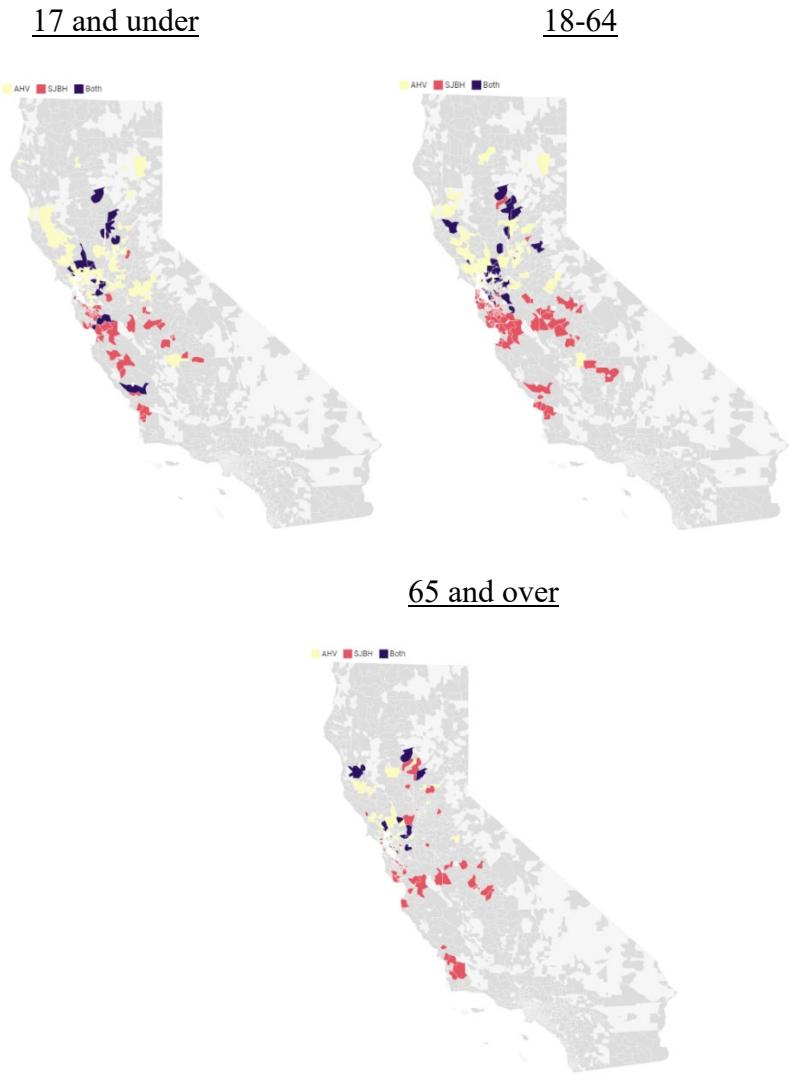
We calculated the primary service areas for both AHV and SJBH in each of the three product markets (under 17, 18-64, 65 and over) that we discussed previously. Primary service areas (PSAs) are defined as the smallest number of zip codes that account for 75% of a hospital's discharges and are frequently calculated in market impact analyses as an initial step in assessing the overlap in the patient bases of facilities proposing to merge.¹⁸

Figure 1 shows the zip codes that make up AHV and SJBH's PSAs in each of the three product markets. The zip codes that are only part of AHV's PSA are colored yellow. The zip codes that are only part of SJBH's PSA are colored red. The zip codes that are in both AHV and SJBH's PSAs (i.e., the overlap of the PSAs) are colored purple.

Figure 1 also illustrates the minimal overlap of the AHV and SJBH PSAs in each of the three product markets. Take the 18-64 market, which accounted for the majority of both AHV (67%) and SJBH's (79%) psychiatric discharges in 2018 and 2019, as an example. In this market, 91 zip codes are colored yellow (AHV PSA only), 128 are colored red (SJBH PSA only), and 41 are colored purple (both PSAs). This means that 31% of the zip codes in AHV's PSA are also part of SJBH's PSA and 24% of the zip codes in SJBH's PSA are also part of AHV's PSA. More importantly, 30% of AHV's 18-64 psychiatric discharges and only 14% of SJBH's 18-64 psychiatric discharges come from the zip codes that are part of both PSAs.

¹⁸ See, e.g., Vistnes GS. Competitive Effects Analysis of the Proposed Cedars-Sinai Health System / Huntington Memorial Hospital Affiliation. December 4, 2020.

Figure 1. AHV and SJBH Primary Service Areas by Three Product Markets, 2018-2019



Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: AHV = Adventist Health Vallejo. SJBH = San Jose Behavioral Health. The zip codes that are only part of AHV's PSA are colored yellow. The zip codes that are only part of SJBH's PSA are colored red. The zip codes that are in both AHV and SJBH's PSAs (i.e., the overlap of the PSAs) are colored purple.

5.2 HHI

We calculate pre- and post-merger zip code-level HHIs in what follows to again communicate that any horizontal concerns arising from the proposed acquisition are likely to be limited. Figure 2 shows the increase in HHI that the merger would generate in the 18-64 market. We first

calculated the pre-merger HHIs for each of the zip codes that were in either of AHV or SJBH's 18-64 PSAs. The pre-merger average HHI (weighted by number of discharges) across the 260 zip codes in Figure 2 was 3,340. This level of HHI typically indicates that the market is highly concentrated.¹⁹

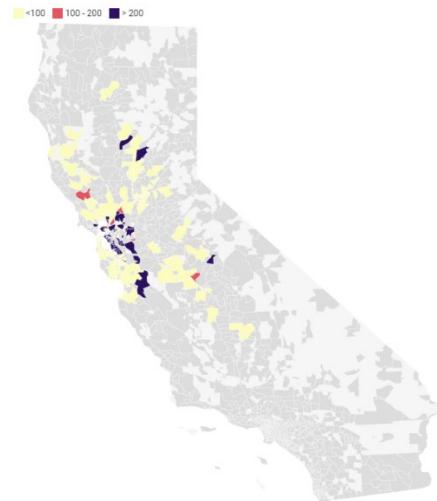
To calculate post-merger HHIs, we combined AHV and SJBH's market shares in each zip code and then recalculated HHIs. The differences between the post-merger HHI and pre-merger HHI are the HHI changes shown in Figure 2. The 203 yellow zip codes in Figure 2 represent zip codes that would experience an HHI increase of less than 100 points. The 5 red zip codes in the figure would experience an HHI increase of 100-200 points while the 52 purple zip codes would experience an HHI increase of over 200 points.

The purpose of Figure 2 is to show that while the proposed acquisition would lead several zip codes to be more highly concentrated, the net impact on horizontal concentration is limited. The increase in HHIs at the zip code-level are small. The average HHI increase (weighted by the number of discharges) across the 260 zip codes shown in Figure 2 is 82 points. In Figure 3 we repeat this same analysis for the 17 and under market. The average HHI increase (weighted by the number of discharges) for this market is 120 points, meaning any potential horizontal concerns are larger for the 17 and under market than the 18-64 market, but an increase of 120 points in zip code-level HHIs is still fairly small. If we were to expand the geographic market to counties (or any other geography larger than zip codes) the HHI changes are likely to be even

¹⁹ See OpenStax. “Chapter 11. Monopoly and Antitrust Policy” in *Principles of Economics*. Available at <https://opentextbc.ca/principlesofeconomics/chapter/11-1-corporate-mergers/>

smaller than those we're reporting here given more hospitals would start entering into each HHI calculation.

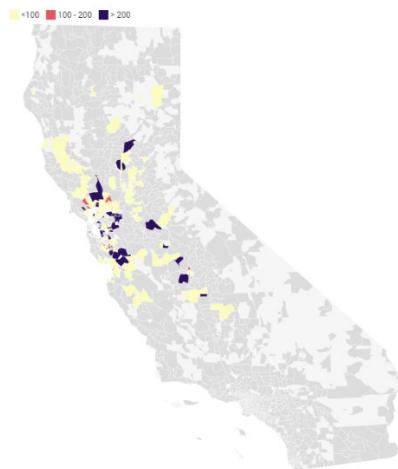
Figure 2. 18-64 Market Zip Code-Level HHI Changes, 2018-2019



Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: AHV = Adventist Health Vallejo. SJBH = San Jose Behavioral Health. HHI=Herfindahl-Hirschman Index. The zip codes with HHI changes of less than 100 points are colored yellow. The zip codes with HHI changes of 100-200 points are colored red. The zip codes with HHI changes of greater than 200 points are colored purple.

Figure 3. 17 & Under Market Zip Code-Level HHI Changes, 2018-2019



Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: AHV = Adventist Health Vallejo. SJBH = San Jose Behavioral Health. HHI=Herfindahl-Hirschman Index. The zip codes with HHI changes of less than 100 points are colored yellow. The zip codes with HHI changes of 100-200 points are colored red. The zip codes with HHI changes of greater than 200 points are colored purple.

5.3 Diversion Analysis

We conducted a diversion analysis to assess the extent of competition in the market. Diversion analyses are used frequently in the context of hospital mergers and typically involve estimating a patient choice model that takes patient and hospital characteristics as inputs; outputs are the probabilities that each patient will choose a particular hospital. This creates a ranking of hospitals for each patient. The ranking is then used to calculate where patients would go to (i.e., divert to) in the event that their first-choice hospital became unavailable. The greater the diversion between two merging hospitals, the stronger the case that they are close substitutes to one another and thus in direct competition.

We modeled the choice of commercial enrollees as a function of five patient characteristics – county, zip code, type of admission (emergency, urgent, or elective), age, and sex. Research on hospital choice has generally shown that patient location is the strongest predictor of hospital choice followed by diagnosis and then patient demographics. We follow the approach of Raval et al. (2017) by first grouping patients that match along the five patient characteristics and then calculating the hospital choice probabilities for each group.²⁰ We also use the same minimum group size of 25 that Raval et al. (2017) use.

Tables 4 and 5 display the estimates from our diversion analysis. Table 4 asks where would AHV's commercial patients flow to if AHV were no longer an option. Table 5 asks where would SJBH's patients flow to if SJBH were no longer an option. The hospitals at the top of

²⁰ Raval D, Rosenbaum T, Tenn SA. A semiparametric discrete choice model: An application to hospital mergers. *Economic Inquiry*. 2017 Oct;55(4):1919-44.

Table 4 are the strongest competitors to AHV while the hospitals at the top of Table 5 are the strongest competitors to SJBH.

Table 4 estimates that 12% of AHV's patients would flow to SJBH. This makes SJBH the fourth strongest competitor to AHV behind Fremont Hospital, Aurora Behavioral Healthcare – Santa Rosa, and Sierra Vista Hospital. Table 5 estimates that 9% of SJBH's patients would flow to AHV. This makes AHV the third strongest competitor to SJBH behind Fremont Hospital and El Camino Hospital. While the 12% diversion from AHV to SJBH and 9% diversion from SJBH are mildly concerning, it is our opinion that these estimates are not large enough to conclude that the proposed acquisition raises significant horizontal concerns.

Table 4. Diversion Estimates from AHV, 2018-2019

Rank	Facility Name	City	Diversion from AHV
1	FREMONT HOSPITAL	FREMONT	16%
2	AURORA BEHAVIORAL HEALTHCARE-SANTA ROSA, LLC	SANTA ROSA	15%
3	SIERRA VISTA HOSPITAL	SACRAMENTO	14%
4	SAN JOSE BEHAVIORAL HEALTH	SAN JOSE	12%
5	SUTTER CENTER FOR PSYCHIATRY	SACRAMENTO	7%
6	WOODLAND MEMORIAL HOSPITAL	WOODLAND	5%
7	ADVENTIST HEALTH ST. HELENA	ST. HELENA	3%
8	ST. JOSEPH'S BEHAVIORAL HEALTH CENTER	STOCKTON	3%
9	HERITAGE OAKS HOSPITAL	SACRAMENTO	3%
10	LANGLEY PORTER PSYCHIATRIC INSTITUTE	SAN FRANCISCO	3%
11	ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	SAN FRANCISCO	3%
12	ALTA BATES SUMMIT MEDICAL CENTER-HERRICK CAMPUS	BERKELEY	2%
13	MILLS-PENINSULA MEDICAL CENTER	BURLINGAME	2%
14	EL CAMINO HOSPITAL	MOUNTAIN VIEW	2%
15	STANFORD HEALTH CARE	PALO ALTO	2%
16	DOCTORS MEDICAL CENTER	MODESTO	1%
17	JOHN MUIR BEHAVIORAL HEALTH CENTER	CONCORD	1%
18	GOOD SAMARITAN HOSPITAL-SAN JOSE	SAN JOSE	1%
	Other Hospitals		5%

Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: AHV = Adventist Health Vallejo. All hospitals with diversion estimates of 1% or more are listed in the table.

Table 5. Diversion Estimates from SJBH, 2018-2019

Rank	Facility Name	City	Diversion from SJBH
1	FREMONT HOSPITAL	FREMONT	21%
2	EL CAMINO HOSPITAL	MOUNTAIN VIEW	11%
3	ADVENTIST HEALTH VALLEJO	VALLEJO	9%
4	AURORA BEHAVIORAL HEALTHCARE-SANTA ROSA, LLC	SANTA ROSA	8%
5	MILLS-PENINSULA MEDICAL CENTER	BURLINGAME	6%
6	SIERRA VISTA HOSPITAL	SACRAMENTO	5%
7	LANGLEY PORTER PSYCHIATRIC INSTITUTE	SAN FRANCISCO	5%
8	GOOD SAMARITAN HOSPITAL-SAN JOSE	SAN JOSE	4%
9	STANFORD HEALTH CARE	PALO ALTO	3%
10	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	FRESNO	3%
11	DOCTORS MEDICAL CENTER	MODESTO	2%
12	ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	SAN FRANCISCO	2%
13	SUTTER CENTER FOR PSYCHIATRY	SACRAMENTO	2%
14	ST. JOSEPH'S BEHAVIORAL HEALTH CENTER	STOCKTON	2%
15	COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA	MONTEREY	2%
16	HERITAGE OAKS HOSPITAL	SACRAMENTO	2%
17	WOODLAND MEMORIAL HOSPITAL	WOODLAND	2%
18	ST. FRANCIS MEMORIAL HOSPITAL	SAN FRANCISCO	2%
19	JOHN MUIR BEHAVIORAL HEALTH CENTER	CONCORD	1%
20	ALTA BATES SUMMIT MEDICAL CENTER-HERRICK CAMPUS	BERKELEY	1%
21	KAWEAH DELTA MEDICAL CENTER	VISALIA	1%
22	NATIVIDAD MEDICAL CENTER	SALINAS	1%
	Other Hospitals		4%

Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: SJBH = San Jose Behavioral Health. All hospitals with diversion estimates of 1% or more are listed in the table.

5.4 Horizontal Market Conclusion

The three analyses presented in this section lead us to the conclusion that the proposed acquisition poses limited horizontal concerns. The concern is limited in the sense that we do not think the acquisition would significantly *increase* the horizontal market power of AHV and SJBH. This is different from saying AHV and SJBH do not have horizontal market power. Our

interviews with health plans provide some evidence of the market power of AHV and SJBH. The data analysis we present in the next section provides further evidence that AHV and SJBH have market power.

6. Potential of Cross-Market Effects

In this section, we assess the potential cross-market effects of the acquisition. We begin by briefly reviewing the theory of cross-market effects and the empirical literature documenting them (Sections 6.1 and 6.2). We then utilize a combination of health plan interviews (Section 6.3.1), market shares by zip codes (Section 6.3.2), and willingness to pay estimates (Section 6.3.3) to determine the extent of AHV's and SJBH's market power. Both AHV and SJBH having market power makes cross-market effects more likely. In Section 6.4 we present our conclusions on what the evidence in Section 6.3 means for the likelihood of cross-market effects arising from the acquisition.

6.1 Cross-Market Theory

There are three principal theories of harm by which the proposed acquisition might cause cross-market effects: tying, common customer/insurer, and change in control.²¹ Tying occurs when a firm with market power in its primary market ties its sales in its primary market to its sales in a secondary market in a way that allows it to leverage its market power from its primary market in the secondary market.

Tying typically assumes a firm has market power in one but not both of the markets being considered. The common customer/insurer theory can apply when the firm has market power in

²¹ See Vistnes GS. Competitive Effects Analysis of the Proposed Cedars-Sinai Health System / Huntington Memorial Hospital Affiliation. December 4, 2020. for more details on each.

both markets. The common customer is often thought to be an employer, but the theory does not require a common customer,²² which is why we refer to it more generally as the common customer/insurer theory. Cross-market effects under the common customer/insurer theory could emerge if a hospital system in multiple markets were able to credibly threaten to create multiple holes in an insurer's provider network. The more holes a multi-market system can create, the more likely its exclusion from the insurer's provider network would diminish the viability of the insurer's product, and thus the more market power for the system.

The change in control theory posits that post-acquisition, the acquired hospital changes its objective, information, or bargaining skills in a way that leads to post-acquisition price increases. One example of a change in objective would be if the hospital being acquired had shown an unwillingness to use its existing market power prior to the acquisition. For instance, if the hospital's nonprofit status had led it to set price below the profit-maximizing level. Converting to a for-profit hospital after an acquisition could lead this hospital to start tapping into its market power and increase price.

6.2 Cross-Market Empirical Evidence

Two recent papers have found evidence that hospital prices are higher for hospitals that are part of a cross-market system. The magnitude of the effects is substantial in each case. Harvard economist Leemore Dafny and colleagues found price increases of 7-10%,²³ while Lewis and Pflum (2017) found increases of 17%.²⁴ Dafny et al. (2019) compared the price changes at

²² See the section entitled “‘Common insurer’ effects with no common customer” (pg. 317) in the Dafny et al. (2019) paper referenced in Section 6.2.

²³ Dafny L, Ho K, Lee RS. 2019. The price effects of cross-market mergers: theory and evidence from the hospital industry. *The RAND Journal of Economics* 50 (2): 286-325.

²⁴ Lewis MS, Pflum KE. 2017. Hospital systems and bargaining power: evidence from out-of-market acquisitions. *The RAND Journal of Economics* 48 (3): 579-610.

hospitals that became part of a cross-market system to price changes at a control group of hospitals that were not involved in a cross-market merger. Lewis and Pflum (2017) similarly compared prices at hospitals involved in cross-market mergers to prices at hospitals that were not exposed to any merger.

6.3 Market Power of AHV and SJBH

The presence of market power is important to the cross-market theory. Health plan interviews (Section 6.3.1), market shares by zip code (Section 6.3.2), and willingness to pay estimates (Section 6.3.3) are the three methods we used to analyze whether AHV and SJBH have market power.

6.3.1 Health Plan Interviews

We already outlined in Section 4.1 the health plans' perspective that acute psychiatric hospitals in Northern California have market power. The only additional sentiment from the health plans that we'll note at this point (which relates directly to cross-market power) is that they said Acadia deciding to contract on an all-or-nothing basis would make price negotiations considerably more difficult.

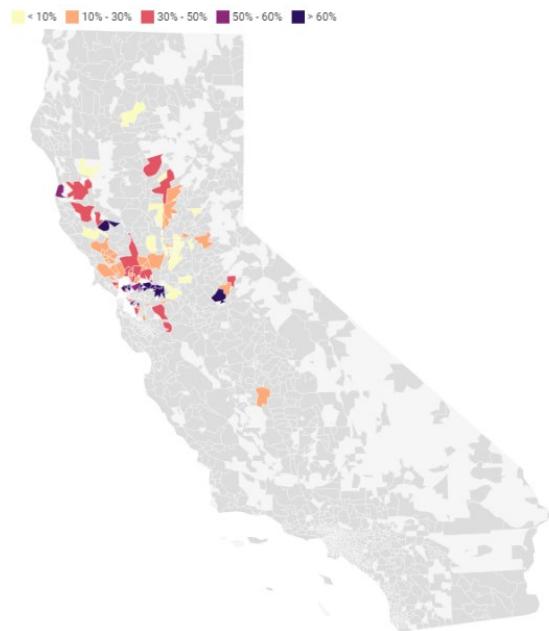
6.3.2 Market Shares by Zip Code

For our next analysis we start with our analytic sample of 83,090 psychiatric discharges in Northern California and then focus in on commercial enrollees ages 18-64. This leaves us with 18,793 psychiatric discharges. Figure 4 plots AHV's share of these discharges in each of the zip codes that are part of its 18-64 PSA. Figure 5 repeats the analysis for SJBH.

Both Figures 4 and 5 make it clear that AHV and SJBH are important to residents in particular areas, and thus to the health plans seeking to sell plans to these individuals (or their employers). Among AHV's 132 18-64 PSA zip codes shown in Figure 4, it had a greater than

30% market share in 50 (or 38%) of them and greater than 60% market share in 22 (or 17%) of them. AHV's average market share (weighted by discharges) across all 132 PSA zip codes shown in Figure 4 was 16%. Among SJBH's 169 18-64 PSA zip codes shown in Figure 5, it had a greater than 30% market share in 21 (or 12%) of them. SJBH's average market share (weighted by discharges) across all 169 PSA zip codes shown in Figure 5 was 14%.

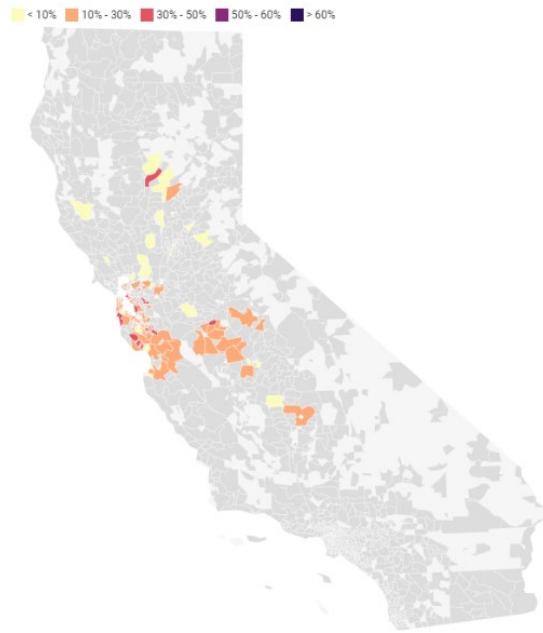
Figure 4. AHV's Share of 18-64 Commercial Psychiatric Discharges by Zip Code, 2018-2019



Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: AHV = Adventist Health Vallejo. Number of zip codes by share category = 42 (<10%), 40 (10-30%), 23 (30-50%), 5 (50-60%), 22 (>60%).

Figure 5. SJBH's Share of 18-64 Commercial Psychiatric Discharges by Zip Code, 2018-2019



Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: SJBH = San Jose Behavioral Health. Number of zip codes by share category = 46 (<10%), 102 (10-30%), 21 (30-50%).

6.3.3 Willingness to Pay

We calculated a measure referred to as “willingness to pay” (WTP) to assess the incremental attractiveness of a hospital to individuals in an area, and thus the importance of the hospital to a health plan. The larger a hospital’s WTP, the greater its likely market power. The units of the WTP measure are in something economists call “utils”, so the absolute level of the WTP estimates (e.g. 1,000 utils) is rather meaningless. What’s important is the relative position of the hospitals in the ranking of WTP estimates and the degree to which one hospital’s WTP is higher than another’s in percentage terms (e.g., 50% higher rather than 1,000 utils higher). WTP analyses are particularly useful because they (1) do not require a geographic market to be defined and (2) implicitly take hospital characteristics such as reputation or teaching status (to the extent they’re important to patients) into account.

Table 6 presents the WTP estimates for the top 20 facilities in our analysis. AHV and SJBH place 4th and 5th, respectively, behind Sierra Vista Hospital, Fremont Hospital, and Heritage Oaks Hospital. The importance of Table 6 with respect to the market power of AHV and SJBH is in how far the two facilities are above other facilities in the market for inpatient psychiatric services. Consider the difference between AHV and Stanford. The WTP estimate for AHV is over three times that of Stanford. The same is true when comparing SJBH to Stanford. The WTP estimates for both AHV and SJBH are considerably higher than most of the hospitals in the market for inpatient psychiatric services, which suggests they both have considerable market power.

Table 6. Hospital-Level Willingness to Pay Estimates, 2018-2019

Facility Name	Willingness to Pay
SIERRA VISTA HOSPITAL	4,002
FREMONT HOSPITAL	3,823
HERITAGE OAKS HOSPITAL	2,494
ADVENTIST HEALTH VALLEJO	2,196
SAN JOSE BEHAVIORAL HEALTH	2,130
AURORA BEHAVIORAL HEALTHCARE-SANTA ROSA, LLC	2,020
SUTTER CENTER FOR PSYCHIATRY	1,996
MILLS-PENINSULA MEDICAL CENTER	1,812
ST. JOSEPH'S BEHAVIORAL HEALTH CENTER	1,482
EL CAMINO HOSPITAL	1,197
COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	1,173
WOODLAND MEMORIAL HOSPITAL	951
DOCTORS MEDICAL CENTER	862
KAWeah DELTA MEDICAL CENTER	684
GOOD SAMARITAN HOSPITAL-SAN JOSE	635
LANGLEY PORTER PSYCHIATRIC INSTITUTE	621
JOHN MUIR BEHAVIORAL HEALTH CENTER	612
STANFORD HEALTH CARE	522
ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	488
COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA	465

Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: The top 20 hospitals in terms of willingness to pay estimates are included in the table.

In Table 7 we present the WTP estimates calculated at the system-level as opposed to the hospital-level. For this analysis we have assumed AHV and SJBH are part of one system called Acadia.

The top three hospitals in the hospital-level version (Table 6) are all owned by Universal Health Services. Thus, we'd expect Universal Health Services to have a very high WTP estimate in our system-level analysis. That is exactly what Table 7 shows. Universal Health Services has a WTP estimate of 24,164 which is significantly higher than the WTP estimates of all other systems. In fact, it is three times higher than Acadia – the system with the second highest WTP. Acadia's WTP in turn is significantly higher than the other systems in the market. For instance, Acadia's WTP estimate is nearly four times larger than Signature Healthcare Services' WTP estimate. This suggests an Acadia with AHV and SJBH would have significant market power.

Table 7. System-Level Willingness to Pay Estimates, 2018-2019

System Name	Willingness to Pay
UNIVERSAL HEALTH SERVICES, INC.	24,164
ACADIA*	7,632
SUTTER HEALTH	7,520
DIGNITY HEALTH	6,081
SIGNATURE HEALTHCARE SERVICES	2,020
EL CAMINO HOSPITAL DISTRICT	1,197
COMMUNITY MEDICAL CENTERS	1,173
TENET HEALTHCARE CORPORATION	862
KAWEAH DELTA HEALTH CARE DISTRICT	684
HCA HEALTHCARE CORPORATION	635
REGENTS OF THE UNIVERSITY OF CALIFORNIA	621
JOHN MUIR HEALTH	612
STANFORD HEALTH CARE	522
COMMUNITY HOSPITAL FOUNDATION	465
COUNTY OF MONTEREY	221
ADVENTIST HEALTH**	179
HEBREW HOME FOR THE AGED	110
COUNTY OF SANTA CLARA	100
ENLOE MEDICAL CENTER	73
MARIN HEALTHCARE DISTRICT	49

Source: Authors' analysis of 2018-2019 OSHPD Patient Discharge Data (PDD).

Notes: The top 20 systems in terms of willingness to pay estimates are included in the table. *Assumes AHV and SJBH are both members of the Acadia system. **Adventist Health still shows up in the table because of Adventist Health St. Helena.

6.4 The Cross-Market Mechanisms for AHV and SJBH

Of the three mechanisms for cross-market effects that we outlined in Section 6.1 we view common customer/insurer and/or change in control as particularly likely mechanisms in this case. We outline the factual basis for this view by discussing each mechanism in turn.

6.4.1 Common Customer/Insurer

We purposefully focused on insurers in our discussion of the common customer/insurer theory in Section 6.1. Again, the theory does not require an employer that spans multiple markets. The price increases that the theory predicts still hold when there are common insurers, but no

common customers.²⁵ We think it is exceedingly likely there are employee groups (e.g. CalPERS, UFCW) that would need coverage in both Solano County (where AHV is located) and Santa Clara County (where SJBH is located), but we did not do a detailed accounting of these groups for this report. However, we learned from the health plan interviews that we conducted that there are certainly health plans that offer coverage in both counties. [REDACTED]

[REDACTED]
[REDACTED]
²⁶ – definitely cover both counties and communicated to us the necessity of keeping both AHV and SJBH in-network. Additionally, [REDACTED] contracts with both AHV and SJBH. In fact, [REDACTED] stated SJBH was their second most used facility in the last year. This might be surprising given [REDACTED] [REDACTED] is only responsible for patients residing in [REDACTED], but it speaks to the notion that even county-focused groups are common insurers for this acquisition.

6.4.2 Change in Control

The risk of change in control leading to cross-market effects comes from the fact that Adventist Health and Acadia are very different corporate entities. Adventist Health is a faith-based, nonprofit integrated health system serving patients on the West Coast of the United States and in Hawaii. Acadia is a private equity backed for-profit corporation. The differences of course do not guarantee that the objectives of AHV will change after the acquisition, but it seems likely that the corporate philosophies of Adventist Health and Acadia would differ in at least some meaningful ways. Recent academic studies have identified spending increases and quality

²⁵ See the section entitled “‘Common insurer’ effects with no common customer” (pg. 317) in the Dafny et al. (2019) paper referenced earlier.

²⁶ See California Health Care Foundation. 2020. “California Health Insurers, Enrollment.” Available at <https://www.chcf.org/wp-content/uploads/2020/07/CAHealthInsurersEnrollmentAlmanac072020QRG.pdf>

decreases following private equity healthcare acquisitions. Gupta et al. (2021) estimated that private equity ownership increased the short-term mortality of Medicare patients by 10% (which implies 20,150 lives lost over a 12-year period) and was accompanied by an 11% increase in taxpayer spending per patient episode.²⁷ A recent paper in *Health Affairs* analyzed private equity acquisitions of dermatology practices. The authors found the volume of patients per private equity dermatologist ranged from 4.7% to 17% higher than the volume per non-private equity dermatologist.²⁸ Additionally, the authors found prices paid to private equity dermatologists for routine medical visits were 3-5% higher than those paid to non-private equity dermatologists.

6.5 Cross-Market Conclusion

We conclude the proposed acquisition creates the potential of “cross-market” effects. Specifically, we conclude that in that absence of conditions, post-acquisition prices are likely to increase at AHV, SJBH, or both even though few patients (or health plans) would likely consider the hospitals to be good substitutes for each other. The evidence we presented in Section 6.3 showing both AHV and SJBH have market power makes cross-market effects particularly likely.²⁹

²⁷ Gupta A, Howell ST, Yannelis C, Gupta A. 2021. “Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes.” National Bureau of Economics Working Paper #28474. Available at <https://www.nber.org/papers/w28474>

²⁸ Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. 2021. “Private Equity in Dermatology: Effect on Price, Utilization, and Spending” *Health Affairs* 40 (5): 727-735.

²⁹ Private equity groups that purchase healthcare providers or institutions often encumber them with extreme debt, leading to a range of adverse effects ranging from price increases to decreases in quality through reduction in staffing to the closure of the facility or a declaration of bankruptcy. All of these effects can adversely impact the access, quality, and availability of care in an affected community. Scheffler R, Alexander L, Godwin J. 2021. “Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients At Risk,” Report of the American Antitrust Institute and the Petris Center. Available at <https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf>. Based on its corporate record, it is indeed a distinct possibility that Acadia could encumber Adventist Vallejo with such debt, leading to these serious effects. Acadia purchased behavioral health facilities (which already had incurred debt) in the United Kingdom in 2017, then used those facilities as collateral for debt, and finally sold them off in 2020 to another private equity group in a debt-financed transaction. Plimmer G. 2021. “Priory Property Deal Saddles

7. Quality Evaluation

The previous sections have focused on the potential price effects of the proposed acquisition. In this section we outline our quality-of-care concerns about the proposed acquisition.

The National Academy of Medicine (formerly known as the Institute of Medicine) defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."³⁰ The merger of two hospitals creates opportunities for improvements as well as risks for a decline in quality.

We reviewed several documents and data sources to consider quality of care concerns at AHV and SJBH that might be impacted by the proposed acquisition of AHV by Acadia. Only limited information about each facility's operations and quality of care was available. However, there appeared to be at least 3 critical findings that stood out and raised serious concerns about quality of care at both facilities:

Mental Health Chain with High Rents," Financial Times. Available at <https://www.ft.com>; Acadia Initial Acquisition of Priory Group, 2017 10-K SEC Report, <https://acadiahealthcare.gcs-web.com/static-files/c77e4e90-97f1-4458-8b83-cd3a2cc57d2e>; Use of Acadia Facilities as Collateral for Debt, <https://acadiahealthcare.gcs-web.com/static-files/14d131ae-0000-428f-b4aa-9e009cc3ebad>; Acadia Sells Priory Group, 8-K SEC Report, <https://acadiahealthcare.gcs-web.com/static-files/1c766999-9690-49ad-ba8c-0f09f60aea93> (additional financial details in 8-K SEC Reports dating from Dec. 20, 2020 to Jan. 17, 2021); Asset Purchase Agreement, pp. 103-172, <https://acadiahealthcare.gcs-web.com/static-files/8498a603-f30a-4208-ac68-f8cbfb14151b>; Medical Properties Trust, 8-K SEC Report, <https://investor-relations.medicalpropertiestrust.com/static-files/248dd450-5ba8-48cc-88db-85f7351fd33b> (additional financial details in 8-K SEC Reports dating from Jan. 1 to Jan. 21, 2021); Bawden A. 2011. "Priory hospital owners, Advent International, looking 'to consolidate,'" The Guardian. Available at <https://www.theguardian.com/society/2011/nov/01/priory-group-advent-international-consolidation>. Without imposing conditions relating to debt encumbrance, any resulting reduction in quality and or services, increase in prices, as well as closure of the facility, or declaration of bankruptcy, for Adventist Vallejo would reduce access to essential mental health services in Northern California which are already in short supply. See Sections 4.1 to 4.4 (describing lack of psychiatric services for children and adolescents). For all of these reasons, we recommend the Attorney General impose conditions that would prevent Acadia from encumbering Adventist Vallejo with debt that would present a substantial risk of a reduction in quality at Adventist Vallejo, closure, bankruptcy, or that would constitute a direct or indirect violation of the other conditions we also recommend.

³⁰ <https://www.ahrq.gov/patient-safety/quality-resources/tools/chtoolbx/understand/index.html>

- Comparisons in the rate of seclusion and restraint incidents available from the Centers for Medicare & Medicaid Services (CMS/Medicare) publicly available data
- A Department of Health and Human Services CMS survey conducted at SJBH on 1/5/2018
 - A Compliance Validation Survey conducted at SJBH by the California Department of Public health on 7/19/19 for Federal “Conditions for Coverage” (42CFR482.23).

The National Academy of Medicine has identified six core domains of health care quality; amongst the six domains, safety and effectiveness are critical indicators of hospital performance.³¹ Rates of seclusion and restraint are an excellent proxy measure for both of these quality domains; significant injuries and psychological trauma can be associated with these interventions for both patients and staff.³² Moreover, seclusion and restraint episodes are often viewed as a “treatment failure.”³³ About 15 years ago, The Joint Commission began to include seclusion and restraint rates as one of several quality-of-care indicators for hospital-based inpatient psychiatric services.³⁴ Their inclusion was the result of abuse of these practices, wide variation across hospitals, and cultural influences, including the consumer and recovery movements.

³¹ <https://www.ahrq.gov/talkingquality/measures/six-domains.html>

³² Sacks, MH, Walton, MF. 2014. “Seclusion and Restraint as Measures of the Quality of Hospital Care: Any Exceptions?” *Psychiatric Services* 65 (11): 1373-1375.

³³ https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf

³⁴ Specifications Manual for Joint Commission National Quality Measures (v2014A). Oakbrook Terrace, Ill, The Joint Commission, 2013.

During our initial data gathering and analysis, we found published reports indicating that in 2019 AHV had 1.53 hours of physical restraint per 1,000 patient care hours and 2.22 hours in seclusion per 1,000 patient care hours; the California state average for these metrics is 0.42 and 0.32 hours respectively. Subsequently, we have learned from Counsel representing Acadia Healthcare that there was an error in the calculations leading to the published report and new/corrected data do not support our original observation of problems with seclusion and restraint practices at AHV. Additionally, it has come to our attention that CMS has recommended the removal of eight of the Inpatient Psychiatric Facility Quality Reporting Program measures—including rates of seclusion and restraint--beginning with the FY 2020 payment determination.³⁵ Accordingly, there is no ongoing concern about seclusion and restraint practices at AHV.

However, in addition to our initial concerns about seclusion and restraint at AHV, serious problems related to safety and quality of care at SJBH were also identified. During the 2018 CMS survey at SJBH, serious deficiencies regarding nursing staff were identified. In their findings pertaining to 482.23(a), Organization of Nursing Services the report states:

The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to conduct necessary training and evaluation. These failures had the potential to impact the patients' care and safety.

³⁵ <https://www.cms.gov/newsroom/fact-sheets/ipf-fiscal-year-fy-2019-medicare-payment-and-quality-reporting-updates-inpatient-psychiatric>

In addition, they found that compliance with 482.23(b) Staffing and Delivery of Care was deficient. The report stated:

Based on interview and record review, the facility failed to follow the nurse-patient ratios. This failure potentially impacts patient's care and safety.

On July 19, 2019, during a compliance survey at SJBH conducted by the California Department of Public Health (CDPH), several Federal “Conditions for Coverage” (42CFR482.23) deficiencies were cited – including serious problems with governing body functioning and performance at SJBH. CDPH found multiple deficiencies related to treatment effectiveness and safety. Their report stated: “Four Conditions for Coverage (42 CFR § 482.12, including Governing Body; § 482.13, Patient Rights; § 482.21, Quality Assessment and Performance Improvement (QAPI); and § 482.23, Nursing Services) were not met.”

Amongst the several deficiencies identified, the survey found:

1. A failure to identify and correct problems with regards to the sexual allegations that occurred in the units.
2. A failure to identify omission of reporting of alleged sexual abuse and other forms of abuse in the hospital.
3. A failure to evaluate the effectiveness of the services provided by the laboratory contracted services when 50 laboratory samples were reported lost in May 2019.

In CDPH’s conclusion that the Conditions for Coverage were not met, they determined that the hospital failed to have an effective governing body legally responsible for the conduct of the hospital as an institution. Effective hospital governance and leadership is critical to assuring quality of care and promoting ongoing quality improvement.

Based upon copies of correspondence provided by Acadia's attorneys, we determined that in an August 7, 2019 letter to the Hospital's Executive Director, CMS suspended SJBH's participation in the Medicare program and advised that termination of payments would be effective November 8, 2019. In a follow-on letter dated September 6, 2019, CMS informed SJBH of restoration of their participation and deemed status as a Joint Commission accredited facility. This decision was based upon the Hospital's plan of correction (PoC) addressing the findings from the July 19, 2019 survey. To date, we have not found nor have we been informed of any subsequent survey specifically verifying actual implementation of the PoC and success in addressing the identified problems.

This is not the first time that concerns about governance and patient safety at an Acadia Healthcare Facility have been cited during a survey. The report from a March 10, 2017 CMS review at Cascade Behavioral Health in Tukwila, Washington stated:

The Governing Body failed to effectively manage the hospital to protect patients from harm...[and that] due to the scope and severity of deficiencies detailed under 42 CFT 482.13, the Condition of Participation for Patient Rights was NOT MET.³⁶

The importance of effective governance in assuring safety, making changes in clinical operations and promoting ongoing quality improvement cannot be overstated. In the acquisition of AHV Acadia will likely want and need to make numerous changes at their new facility that will of necessity engage the highest levels of leadership, e.g., the governing body, as well efforts involving administration and clinical staff. However, we have identified report after report that establish a pattern of failure by Acadia to provide just that kind of leadership in facilities around

³⁶ We have included the full report as appendix material to this report.

the country; repeatedly, Acadia has been called out for significant deficiencies in governance and leadership related to assuring as well as improving the quality and safety of care.

In an August 21, 2020 letter dated from the Vice-President of the Patricia Hall Talbott Legacy Centers (TLC) to the Tennessee Health Services & Development Agency, they opposed Certificate of Need applications by Acadia for new programs asserting that “the parent company of these applications [Acadia] has a long and demonstrated history of failing to adhere to appropriate quality standards across their vast treatment center network.” TLC identified “reports in Attachment B [that] go back nearly 7 years, establishing a clear pattern of failing to adhere to appropriate quality standards.” Appendix B identifies problems at over 80 different facilities.³⁷

TLC is not alone in raising concerns about Acadia. In an October 11, 2018 report entitled “Acadia Healthcare: Destructive Greed” Marcus Aurelius Value, an investment analysis and advisory firm, opined:

[Acadia] has concealed widespread patient abuse and neglect that results from pervasive understaffing at its facilities. At Acadia, cutting staffing costs to the bone is the “secret sauce” used by management to inflate short term profits. Acadia’s existence makes the world a worse place because its business model depends on acquiring new facilities and then degrading care, a losing proposition that victimizes patients. We believe the fundamental problem for investors is that Acadia’s slash and burn approach to behavioral healthcare is inherently unsustainable and increasingly at risk of unraveling.

The report goes on to assert:

Over several months, we gathered and reviewed thousands of pages of public documents including over 600 state and federal inspection reports as well as court records, media reports, lawsuits, and police records. We found that numerous patients, including children and teenagers, have died due to alleged negligence or malpractice at Acadia facilities. We found recurring reports of sexual abuse and physical assaults on vulnerable patients that have allegedly been perpetrated by

³⁷ We have included a copy of the letter and Appendix B as an attachment.

Acadia employees or unmonitored patients. We found repeated instances of patient neglect or deficient care linked directly to staffing problems at Acadia facilities. We found a pattern of whistleblower allegations made by former employees who say Acadia retaliated against them after they reported fraud or misconduct.

Acadia's undisclosed problems are not isolated to just a few bad facilities or a handful of rogue employees. We found indications of understaffing or deficient care at over 75 Acadia facilities in 24 states. Not only did we uncover problems at the majority of Acadia's U.S. inpatient hospitals, which in aggregate generate 43% of the company's U.S. revenue, but we also flagged significant issues within Acadia's national network of outpatient addiction facilities. We have posted extensive source documents at www.acadiaexposed.com, where we will individually profile 30 of Acadia's most problematic facilities in a series of additional releases. Some of these facilities are also reportedly under government investigation, have received patient referral holds, or are being permanently closed.³⁸

It should be noted that both facilities are not only accredited by The Joint Commission and granted deemed status, they are also subject to periodic licensure and certification surveys as well as investigation of complaints by CDPH for compliance with both State and Federal regulations. However, it appears that this level of external oversight alone has not been sufficient to address the totality of safety and quality of care concerns identified above. CMS, in its FY 2019 Report to Congress (RTC): *Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* acknowledges that there are inevitable discrepancies between State/Federal reviews and accreditation surveys.

CMS is not alone in their concerns about the limitations and sufficiency of Joint Commission accreditation and deemed status in assuring patient safety and quality of care. In 2017, Senator Charles Grassley criticized the Joint Commission over it designating a Universal

³⁸ We have included a copy of the report as an attachment.

Health Services (UHS) behavioral facility, Shadow Mountain in Oklahoma, with a “Gold Seal of Approval” when there were serious allegations of patient abuse and sexual misconduct against it. The Senator wrote the Joint Commission, saying it “appears to be unable to aggressively enforce the necessary standards on all facilities.” He also cited a *Wall Street Journal* story about Cooley Dickinson Hospital in Northampton, Massachusetts [an Acadia facility], which was given the “Gold Seal of Approval” by the Joint Commission even after CMS threatened to cut it off over safety problems which led to preventable patient deaths.³⁹

Survey deficiencies typically require that a facility submit and implement an approved plan of corrections (PoC). In our experience, PoCs following survey findings do not always result in successful change, and efforts may not be sufficient to promote/sustain needed change over time. It is not unusual to see the same problems and deficiencies merely cited and carried forward over multiple years of survey and review with little meaningful improvement. This type of failure has specifically been observed at Acadia facilities. In a September 8, 2019, *Seattle Times* investigative report about problems at Acadia’s Cascade Behavioral Hospital entitled “Public Crisis, Private Toll,” Daniel Gilbert wrote:

Inspectors often found violations they had cited in past surveys, notably for the hospital’s readiness to respond to medical emergencies. The hospital would submit a plan of correction, the regulator would approve it, and the cycle would repeat at least annually.

Marcus Aurelius Value’s report cited above also included similar findings regarding implementation of PoCs. They quote a letter from the Michigan Department of Health and Human Services regarding multiple instances of **child abuse** by staff at Acadia’s Capstone

³⁹ <https://www.healthexec.com/topics/quality/joint-commissions-failure-has-senator-asking-how-make-its-inspections-public>

Academy in Michigan. The letter demanded, in bold print, “*an explanation why previous corrective action plans have not obtained and maintained compliance for rules found in repeat noncompliance.*”

Taken all together, these findings lead us to seriously question the fitness of Acadia as a new owner of AHV. We have substantial concern that Acadia does not have the ability to provide and sustain the leadership and accountability needed to adequately address the quality of care and safety issues at either facility and to successfully take on the challenges that will come with their acquisition of AHV.

8. Conclusions and Recommendations

Based on our analysis we conclude that the proposed acquisition is very likely to lead to cross-market price effects if it is allowed to proceed without conditions. We recommend putting the following conditions on the acquisition to ensure that it does not lead to price increases from increased market power.⁴⁰

1. For 5 years the maximum annual price increase that Acadia may charge a payer of any commercial or government-sponsored product for hospital services performed at AHV cannot exceed 6% per year for commercial prices and 2.8% per year for Medi-Cal prices.
- This should apply only if a payer contract expires or is up for renewal during the 5-year

⁴⁰ We describe these conditions at a high-level here but support the more detailed versions written by the California Office of the Attorney General, including the use of a monitor. We also recommend conditions to address the encumbrance of debt by Acadia based on our findings elsewhere in the report, specifically the following: (1) for 5 years, Adventist Vallejo and Acadia shall not encumber or obligate the Adventist Vallejo facility with debt, or otherwise incur any liability, to the extent that such an encumbrance or obligation places the short-term or long-term financial viability of the facility at substantial risk of the facility closing, becoming insolvent, or entering bankruptcy; and (2) for 5 years, Adventist Vallejo and Acadia shall not encumber or obligate the Adventist Vallejo facility with debt, or otherwise incur any liability that leads to a reduction in quality or safety, a price increase in an agreement with a payor, or any other direct or indirect violation of other conditions. As with the conditions mentioned above in the text, we describe them at a high-level here, but support the more detailed versions written by the California Office of the Attorney General, including the use of a monitor.

period; if the contract does not expire, then there is no need to negotiate over a price increase. 6% is the median average annual commercial price increase among Northern California (counties north of San Luis Obispo) acute psychiatric hospitals for the 5 most recent years of OSHPD data (2015-2020) while 2.8% is the median average annual Medi-Cal price increase among Northern California acute psychiatric hospitals for the 5 most recent years of OSHPD data (2015-2020).

2. For 10 years Acadia shall not condition the participation of, or impose contract terms concerning, one of its hospitals on the participation of any of its other hospitals in provider network negotiations with health plans. The prohibition on conditioning of participation or contact terms across Acadia's hospitals includes:
 - a. Engaging a payer in "all-or-nothing" contracting for hospital services by requiring the payer to contract with all (or a group) of its hospitals rather than individual hospitals.
 - b. Penalizing a payer for contracting with individual hospitals. This includes setting significantly higher than existing contract prices or out-of-network fees for any or all of Acadia hospitals, should the payer choose to contract with less than all (or a group) of Acadia hospitals.
 - c. Interfering with the introduction or promotion of new narrow, tiered, or steering commercial products or value-based benefit designs for commercial products.

3. AHV should be required to continue serving patients 12 and under for 10 years after the acquisition. AHV accounts for 20% of the 12 and under psychiatric discharges in Northern California. SJBH does not treat patients 12 and under. Additionally, 12 and under inpatient psychiatric admissions are generally less attractive financially to hospitals

given that a large portion of them are reimbursed by Medi-Cal. These last two facts give us concern about Acadia's willingness to maintain access for patients 12 and under at AHV post-acquisition.

Because it appears that accreditation by The Joint Commission, and periodic licensure and certification surveys by CDPH have not been sufficient to address the safety and quality of care concerns identified above, we recommend the following quality-related conditions be imposed:

1. As soon as possible, the Attorney General should engage a team of experts to evaluate Acadia's implementation of the 2019 Plan of Correction at SJBH. The Team should include at minimum a psychiatrist, nurse, hospital administrator, and quality improvement manager/social worker with experience in the operation and management of a free-standing acute psychiatric hospitals. Within 120 days, the team should complete a review of all relevant documents (and conduct on-site reviews at SJBH as needed) to the implementation of the PoC. This may include but not necessarily be limited to evaluate current operations at the hospital in order to determine resolution of the deficiencies cited by CDPH and CMS. The team should prepare a report of their findings for review by the Attorney General who, as indicated and appropriate, may allow SJBH/Acadia to review and comment upon the findings.
2. If the team finds substantial implementation and ongoing maintenance of the PoC, along with sufficient continuous quality management to prevent recurrences of the cited and other related deficiencies, then no further actions should be necessary.
3. If the team finds that either 1) the PoC has not been fully implemented, or 2) the proposed changes have not been sustained over time, or 3) that new urgent/critical quality

of care and safety concerns are identified, the Attorney General should appoint a quality assurance/improvement and safety monitor for a period of no less than 5 years to review and evaluate performance at both SJBH and AVH. The monitor's activities should include but not necessarily be limited to 1) on-site reviews, 2) attendance at governing body meetings, 3) staff and patient interviews, 4) review of critical incident reports, 5) review of accreditation and licensing surveys, 6) implementation of plans of corrections, 7) review of actual staffing levels and ratios, and 8) review of performance indicators and measures including comparisons to both State and Federal averages. The monitor should report their findings to the California Office of the Attorney General every 6 months. After 5 years, the monitor should recommend either the termination of the oversight process or extension of the monitoring for up to an additional 5 years.



9/25/21

Richard M. Scheffler

Date



9/25/21

Neal Adams

Date



9/25/21

Daniel R. Arnold

Date

Appendix

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 054154	(X1) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 07/19/2019
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A000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a complaint validation survey conducted on 7/19/19.</p> <p>The hospital was licensed for 80 beds. The census at the time of the survey was 69. The sample size was 30.</p> <p>Immediate Jeopardy (IJ) was called on 7/18/19 at 3:07 p.m. for §482.23, Nursing Services and was removed on 7/18/19 at 8:30 p.m. with an acceptable removal plan from the hospital (refer to A392).</p> <p>Four Conditions for Coverage (42 CFR §482.12, Governing Body; §482.13, Patient Rights; §482.21, Quality Assessment and Performance Improvement (QAPI); and §482.23, Nursing Services) were not met.</p> <p>Representing the California Department of Public Health: 32999, Health Facilities Evaluator Supervisor; 29766, Health Facilities Evaluator Manager I; 26295, Health Facilities Evaluator Manager I; and 29328, Health Facilities Evaluator Manager II.</p>	A000		
A043	482.12 GOVERNING BODY	A043		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are due within 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are due within 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.

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	<p>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...</p> <p>This Statute is not met as evidenced by:</p> <p>Based on interviews and record reviews, the hospital failed to have an effective governing body legally responsible for the conduct of the hospital as an institution as evidenced by:</p> <ol style="list-style-type: none"> 1. Failure to respond timely to a system failure that jeopardized the health and safety of patients with potential harm to other patients (refer to A049) 2. Failure to ensure that the quality of nursing services was effectively assessed and monitored, and ensure the identified problems were effectively resolved (refer to A273) 3. Failure to ensure that nursing staff provided care to meet the needs of the patients (refer to A392) 4. Failure to ensure that laboratory services provided under the contract were safe and effective (refer to A084) <p>The cumulative effect of these systemic problems resulted in the governing body's inability to govern the hospital effectively in compliance with the statutorily-mandated Condition of Participation for the Governing Body.</p>			

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A049	<p>482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY</p> <p>[The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This Statute is not met as evidenced by: Based on interview and record review, the hospital failed to hold the medical staff accountable for the issues of sexual incidents in the adolescent unit. This resulted in an ineffective management of the sexual incidents frequently recurring in the unit.</p> <p>Findings:</p> <p>During an interview and record review on 7/19/19 at 1:30 p.m., the chief executive officer (CEO), he stated the governing body meets quarterly. Review of the minutes, dated April, July, and November 2018, March 8, 2019, and May 9, 2019, did not indicate any documentation or discussion of any sexual incidents in the adolescent unit. The minutes were not even readily available for review.</p> <p>On concurrent interview and record review with the CEO, he stated the Medical Executive Committee (MEC) meets on monthly basis. Review of the minutes from January 2019 to June 2019 of the MEC also indicated no discussion of the sexual incidents in the adolescent unit.</p> <p>Review of the hospital's policy, "PROCESS IMPROVEMENT PROGRAM" dated 1/2019, indicated the Governing Board has the ultimate responsibility and authority to establish, maintain, and support an effective process improvement program. The Governing Board assures that the necessary structures are established and processes are implemented to</p>	A049		

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A084	<p>assess and continually improve the overall quality and efficiency of patient care. The Medical Executive Committee is delegated the authority and accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness, and efficiency of patient care outcomes. It indicated the committee will recommend and implement appropriate actions and assess the effectiveness of such actions, in collaboration with the quality council, when significant problems in patient care and clinical performance or opportunities to improve care are identified and document the findings and results of medical Executive committee.</p> <p>482.12(e)(1) CONTRACTED SERVICES</p> <p>The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This Statute is not met as evidenced by: Based on interview and record review, the hospital failed to ensure the services provided under the laboratory contract were provided in a safe and effective manner when 50 laboratory samples were found to be missing and the Quality Director does not have a system to evaluate the quality of the service provided by the contracted vendors. These failures had the potential to put the hospital at risk for receiving unsafe and ineffective services from the contracted vendors.</p>	A084		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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	<p>Findings:</p> <p>During a review and interview on 7/19/19 at 1:30 p.m. with CEO on the Governing Board Minutes, dated June 2019, 50 laboratory samples were reported missing in May 2019 from the hospital's laboratory vendor. When asked about this incident, the CEO stated it was lost in the laboratory site. There were no other documentation about this incident.</p> <p>During an interview with Director of Quality Assurance (DQA) on 7/19/19 at 2:45 p.m., she stated she did not do onsite visits to any of the hospital's contract vendors. She further stated the laboratory vendor provides the hospital with quarterly quality reports.</p>			

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A115	<p>482.13 PATIENT RIGHTS</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to comply with the Condition of Coverage for Patient Rights as evidenced by:</p> <ol style="list-style-type: none"> 1. Failure to ensure patients to receive care in a safe setting (refer to A144) 2. Failure to ensure patients were free from sexual abuse (refer to A145) <p>The cumulative effects of these systemic problems resulted in the hospital's inability to ensure the provision of quality of healthcare in a safe environment.</p>	A115		
A144	<p>482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff provided adequate supervision:</p> <ol style="list-style-type: none"> 1. Patient 8 had sex with another peer in the room when he was supposed to be under 1:1 supervision; and, 2. From March 2019 to June 2019, sixteen (16) patients (Patients 5, 6, 9, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, and 30), who were on Q15 minutes monitoring, had various incidents involved. 	A144		

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	<p>This failure had the potential for all patients to be unprotected from various possible incidents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Patient 8's Discharge Summary, dated 4/25/19, indicated Patient 8 was a 17-year-old transgender female (denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex) with history of sexually trafficked and abducted. 2. Review of Patient 8's Psychiatrist Progress Notes, dated 3/14/19, indicated the patient was found with a male peer in her room after shift change at about 11:10 p.m. Both patients did not wear clothes. Patient 8 reported they had consensual sex. 3. Review of Patient 8's Patient Observations, dated 3/14/19, indicated the patient was on every 15 minutes observation and should be on 1:1 monitoring when he was in the room for sexual precautions. 4. Review of Patient 5's Progress notes, dated 6/3/19 at 7:30 p.m. indicated the patient was 55-year-old female and she shouted, yelled, and cursed another male peer, who was seen going out of the patient's room. She stated another male peer came to her room and touched her. 5. Review of Patient 6's Psychiatrist Progress Notes, dated 6/2/19, indicated the patient was 50-year-old male with schizoaffective disorder (a serious mental disorder in which people interpret reality abnormally). It indicated throughout day, the patient remained inappropriate, threatening on the unit the 			

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	<p>psychiatrist overheard multiple times by staff he was walking up to a peer and saying "I am going to fucking rape you and then you are going to put your finger in my ass." and making obscene sexual gestures at the peer, to the point that peer complained multiple times to staff feeling unsafe to leave her room.</p> <p>Review of Patient 6's Patient Observations, dated on 6/2/19, indicated the patient was on every 15 minutes monitoring and the monitoring had changed to every 5 minutes at 11:30 p.m. at the end of the day.</p> <p>Review of Patient 9's clinical record indicated he was 32-year-old male, admitted on 2/16/19 with diagnoses including paranoid schizophrenia and severe amphetamine use disorder. On 2/18/19, he informed the psychiatrist that he was sex-deprived.</p> <p>Review of Patient 16's Discharge Summary, dated 3/12/19, indicated the patient was a 33-year-old female and admitted on 2/24/19 on 5150 hold for being gravely disabled. On admission, she presented herself as disorganized, and tangential paranoid.</p> <p>Review of Patient 16's Progress notes, dated 3/2/19, at approximately 5:35 p.m., a peer informed staff nurse Patient 9 went in to Patient 16's room. Patient 16 was found on her knees in bed while Patient 9 was found standing behind her back with his pants down below his waist.</p> <p>Review of Patients 9 and 16' Patient Observations, dated 3/2/19, indicated both patients remained on every 15 minutes monitoring for sexual precautions.</p> <p>Review of Patient 15's Discharge Summary, dated 5/7/19, indicated Patient 15 was a 17-</p>			

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	<p>year- old female with history of major depressive disorder, post traumatic stress disorder, and sexual and physical abuse. She was admitted under 5150 for suicidal behavior.</p> <p>Review of Patient 15's Progress notes, dated 4/30/19 at 4:30 p.m., staff noticed Patient 15 was sexually inappropriate as exhibited by sucking on a peer's fingers.</p> <p>Review of Patient 15's Progress notes, dated 5/1/19 at 7 p.m., in activity room, staff saw Patient 22 sucking Patient 15's left middle finger.</p> <p>Review of Patient 22's Discharge Summary, dated 5/6/19, indicated the patient was "sexually acting out" by licking female peer's finger.</p> <p>Review of Patients 15 and 22's Patient Observation, dated 5/1/19, indicated both patients were placed on every 15 minutes observation for sexual acting out precautions.</p> <p>Review of Patient 17's Discharge Summary, dated 5/26/19, indicated the patient was a 14-year-old male and admitted under 5150 hold for danger to self with suicidal ideation.</p> <p>Review of Patient 17's Progress Notes, dated 5/25/19, indicated at approximately 7:30 p.m., a staff reported Patient 17 was seen kissing Patient 24 on the lips in the activity room.</p> <p>Review of Patient 17's Patient Observations, dated 5/25/19, indicated when the incident occurred the patient was on every 15 minutes monitoring for sexual precaution.</p> <p>Review of Patient 24's Progress Notes, dated 5/25/19, indicated the patient was a 14-year-old</p>			

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	<p>female, had poor boundaries with a male peer, and required consistent redirection. Staff saw the patient kissed Patient 17.</p> <p>Review of Patient 24's Patients Observations, dated 5/25/19, indicated when the incident occurred, the patient was on every 15 minutes monitoring for sexual precautions.</p> <p>Review of Patient 24's Progress Notes, dated 5/27/19 at 11:44 a.m., indicated another female patient punched her face twice after they got into a verbal altercation in the cafeteria. Patient 24 had a swelling on the bottom lip and complained of 7 of 10 pain (0-10 pain scale, 10/10 is the worst pain).</p> <p>Review of Patient 24's Patients Observations, dated 5/27/19, indicated the patient was on Q15 minutes monitoring.</p> <p>Review of Patient 18's Discharge Summary dated 3/22/19, indicated Patient 18 was a 14-year-old male and admitted under 5150 hold for danger to self for having suicidal thoughts.</p> <p>Review of Patient 18's Progress Notes, dated 3/19/19 at 9:30 a.m., while kids were lined up in front of the nurses' station to go to the gym, the nurse went back to the nurses' station to get a clipboard. When the nurse came back to the line, she saw Patient 18 and another female peer were kissing at a corner, which was an area that was not a direct view from the nurses' station.</p> <p>Review of Patient 18's Patient Observations, dated 3/19/19, indicated the patient was on every 15 minutes observation for sexual acting out.</p> <p>Review of Patient 19's Progress Notes, dated 6/24/19, indicated Patient 19 kissed a female</p>			

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	<p>peer at 4:20 p.m. when they were going to a gym.</p> <p>Review of Patient 19's Patient Observations, dated 6/24/19, indicated the patient was on Q15 minutes monitoring when the incident occurred.</p> <p>Review of Patient 21's Progress Notes, dated 3/8/19, indicated the patient had a fight with another peer, which resulted in a bump on the back of the head.</p> <p>Review of Patient 21's Patient Observations, dated 3/8/19, indicated when the incident occurred, the patient was on Q5 minutes monitoring</p> <p>Review of Patient 21's record indicated there was no evidence a progress note or Incident Report Form was initiated regarding the 3/8/19 incident.</p> <p>During an interview on 7/19/19 at 1:35 p.m., the nursing house supervisor stated there should always be an incident report for investigation and progress notes written when an incident happened.</p> <p>Review of Patient 23's Progress Notes, dated 6/10/19, indicated the patient was involved in a verbal altercation with a female peer. Patient 23 was physically attacked by the female peer while being in the activity room.</p> <p>Review of Patient 23's Patient Observations, dated 6/10/19, indicated when the incident occurred, the patient was on Q15 minutes monitoring.</p> <p>Review of Patient 25's Progress notes, dated 6/10/19 at 8:21 p.m., indicated the patient was a 15-year-old female, went to the back of the</p>			

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	<p>activity room with another peer, where they knew it was a blind spot, and kissed.</p> <p>Review of Patient 25's Patient Observations, dated on 6/10/19, indicated when the incident occurred, the patient was on Q15 minutes monitoring.</p> <p>Review of Patient 26's Progress notes, dated 3/15/19, indicated the patient was a 15-year-old female and discharged on that day.</p> <p>During an interview on 7/19/19 at 10:23 a.m., Director of Quality Assurance (DQA) stated after Patient 26's discharge, her mother called and stated the patient was sexually assaulted by her roommate during the hospitalization. DQA stated she investigated and the patient's roommate stated both had kissed but, Patient 26 started kissing.</p> <p>Review of Patient 27's Progress Notes, dated 6/24/19, indicated the patient was a 15-year-old female and kissed another peer in a hallway going toward a gym.</p> <p>Review of Patient 27's Patient Observations, dated on 6/24/19, indicated the patient was on Q15 minutes monitoring.</p> <p>Review of Patient 30's Progress Notes, dated 4/27/19 at 4:50 p.m., indicated the patient was seen kissing another peer and she stated "He kissed me first."</p> <p>Review of Patient 30's Patient Observations, dated on 4/27/19, indicated the patient was on Q15 minutes monitoring.</p> <p>During an interview with Director of Quality Assurance (DQA) on 7/17/19 at 1 p.m., the incidents were reviewed. DOQ stated even though the patients were under various</p>			

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A145	<p>monitoring, the incidents happened so quickly and staff could not prevent them.</p> <p>Review of the hospital's job description for registered nurses (RN), dated 5/1/18, indicated RNs are responsible for providing professional nursing care to patient in a supportive and therapeutic environment.</p> <p>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff supervise patients to be free from sexual abuse when Patient 2 sexually assaulted Patient 1 and Patient 4, who was under every 15 (Q15) minutes and every 5 (Q5) minutes monitoring, was able to perform various forms of sexual activities with three female peers at six different times. This failure had the potential for all patients to be unprotected from sexual abuse.</p> <p>Findings:</p> <p>1. Review of Patient 1's Discharge Summary, dated 6/1/19, indicated the patient was a 16-year-old male and admitted to the hospital on</p>	A145		

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	<p>5/20/19 with diagnoses of major depressive disorder, PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit Hyperactive Disorder), and social anxiety disorder.</p> <p>Review of Patient 1's Progress Notes, dated 5/29/19 at 11:16 a.m., indicated "a peer pressured/threatened him into letting peer perform manual and oral sex on/to him in the activity room...on 5/27/(2019) ([Patient 1] reports "she gave me a hand job") and on 5/28/(2019) (pt [patient] reports "she performed oral sex on me.")" The patient reported the peer threatened him into participating in acts and the peer was "scary". The patient stated both incidents occurred in the back of the activity room between 8 p.m. to 9 p.m. There was no evidence staff was present and supervised patients in the activity room during the incidents occurred.</p> <p>Review of patient 1's Patient Observations, dated 5/27/19 and 5/28/19, indicated the patient was on Q15 minutes monitoring when the incidents occurred.</p> <p>Review of Patient 2's Discharge Summary, dated 6/1/19, indicated on 5/25/19, the patient was a 15-year-old female (whom identified himself as male) and admitted to the hospital with diagnoses of general anxiety, major depression, and borderline personality.</p> <p>Review of Patient 2's Progress Note, dated 5/29/19 at 1:13 p.m., indicated on 5/28/19, the patient reported he performed oral sex on a peer in the back of the activity room. The patient also reported he and some peers touched each other's private areas and gave a peer a hand job between 8 p.m. to 9 p.m. There was no evidence the staff supervised them during the incident.</p>		

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	<p>Review of Patient 2's Patients Observations, dated 5/27/19 and 5/28/19, indicated the patient was on Q15 minutes monitoring when the incident occurred.</p> <p>Review of the police report, dated 7/23/19, indicated Patient 1, the victim, wanted to press charges against Patient 2. Patient 2 was released from the hospital into the custody of Child Protective Services (CPS) and this case was forwarded to the Santa Clara County Juvenile District Attorney.</p> <p>During an interview on 7/17/19 at 2:00 p.m., the Director of Quality Assurance (DQA) stated that during the events no staff supervised the patients in the activity room and there should be always staff to supervise the patients.</p> <p>2. Review of Patient 4's Discharge Summary, dated 5/11/19, indicated the patient was a 14-year-old male and admitted on 5/2/19 under 5150 hold (California law code for temporary, involuntary psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness) with diagnoses including bipolar disorder (any of several psychological disorders of mood characterized by alternating episodes of depression and mania), severe depression with psyche features. During his course of hospitalization, Patient 4 continued to have mood lability and significant difficulty with impulse control. He required 5 minute checks and one-on-one for a lot of his hospital stay as he was hypersexual.</p> <p>Review of Patient 4's Psychiatrist Progress Notes, dated 5/4/19, indicated he has said provocative statements to nursing staff and he has called them "honey" that was said in a way that felt malicious and sexualized. He was also intrusive of others. He knocked a hoodie off of</p>			

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	<p>a peer's head while he was on every 15 min monitoring for sexual acting out. It indicated the patient had inappropriate touching with female peers and seems to be hypersexual with no history of abuse. He was placed on every 15 minutes observation for sexual precautions.</p> <p>Review of Patient 4's Nurses progress notes, dated 5/5/19, indicated a peer reported to nursing staff, on 5/4/19 between 6 to 7 p.m., Patient 4 and Patient 3, who was 16-year-old female, were in the activity room covered up with a blanket and appeared to be fondling each other underneath the blanket. There were no staff present in the activity room at that time. Patient 4 remained on every 15 minutes observation.</p> <p>Review of Patient 3's Progress Notes, dated 5/5/19 at 1:54 p.m., indicated the patient reported Patient 4 made inappropriate comments, stating "He told me he wants to have sex" and kissed her in the activity room. It stated the incident was consensual and unwitnessed.</p> <p>Review of Patient 3's discharge summary dated 5/6/19, indicated on 5/5/19, she was observed to be crying, feeling emotional, and upset. She reported she had oral sex with Patient 4 in her room. Patient 4 pretended to be in the shower by turning the water on, snuck out of shower in between every 15 minute observation, went into Patient 3's room, and had oral sex with her.</p> <p>Review of Patient 4's Patient Observations, dated 5/5/19, indicated the patient was on every 15 minutes monitoring when the incident occurred.</p> <p>Review of Patient 28's Progress Notes, dated 5/5/19 1:54 p.m., indicated the patient reported</p>			

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	<p>Patient 4 made inappropriate remarks on her, stating "He told me he wants to have sex" and kissed her in the activity room. It stated the kiss was consensual.</p> <p>Review of Patient 28's Discharge Summary, dated 5/4/19, indicated patient 28 was a 15-year-old female under the guardianship of her parents. Patient 28 had a diagnosis of autism spectrum disorder (a serious developmental disorder that impairs the ability to communicate and interact)</p> <p>Review of Patient 4's Patient Observations indicated on 5/5/19 he was on every 15 minutes monitoring and at 4 p.m. on that day, the patient was placed on 1:1 monitoring. On 5/9/19 8:30 a.m., the monitoring had changed to every 5 minutes.</p> <p>Review of Patient 4's Patient Observations, dated 5/9/19, the patient was on every 5 minutes monitoring when the physical altercation occurred.</p> <p>Review of Patient 7's Discharge Summary, dated 5/16/19, indicated the patient was a 15-year-old female with diagnoses of major depressive disorder and was undergoing intensive outpatient program. She was admitted on 5/10/19 under 5150 hold for danger to self due to suicidal ideation.</p> <p>Review of Patient 7's nurses progress notes, late entry dated 5/14/19 for 5/11/19, indicated on 5/11/19, Patient 7 reported to staff on 5/10/19, while in the activity room before bedtime, Patient 4 grabbed her hand and placed it on his private part. She immediately pulled her hand away. A peer, who was in the same room at the same time, stated she saw both of them sitting next to each other. Patient 7 also reported sometime in the morning of</p>			

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A263	<p>5/11/19, Patient 4 went into her room and touched her breast. She told Patient 4 to leave her room and he did. Patient 7 felt uncomfortable and verbalized she wanted to press charges. Incident was reported to law enforcement and to the attending physician. Patient 4 was on every 5 minutes monitoring at the time of the incident.</p> <p>During a telephone interview with the director of nursing (DON) on 7/19/19 at 11:50 a.m., she stated for the incident with Patient 4, "the 1:1 monitoring should have been done clearly".</p> <p>482.21 QAPI</p> <p>The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</p> <p>The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.</p> <p>The hospital must maintain and demonstrate</p>	A263		

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A273	<p>evidence of its QAPI program for review by CMS.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to comply with the Condition of Coverage for the Quality Assessment and Performance Improvement (QAPI) program as evidenced by:</p> <ol style="list-style-type: none"> 1. Failure to identify and correct problems with regards to the sexual allegations that occurred in the units (refer to A273, A283, and A286) 2. Failure to identify omission of reporting of alleged sexual abuse and other forms of abuse in the hospital (refer to A392); and 3. Failure to evaluate the effectiveness of the services provided by the laboratory contracted services when 50 laboratory samples were reported lost in May 2019 (refer to A084). <p>The cumulative effect of these systemic problems resulted in an ineffective QAPI program that did not involve all hospital departments and services in compliance with the statutorily mandated Condition of Participation for Quality Assessment and Performance Improvement.</p>	A273		

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	<p>limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ...</p> <p>(2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations.</p> <p>(b) Program Data</p> <p>(1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization.</p> <p>(2) The hospital must use the data collected to--</p> <ul style="list-style-type: none"> (i) Monitor the effectiveness and safety of services and quality of care; and (3) The frequency and detail of data collection must be specified by the hospital's governing body. <p>This Statute is not met as evidenced by: Based on interview and record review, the hospital failed to use their data to monitor the effectiveness and safety of services provided on the high incidents of sexual encounters between patients in the adolescent unit. This resulted in the reoccurrences of sexual assaults of adolescent patients in the unit.</p> <p>Findings:</p> <p>During the survey, the survey team reviewed approximately 25 sexual incidents occurred in the adolescent unit, from March 2019 to June 2019 (refer to A392).</p>			

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	<p>During an interview and record review on 7/19/19 at 8:30 a.m., Director of Quality Assurance (DQA) showed some data and incident reports completed by their staff. There were no documentation of what the hospital or nursing services did to resolve these sexual incidents.</p> <p>These were not brought to the Medical Executive Committee meetings nor was it in the Governing Board minutes.</p> <p>Review of the hospital's policy, "PROCESS IMPORVEMENT PROGRAM" dated 2/2019, indicated the hospital is dedicated to providing quality care and services for all patients in a safe, clean, and therapeutic environment. The facility fulfills its responsibilities to patients, professionals, support staff, and the community through continuous and systematic measurement, assessment, and improvement of its systems and processes. The process improvement program is designed to provide a coordinated, objective, and systematic approach to facility-wide quality assurance activities. The program based on desired patient outcomes by assessing and improving those governance, managerial, clinical, and support processes that most affect patient outcomes. The objectives are to enhance, maintain, and continually improve the quality of patient care through intra-and/or interdepartmental/service measurement and assessment of patient care, resolution of problems and ongoing pursuit of opportunities to improve patient care. Facility-wide quality assessment and robust process improvement activities include safety, risk management and quality control activities. Quality assessment findings are communicated to the medical staff and the governing board at least quarterly.</p>			

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A283	<p>482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES</p> <p>(b) Program Data</p> <p>(2) [The hospital must use the data collected to -]</p> <ul style="list-style-type: none"> (ii) Identify opportunities for improvement and changes that will lead to improvement. <p>(c) Program Activities</p> <p>(1) The hospital must set priorities for its performance improvement activities that--</p> <ul style="list-style-type: none"> (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. <p>(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.</p> <p>This Statute is not met as evidenced by: Based on interview and record reviews, the hospital failed to use their data collection on sexual incidents with quality improvement activities to prevent the reoccurrences of these incidents to the patients. This failure placed all patients in the hospital at risk for victims of sexual abuses.</p> <p>Findings:</p>	A283		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 054154	(X1) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 07/19/2019
NAME OF PROVIDER OR SUPPLIER SAN JOSE BEHAVIORAL HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 455 Silicon Valley Boulevard San Jose, CA 95138		
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	<p>During an interview and record review on 7/19/19 at 8:50 a.m. with QAPI director stated their quality council meets every month. She also showed their tracking system of incidents in the various units of the hospital. there were also no performance improvement activities geared towards the improvement of the recurring sexual incidents in the adolescent unit.</p> <p>Review of the hospital's policy, "PROCESS IMPORVEMENT PROGRAM" dated 2/2019, indicated the hospital is dedicated to providing quality care and services for all patients in a safe, clean, and therapeutic environment. The facility fulfills its responsibilities to patients, professionals, support staff, and the community through continuous and systematic measurement, assessment, and improvement of its systems and processes. The process improvement program is designed to provide a coordinated, objective, and systematic approach to facility-wide quality assurance activities. The program based on desired patient outcomes by assessing and improving those governance, managerial, clinical, and support processes that most affect patient outcomes. The objectives are to enhance, maintain, and continually improve the quality of patient care through intra-and/or interdepartmental/service measurement and assessment of patient care, resolution of problems and ongoing pursuit of opportunities to improve patient care. Facility-wide quality assessment and rebust process improvement activities include safety, risk management and quality control activities.</p>			

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A286	<p>482.21(a), (c)(2), (e)(3) PATIENT SAFETY</p> <p>(a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...</p> <p>(c) Program Activities</p> <p>(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.</p> <p>(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This Statute is not met as evidenced by: Based on interview and record review, the hospital's QAPI failed to address the issues of sexual incidents in the adolescent unit. This failure led to repetitive sexual events in the unit.</p> <p>Findings:</p> <p>During a review and interview on 7/19/19 at 8:30 a.m., the QAPI director showed the hospital's tracking system for their adverse events, near missed medication errors, restraints suicide risks, falls and contrabands. She stated the sexual incidents in the adolescent unit are entered through the</p>	A286		

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A385	<p>incident report which the staff fills out after the incident occurs.</p> <p>During the survey, the survey team reviewed approximately 25 sexual incidents occurred in the adolescent unit, from March 2019 to June 2019 (refer to A392).</p> <p>There were no documentation this was discussed with the governing body, medical staff, and administrative officials who are responsible for the operations of the hospital. There were no documentation that the majority of these were reported to the State Agency as alleged sexual or physical abuses.</p> <p>482.23 NURSING SERVICES</p> <p>The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to comply with the Condition of Coverage for Nursing Services as evidenced by:</p> <ol style="list-style-type: none"> Failure to provide adequate supervision to prevent Patient 2's sexual assault to Patient 1 (refer to A392). Failure to provide adequate supervision to prevent Patient 4's various forms of sexual activities with three female peers at six different times and a physical altercation with another peer (refer to A392). 	A385		

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A392	<p>3. Failure to provide adequate supervision to prevent Patient 8's sexual activity (refer to A392).</p> <p>4. Failure to effectively monitor 16 patients (Patients 5, 6, 9, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, and 30) who had various incidents involved. (Refer to A392).</p> <p>The cumulative effects of these systemic problems resulted in the facility's inability to ensure the provision of quality in a safe environment.</p> <p>482.23(b) STAFFING AND DELIVERY OF CARE</p> <p>The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.</p> <p>This Statute is not met as evidenced by:</p>	A392		

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	<p>Based on interview and record review, the facility failed to ensure staff provided adequate supervision when:</p> <ol style="list-style-type: none"> 1. Patient 2 sexually assaulted Patient 1 in the activity room, twice at different times; 2. Patient 4, who was under every 15 (Q15) minutes and every 5 (Q5) minutes monitoring, was able to perform various forms of sexual activities with three female peers at six different times. Also, Patient 4 had a physical altercation with another peer; 3. Patient 8 had sex with another peer in the room when he was supposed to be under 1:1 supervision; and, 4. From March 2019 to June 2019, sixteen (16) patients (Patients 5, 6, 9, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, and 30), who were on Q15 minutes monitoring, had various incidents involved. <p>These failures resulted in serious emotional trauma to the affected patients and had likelihood of potential reoccurrences to all patients in the hospital.</p> <p>On 7/18/19 at 3:07 p.m., Immediate Jeopardy (IJ) was called for lack of effective supervision and monitoring and removed on 7/18/19 at 8:30 p.m. with an acceptable removal plan from the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Patient 1's Discharge Summary, dated 6/1/19, indicated the patient was a 16-year-old male and admitted to the hospital on 5/20/19 with diagnoses of major depressive disorder, PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit Hyperactive 			

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	<p>Disorder), and social anxiety disorder.</p> <p>Review of Patient 1's Progress Notes, dated 5/29/19 at 11:16 a.m., indicated "a peer pressured/threatened him into letting peer perform manual and oral sex on/to him in the activity room...on 5/27(/2019) ([Patient 1] reports "she gave me a hand job") and on 5/28 (/2019) (pt [patient] reports "she performed oral sex on me.")" The patient reported the peer threatened him into participating in acts and the peer was "scary". The patient stated both incidents occurred in the back of the activity room between 8 p.m. to 9 p.m. There was no evidence staff was present and supervised patients in the activity room during the incidents occurred.</p> <p>Review of patient 1's Patient Observations, dated 5/27/19 and 5/28/19, indicated the patient was on Q15 minutes monitoring when the incidents occurred.</p> <p>Review of Patient 2's Discharge Summary, dated 6/1/19, indicated on 5/25/19, the patient was a 15-year-old female (whom identified himself as male) and admitted to the hospital with diagnoses of general anxiety, major depression, and borderline personality.</p> <p>Review of Patient 2's Progress Note, dated 5/29/19 at 1:13 p.m., indicated on 5/28/19, the patient reported he performed oral sex on a peer in the back of the activity room. The patient also reported he and some peers touched each others' private areas and gave a peer a hand job between 8 p.m. to 9 p.m. There was no evidence the staff supervised them during the incident.</p> <p>Review of Patient 2's Patients Observations, dated 5/27/19 and 5/28/19, indicated the patient was on Q15 minutes monitoring when</p>			

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	<p>the incident occurred.</p> <p>Review of the police report, dated 7/23/19, indicated Patient 1, the victim, wanted to press charges against Patient 2. Patient 2 was released from the hospital into the custody of Child Protective Services (CPS) and this case was forwarded to the Santa Clara County Juvenile District Attorney.</p> <p>During an interview on 7/17/19, at 2:00 p.m., the Director of Quality Assurance (DQA) stated that during the events no staff supervised the patients in the activity room and there should be always staff to supervise the patients.</p> <p>2. Review of Patient 4's Discharge Summary, dated 5/11/19, indicated the patient was a 14-year-old male and admitted on 5/2/19 under 5150 hold (California law code for temporary, involuntary psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness) with diagnoses including bipolar disorder (any of several psychological disorders of mood characterized by alternating episodes of depression and mania), severe depression with psyche features. During his course of hospitalization, Patient 4 continued to have mood lability and significant difficulty with impulse control. He required 5 minute checks and one-on-one for a lot of his hospital stay as he was hypersexual.</p> <p>Review of Patient 4's Psychiatrist Progress Notes, dated 5/4/19, indicated he has said provocative statements to nursing staff and he has called them "honey" that was said in a way that felt malicious and sexualized. He was also intrusive of others. He knocked a hoodie off of a peer's head while he was on every 15 min monitoring for sexual acting out. It indicated the patient had inappropriate touching with female peers and seems to be hypersexual with no</p>			

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	<p>history of abuse. He was placed on every 15 minutes observation for sexual precautions.</p> <p>Review of Patient 4's Nurses progress notes, dated 5/5/19, indicated a peer reported to nursing staff, on 5/4/19 between 6 to 7 p.m., Patient 4 and Patient 3, who was 16-year-old female, were in the activity room covered up with a blanket and appeared to be fondling each other underneath the blanket. There were no staff present in the activity room at that time. Patient 4 remained on every 15 minutes observation.</p> <p>Review of Patient 3's Progress Notes, dated 5/5/19 at 1:54 p.m., indicated the patient reported Patient 4 made inappropriate comments, stating "He told me he wants to have sex" and kissed her in the activity room. It stated the incident was consensual and unwitnessed.</p> <p>Review of Patient 3's discharge summary dated 5/6/19, indicated on 5/5/19, she was observed to be crying, feeling emotional, and upset. She reported she had oral sex with Patient 4 in her room. Patient 4 pretended to be in the shower by turning the water on, snuck out of shower in between every 15 minutes monitoring, went into Patient 3's room, and had oral sex with her.</p> <p>Review of Patient 4's Patient Observations, dated 5/5/19, indicated the patient was on every 15 minutes monitoring when the incident occurred.</p> <p>Review of Patient 28's Progress Notes, dated 5/5/19 1:54 p.m., indicated the patient reported Patient 4 made inappropriate remarks on her, stating "He told me he wants to have sex" and kissed her in the activity room. It stated the kiss was consensual.</p>			

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	<p>Review of Patient 28's Discharge Summary, dated 5/4/19, indicated patient 28 was a 15-year-old female under the guardianship of her parents. Patient 28 had a diagnosis of autism spectrum disorder (a serious developmental disorder that impairs the ability to communicate and interact)</p> <p>Review of Patient 4's Patient Observations indicated on 5/5/19 he was on every 15 minutes monitoring and at 4 p.m. on that day, the patient was placed on 1:1 monitoring. On 5/9/19 8:30 a.m., the monitoring had changed to every 5 minutes.</p> <p>Review of Patient 4's Progress Notes, dated 5/9/19 at 9:28 p.m. the patient hit another peer.</p> <p>Review of Patient 4's Patient Observations, dated 5/9/19, the patient was on every 5 minutes monitoring when the physical altercation occurred.</p> <p>Review of Patient 7's Discharge Summary, dated 5/16/19, indicated the patient was a 15-year-old female with diagnoses of major depressive disorder and was undergoing intensive outpatient program. She was admitted on 5/10/19 under 5150 hold for danger to self due to suicidal ideation.</p> <p>Review of Patient 7's nurses progress notes, late entry dated 5/14/19 for 5/11/19, indicated on 5/11/19, Patient 7 reported to staff on 5/10/19, while in the activity room before bedtime, Patient 4 grabbed her hand and placed it on his private part. She immediately pulled her hand away. A peer, who was in the same room at the same time, stated she saw both of them sitting next to each other. Patient 7 also reported sometime in the morning of 5/11/19, Patient 4 went into her room and</p>			

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	<p>touched her breast. She told Patient 4 to leave her room and he did. Patient 7 felt uncomfortable and verbalized she wanted to press charges. Incident was reported to law enforcement and to the attending physician. Patient 4 was on every 5 minute monitoring at time of the incident.</p> <p>During a telephone interview with the director of nursing (DON) on 7/19/19 at 11:50 a.m., she stated for the incident with Patient 4, "the 1:1 monitoring should have been done clearly".</p> <p>3. Review of Patient 8's Discharge Summary, dated 4/25/19, indicated Patient 8 was a 17-year-old transgender female (denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex) with history of sexually trafficked and abducted.</p> <p>Review of Patient 8's Psychiatrist Progress Notes, dated 3/14/19, indicated the patient was found with a male peer in her room after shift change at about 11:10 p.m. Both patients did not wear clothes. Patient 8 reported they had consensual sex.</p> <p>Review of Patient 8's Patient Observations, dated 3/14/19, indicated the patient was on every 15 minutes observation and should be on 1:1 monitoring when he was in the room for sexual precautions.</p> <p>4. Review of Patient 5's Progress notes, dated 6/3/19 at 7:30 p.m. indicated the patient was 55-year-old female and she shouted, yelled, and cursed another male peer, who was seen going out of the patient's room. She stated another male peer came to her room and touched her.</p> <p>Review of Patient 6's Psychiatrist Progress Notes, Dated 6/2/19, indicated the patient was</p>			

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	<p>50-year-old male with schizoaffective disorder (a serious mental disorder in which people interpret reality abnormally). It indicated throughout day, the patient remained inappropriate, threatening on the unit the psychiatrist overheard multiple times by staff he was walking up to a peer and saying "I am going to fucking rape you and then you are going to put your finger in my ass." and making obscene sexual gestures at the peer, to the point that peer complained multiple times to staff feeling unsafe to leave her room.</p> <p>Review of Patient 6's Patient Observations, dated on 6/2/19, indicated the patient was on every 15 minutes monitoring and the monitoring had changed to every 5 minutes at 11:30 p.m. at the end of the day.</p> <p>Review of Patient 9's clinical record indicated he was 32-year-old male, admitted on 2/16/19 with diagnoses including paranoid schizophrenia and severe amphetamine use disorder. On 2/18/19, he informed the psychiatrist that he was sex-deprived.</p> <p>Review of Patient 16's Discharge Summary, dated 3/12/19, indicated the patient was a 33-year-old female and admitted on 2/24/19 on 5150 hold for being gravely disabled. On admission, she presented herself as disorganized, and tangential paranoid.</p> <p>Review of Patient 16's Progress notes, dated 3/2/19, at approximately 5:35 p.m., a peer informed staff nurse Patient 9 went in to Patient 16's room. Patient 16 was found on her knees in bed while Patient 9 was found standing behind her back with his pants down below his waist.</p> <p>Review of Patients 9 and 16' Patient Observations, dated 3/2/19, indicated both</p>			

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	<p>patients remained on every 15 minutes monitoring for sexual precautions.</p> <p>Review of Patient 15's Discharge Summary, dated 5/7/19, indicated Patient 15 was a 17-year-old female with history of major depressive disorder, post traumatic stress disorder, and sexual and physical abuse. She was admitted under 5150 for suicidal behavior.</p> <p>Review of Patient 15's Progress notes, dated 4/30/19 at 4:30 p.m., staff noticed Patient 15 was sexually inappropriate as exhibited by sucking on a peer's fingers.</p> <p>Review of Patient 15's Progress notes, dated 5/1/19 at 7 p.m., in activity room, staff saw Patient 22 sucking Patient 15's left middle finger.</p> <p>Review of Patient 22's Discharge Summary, dated 5/6/19, indicated the patient was "sexually acting out" by licking female peer's finger.</p> <p>Review of Patients 15 and 22's Patient Observation, dated 5/1/19, indicated both patients were placed on every 15 minutes observation for sexual acting out precautions.</p> <p>Review of Patient 17's Discharge Summary, dated 5/26/19, indicated the patient was a 14-year-old male and admitted under 5150 hold for danger to self with suicidal ideation.</p> <p>Review of Patient 17's Progress Notes, dated 5/25/19, indicated at approximately 7:30 p.m., a staff reported Patient 17 was seen kissing Patient 24 on the lips in the activity room.</p> <p>Review of Patient 17's Patient Observations, dated 5/25/19, indicated when the incident</p>		

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	<p>occurred the patient was on every 15 minutes monitoring for sexual precaution.</p> <p>Review of Patient 24's Progress Notes, dated 5/25/19, indicated the patient was a 14-year-old female, had poor boundaries with a male peer, and required consistent redirection. Staff saw the patient kissed Patient 17.</p> <p>Review of Patient 24's Patients Observations, dated 5/25/19, indicated when the incident occurred, the patient was on every 15 minutes monitoring for sexual precautions.</p> <p>Review of Patient 24's Progress Notes, dated 5/27/19 at 11:44 a.m., indicated another female patient punched her face twice after they got into a verbal altercation in the cafeteria. Patient 24 had a swelling on the bottom lip and complained of 7 of 10 pain (0-10 pain scale, 10/10 is the worst pain).</p> <p>Review of Patient 24's Patients Observations, dated 5/27/19, indicated the patient was on Q15 minutes monitoring.</p> <p>Review of Patient 18's Discharge Summary dated 3/22/19, indicated Patient 18 was a 14-year-old male and admitted under 5150 hold for danger to self for having suicidal thoughts.</p> <p>Review of Patient 18's Progress Notes, dated 3/19/19 at 9:30 a.m., while kids were lined up in front of the nurses' station to go to the gym, the nurse went back to the nurses' station to get a clipboard. When the nurse came back to the line, she saw Patient 18 and another female peer were kissing at a corner, which was an area that was not a direct view from the nurses' station.</p> <p>Review of Patient 18's Patient Observations, dated 3/19/19, indicated the patient was on</p>			

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	<p>every 15 minutes observation for sexual acting out.</p> <p>Review of Patient 19's Progress Notes, dated 6/24/19, indicated Patient 19 kissed a female peer at 4:20 p.m. when they were going to a gym.</p> <p>Review of Patient 19's Patient Observations, dated 6/24/19, indicated the patient was on Q15 minutes monitoring when the incident occurred.</p> <p>Review of Patient 21's Progress Notes, dated 3/8/19, indicated the patient had a fight with another peer, which resulted in a bump on the back of the head.</p> <p>Review of Patient 21's Patient Observations, dated 3/8/19, indicated when the incident occurred, the patient was on Q5 minutes monitoring</p> <p>Review of Patient 21's record indicated there was no evidence a progress note or Incident Report Form was initiated regarding the 3/8/19 incident.</p> <p>During an interview on 7/19/19 at 1:35 p.m., the nursing house supervisor stated there should always be an incident report for investigation and progress notes written when an incident happened.</p> <p>Review of Patient 23's Progress Notes, dated 6/10/19, indicated the patient was involved in a verbal altercation with a female peer. Patient 23 was physically attacked by the female peer while being in the activity room.</p> <p>Review of Patient 23's Patient Observations, dated 6/10/19, indicated when the incident occurred, the patient was on Q15 minutes</p>		

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	<p>monitoring.</p> <p>Review of Patient 25's Progress notes, dated 6/10/19 at 8:21 p.m., indicated the patient was a 15-year-old female, went to the back of the activity room with another peer, where they knew it was a blind spot, and kissed.</p> <p>Review of Patient 25's Patient Observations, dated on 6/10/19, indicated when the incident occurred, the patient was on Q15 minutes monitoring.</p> <p>Review of Patient 26's Progress notes, dated 3/15/19, indicated the patient was a 15-year-old female and discharged on that day.</p> <p>During an interview on 7/19/19 at 10:23 a.m., Director of Quality Assurance (DQA) stated after Patient 26's discharge, her mother called and stated the patient was sexually assaulted by her roommate during the hospitalization. DQA stated she investigated and the patient's roommate stated both had kissed but, Patient 26 started kissing.</p> <p>Review of Patient 27's Progress Notes, dated 6/24/19, indicated the patient was a 15-year-old female and kissed another peer in a hallway going toward a gym.</p> <p>Review of Patient 27's Patient Observations, dated on 6/24/19, indicated the patient was on Q15 minutes monitoring.</p> <p>Review of Patient 30's Progress Notes, dated 4/27/19 at 4:50 p.m., indicated the patient was seen kissing another peer and she stated "He kissed me first."</p> <p>Review of Patient 30's Patient Observations, dated on 4/27/19, indicated the patient was on Q15 minutes monitoring.</p>			

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	<p>During an interview with Director of Quality Assurance (DQA) on 7/17/19 at 1 p.m., the incidents were reviewed. DOQ stated even though the patients were under various monitoring, the incidents happened so quickly and staff could not prevent them.</p> <p>Review of the hospital's job description for registered nurses (RN), dated 5/1/18, indicated RNs are responsible for providing professional nursing care to patient in a supportive and therapeutic environment.</p>			

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A000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a Psychiatric Hospital Complaint Validation Survey conducted from 1/3/18 to 1/5/18.</p> <p>The hospital was licensed for 80 beds. The census at the time of the survey was 58.</p> <p>One Conditions for Coverage (42 CFR §482.23, Nursing Services) was not met (see A0385)</p> <p>Representing the California Department of Public Health: 29328, HFEM II and 32999, Health Facilities Evaluator Supervisor.</p>	A000		
A131	<p>482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT</p> <p>The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care.</p> <p>The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the informed consents for the use of psychotropic medications were obtained prior to administration. This failure had the potential to limit the patients or their</p>	A131		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are due within 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are due within 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.

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	<p>responsible parties to exercise their right to refuse or participate in their plan of care.</p> <p>Findings:</p> <p>Review of Patient 1's Medication Administration Record dated 11/17/17 to 11/19/17, indicated the patient received Risperdal and Zyprexa (psychotropic medications). There were no informed consents for the use of these psychotropic medications.</p> <p>During an interview on 1/4/18 at 2:50 p.m., the director of nursing (DON) reviewed the clinical record and stated there were no informed consents for the use of psychotropic medications and nurses should verify it prior to administration of medications.</p> <p>Review of the facility's 10/2016 policy "Informed Consent for Psychotropic Medication" indicated after the physician has discussed the recommended medication(s) with the patient and the patient has indicated a reasonable understanding of the content of the informed consent and has agreed to the administration of the recommended medication, the patient and physician will sign and date the form. No medication(s) will be administered in the absence of assigned consent form.</p>			

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A385	<p>482.23 NURSING SERVICES</p> <p>The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the hospital failed to comply with the Condition for Coverage for Nursing Services as evidenced by:</p> <ol style="list-style-type: none"> 1. Failure to conduct necessary training and evaluation (refer to A0386) 2. Failure to provide adequate numbers of licensed nurses (refer to A0392) <p>The cumulative effects of these systemic problems resulted in the facility's inability to ensure the provision of quality and safe health care environment for the patients.</p>	A385		
A386	<p>482.23(a) ORGANIZATION OF NURSING SERVICES</p> <p>The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the</p>	A386		

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	<p>facility failed to conduct necessary training and evaluation. These failures had the potential to impact the patients' care and safety.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of new hired Mental Health Technicians (MHTs)'s employee files indicated four (4) of four (4) MHTs (MHTs A, B, C, and D) did not have 90 days evaluations. <p>During an interview with the director of human resources (DHR) on 1/4/18 at 1:50 p.m., she reviewed the employee files and confirmed there was no 90 days evaluations for MHTs A, B, C, and D.</p> <p>During an interview with the director of nursing (DON) on 1/4/18 at 2:50 p.m., she stated the new hired nursing staff were evaluated 90 days after hired and then annually. She stated she should oversee the evaluation of nursing staff.</p> <ol style="list-style-type: none"> During an interview with DON on 1/4/18 at 2:50 p.m., she stated she had not conducted Code Blue drills and the first drill was performed in October, 2017 when a sentinel event occurred in the hospital. <p>Review of the facility's 3/29/16 policy "CODE BLUE" indicated the DON will conduct Code Blue drills each shift, minimum quarterly.</p> <p>There were no documentation the quarterly drill for Code Blue were conducted.</p> <ol style="list-style-type: none"> Review of MHT E's employee file on 1/3/18, indicated his CPI (Crisis Prevention Institute) training certificate was expired on 12/20/17. <p>Review of registered nurse F (RN F)'s employee file on 1/3/18, indicated her CPI (Crisis Prevention Institute) training certificate</p>		

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A392	<p>was expired on 12/20/17.</p> <p>During an interview on 1/3/18 at 1:45 p.m., the DON verified CPI training certificates for MHT E and RN F were expired.</p> <p>Review of the facility's job prescription "DIRECTOR OF NURSING" indicated the DON hire, orient, train, supervise, and evaluate employees.</p> <p>482.23(b) STAFFING AND DELIVERY OF CARE</p> <p>The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to follow the nurse-patient ratios. This failure potentially impacts patient's care and safety.</p> <p>Findings:</p> <p>During an interview on 1/3/18 at 10 a.m., the director of nursing (DON) stated the licensed nurse-to-patient ratio is 1:6.</p> <p>Review of the hospital's staffing assignment and the census from 11/1/17 to 12/31/17, indicated the licensed nurse-to-patient ratio did not meet 1:6.</p> <p>The night shift assignment and the census,</p>	A392		

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	<p>dated 11/5/17, were reviewed. In Unit A, the census was 22, two registered nurses (RNs) worked, and the nurse-to-patient ratio was 1:11. In Unit B, the census was 16, one RN worked, and the ratio was 1:16. In Units C and D, the census was 37, three RNs worked, and the ratio was 1:12.3.</p> <p>The night shift assignment and the census, dated 11/12/17, were reviewed. In Unit A, the census was 20, one RN worked, and the ratio was 1:20. In Unit B, the census was 16, two RNs worked, and the ratio was 1:8. In Unit C, the census was 22, one licensed vocational nurse (LVN) worked, and the ratio was 1:22. In Unit D, the census was 16, one RN worked, and the ratio was 1:16.</p> <p>During an interview with RN G on 1/3/18 at 9:01 p.m., she stated she called 911 for Resident 1 and another nurse initiated the Code Blue for Patient 1. She also confirmed she had 35 patients for the night shift and two mental health techs (MHT) on 11/19/17, night shift. She stated it has always been that way--one RN and two MHTs.</p> <p>Review of Patient 1's Code Blue (a hospital code used to indicate a patient requiring immediate resuscitation) Record dated 11/20/17, indicated at 4:25 a.m. Code Blue was activated in Unit C for the patient.</p> <p>Review of night shift assignment and the census, dated 11/19/17, indicated the census in Unit C was 35, One RN worked in Unit C and another RN worked in both Units C and D. The ratio was 1:17.5</p> <p>The night shift assignment and the census, dated 11/26/17, were reviewed. In Unit A, the census was 23, on RN worked, the ratio was 1:23. In Unit B, the census was 14, one RN</p>			

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	<p>worked, the ratio was 1:14. In Unit C, the census was 21, one RN worked, the ratio was 1:21. In Unit D, the census was 17, two RNs worked and one RN left at 3 a.m. The ratio after 3 a.m. was 1:17.</p> <p>During an interview on 1/4/18 at 1:40 p.m., the DON stated for the licensed nurse-to-patient ratio, the ratio 1:6 was the ideal ratio and the usual ratio was 1:8 or 1:9. She stated she was aware of the short staff and the management was also fully aware regarding the short staff issue.</p> <p>The hospital did not have a policy regarding the licensed nurse-to-patient ratio.</p>			



August 21, 2020

Logan Grant, Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Dear Mr. Grant and Board Members of the HSDA:

It is with significant alarm that that the Patricia Hall Talbott Legacy Centers, LLC (TLC) recently learned about Applications CN2005-14 and CN2005-16.

I write to oppose these applications under the criteria for consideration of a certificate of need based on the following:

Provide Healthcare that Meetings Appropriate Quality Standards: CN2005-14 and CN2005-16

It was with great alarm that we were sent information pertaining to Acadia Healthcare quality practices that span several years earlier this week. Attached hereto, please find the following:

- **Attachment A** – Recent North Carolina state licensure inspections, statements of deficiencies, and plans of correction for opioid treatment programs (OTPs) operated by the parent company in the State of North Carolina
- **Attachment B** – Nationwide state and federal licensure inspections, statements of deficiencies, and news media reports spanning pages that show a lack of adherence to appropriate quality standards back to at least 2007
- **Attachment C** – Official announcement from the U.S. Department of Justice just more than one year ago of the parent company's agreeing to the largest Medicaid fraud settlement in West Virginia state history
- **Attachment D** – Settlement Agreement between Acadia Healthcare and the U.S. Department of Justice
- **Attachment E** – Corporate Integrity Agreement between the Office of the Inspector General of the U.S. Department of Health & Human Services and Acadia Healthcare

As such, we strongly oppose both CN2005-14 as well as CN2005-16 on the grounds that the parent company of these applications has a long and demonstrated history of failing to adhere to appropriate quality standards across their vast treatment center network.

As recently as last year Acadia Healthcare entered into the largest Medicaid fraud settlement with the Department of Justice in West Virginia history. From my reading, this information was



not disclosed in the above referenced Certificate of Need applications. Absent several years proving a corrected course of action, there is no assurance these proposed opioid treatment programs will adhere to necessary quality standards. This is especially alarming at a time the TennCare program in Tennessee is just beginning to enroll OTPs into their network of care. The evidence in the attachments speaks for itself. Pages of state and federal audits and news media reports in Attachment B go back nearly 7 years, establishing a clear pattern of failing to adhere to appropriate quality standards.

Contribution to the Orderly Development of Healthcare: CN2005-16

TLC Maryville (CN1912-51A) was just awarded a Certificate of Need for the establishment of a new opioid treatment program (OTP) in Maryville, Blount County, Tennessee on June 24, 2020. Construction is just about to begin. As indicated at the CON hearing in June, we anticipate initiating services between December 2020 and February 2021.

The Cleveland Comprehensive Treatment Center has submitted application with a proposed service area that overlaps our service area across two counties: McMinn and Loudon. The approval of a Certificate of Need for another opioid treatment program (OTP) with an overlapping service area – especially related to a company that has not reached out to us to collaborate or coordinate in any way – could put our project at risk and skew the data this board used to grant our Certificate of Need in June.

The approval of the Certificate of Need for Cleveland Comprehensive Treatment Center will not contribute to the orderly development of healthcare. While opioid treatment services are of significant need, one only has to look to our neighbors in North Carolina – especially in the Asheville area – to see the very real consequences of market oversaturation. It can lead to patient as well as staff “poaching” and other unethical, predatory business practices that are diametrically opposite the orderly development of healthcare.

Further, the Letter of Intent for CN2005-016 was filed in the Chattanooga, Hamilton County, TN newspaper and not the local newspaper of Cleveland, Bradley County, TN. Although the Chattanooga newspaper does circulate in Bradley County, placing the legal notice in a much larger newspaper outside the county of proposed operations accomplishes nothing aside from diminishing the chances the citizens and leaders of Cleveland, TN will be aware of this application.

TLC brought with us the County Mayor, Circuit Court Clerk, local pastors, and other supporters to speak at our CON hearing in June. We had local support filed from many more Blount County leaders and residents in writing. At a time so many individuals are focused on the COVID-19 crisis, this is not the time to risk an applicant slipping into a community. This is a very real possibility considering the absence of any local support with this application.



The approval of CN2005-016 will not contribute to the orderly development of healthcare. As such, we strongly oppose this application and ask that the Health Services and Development Agency deny the Certificate of Need.

Thank you for your consideration.

With best regards,

Zachary C. Talbott, MSW, LADAC, MAC, QCS
President

Sampling of historical Acadia inspections and news media reports

All of the below contain hyperlinks. The heading is the Acadia-owned facility in question, the bullet points underneath the center name link direct to licensing audits that show specific deficiencies – contrary to the Tennessee quality assurance requirement to be awarded a CON – and/or news media reports related to that facility.

Acadia Montana Treatment Center (Butte, MT)

- [State Inspection Reports \(2014-2017\)](#)

Allentown Comprehensive Treatment Center (Allentown, PA)

- [State Inspection Reports \(2015-2017\)](#)

Appleton Comprehensive Treatment Center (Appleton, WI)

- [State Inspection Report \(2017\)](#)

Ascent Treatment and Outpatient Clinic (10 Facilities in Arkansas)

- [Boy, 5, Found Dead After Spending 8 Hours in Van Outside Children's Health Clinic: Cops \(2017\)](#)
- [Newspaper: MH Ascent vans twice had alarm trouble \(2017\)](#)
- [4 West Memphis Daycare Employees Charged With Manslaughter in Toddler's Hot Van Death \(2017\)](#)
- [Ascent Children's Closes all facilities](#)

Asheville Comprehensive Treatment Center (Asheville, NC)

- [State Inspection Report \(2018\)](#)

Bayside Marin Treatment Center (San Rafael, CA)

- [Patient Lawsuit \(2018\)](#)

Beckley Comprehensive Treatment Center (Beaver, WV)

- [State Inspection Report \(2016\)](#)

Belmont Behavioral Health (Philadelphia, PA)

- [Two Suicides in Five Days at Belmont \(2018\)](#)
- [Philadelphia Hospital Cited In Suicide \(2018\)](#)
- [Federal Inspection Reports \(2015-2017\)](#)
- [State Inspection Reports \(2016-2017\)](#)
- [Belmont Assault Lawsuit \(2018\)](#)

Beloit Comprehensive Treatment Center (Beloit, WI)

- [State Inspection Report \(2016\)](#)

Bowling Green Brandywine Treatment Center (Kennett Square, PA)

- [State Inspection Reports \(2015-2017\)](#)

Burkwood Treatment Center (Hudson, WI)

- [State Inspection Reports \(2016-2018\)](#)

Cascade Behavioral Health Hospital (Tukwila, WA)

- [State Inspection Report \(2014\)](#)

Cedar Crest Hospital and Residential Treatment Center (Belton, TX)

- [Cedar Crest CEO linked to two wrongful retaliation lawsuits \(2015\)](#)
- [Whistleblower Lawsuit \(2015\)](#)
- [Federal Inspections \(2014-2018\)](#)
- [Mental health worker pleads guilty to sexual assault at Belton facility \(2015\)](#)

Charleston Comprehensive Treatment Center (Charleston, WV)

- [State Inspection Report \(2016\)](#)

Clarksburg Comprehensive Treatment Center (Clarksburg, WV)

- [State Inspection Report \(2017\)](#)

Coatesville Comprehensive Treatment Center (Coatesville, PA)

- [State Inspection Reports \(2015-2018\)](#)

Cove Forge Behavioral Health (4 Facilities in Pennsylvania)

- [State Inspection Reports \(2015-2018\)](#)

Covington Behavioral Health Hospital (Covington, LA)

- [Patient Lawsuit \(2016\)](#)
- [Federal Inspection Reports \(2016-2018\)](#)

Crestwyn Behavioral Health (Memphis, TN)

- [Federal Inspections \(2018\)](#)

Cross Creek Behavioral Hospital (Austin, TX)

- [Federal Inspection Reports \(2016-2018\)](#)

Delta Medical Center (Memphis, TN)

- [Federal Inspection Reports \(2015-2017\)](#)

Desert Hills of New Mexico (Albuquerque, NM)

- [CYFD puts youth group home on admissions hold amid escapes, violence \(2017\)](#)
- [Most assault calls occur at youth behavioral facility \(2017\)](#)
- [Youth treatment center strengthens security after 13 runaways \(2018\)](#)

Detroit Behavioral Institute | Capstone Academy (Detroit, MI)

- [LARA Inspections \(2012-2018\)](#)
- [Patient Lawsuits \(2014\)](#)

Discovery House (19 Facilities in 4 States)

- [State Inspection Reports \(2015-2018\)](#)

Dunmore Comprehensive Treatment Center (Dunmore, PA)

- [State Inspection Reports \(2015-2017\)](#)

Fashion Valley Comprehensive Treatment Center (San Diego, CA)

- [Whistleblower Lawsuit \(May, 2018\)](#)
- [Whistleblower Lawsuit \(September, 2018\)](#)

Harbor Oaks Hospital (New Baltimore, MI)

- [Ex-employees: Metro Detroit psych hospital so understaffed it's dangerous \(2017\)](#)

- [3 more abuse claims lead to charges at Harbor Oaks Hospital \(2018\)](#)
- [Whistleblower Lawsuit 2017](#)
- [Federal Inspections \(2014-2018\)](#)
- [Michigan mental health patient charged with two sex assaults at Harbor Oaks \(2017\)](#)
- [Patient Lawsuit \(2017\)](#)
- [Patient Lawsuit \(2016\)](#)

Highland Ridge Hospital (Midvale, UT)

- [Federal Inspection Reports \(2013-2015\)](#)

Huntington Comprehensive Treatment Center (Huntington, WV)

- [State Inspection Report \(2017\)](#)

Huntington Creek Recovery Center (Shickshinny, PA)

- [State Inspection Reports \(2015-2017\)](#)

Lakeland Behavioral Health System (Springfield, MO)

- [New details: A dozen teens involved in Lakeland escape \(2015\)](#)
- [Federal Inspection Reports \(2016-2018\)](#)

Lebanon Comprehensive Treatment Center (Lebanon, PA)

- [State Inspection Reports \(2015-2017\)](#)

Longleaf Hospital (Alexandria, LA)

- [Patient Assault Lawsuit \(2017\)](#)
- [Federal Inspection Report \(2015-2018\)](#)

Madison East Comprehensive Treatment Center (Madison, WI)

- [State Inspection Report \(2016\)](#)

Madison West Comprehensive Treatment Center (Madison, WI)

- [State Inspection Reports \(2016-2017\)](#)

MeadowWood Hospital (New Castle, DE)

- [Patient Lawsuit \(2017\)](#)
- [Federal Inspection Reports \(2013-2017\)](#)

Millcreek Behavioral Health (3 Facilities in 2 states)

- [Whistleblower Lawsuit \(2017\)](#)

North Tampa Behavioral Health Hospital (Wesley Chapel, FL)

- [Federal Inspection Reports \(2014-2017\)](#)
- [State Inspections \(2014-2018\)](#)
- [Whistleblower Lawsuit \(2018\)](#)
- [Locked in hospital, woman caught in Baker Act fight \(2015\)](#)

North West Wisconsin Comprehensive Treatment Center (Eau Claire, WI)

- [State Inspection Reports \(2017-2018\)](#)

Oasis Behavioral Health (Chandler, AZ)

- [Arizona CPS pulls kids from Parc Place \(2012\)](#)
- [State Inspection Reports \(2016-2018\)](#)
- [Federal Inspection Reports \(2016\)](#)

Ohio Hospital for Psychiatry (Columbus, OH)

- [Federal Inspection Reports \(2015-2018\)](#)
- [Disability Rights of Ohio Report \(2018\)](#)
- [Patient referrals temporarily halted at Ohio Hospital for Psychiatry \(2018\)](#)
- [One Flew Out of the New Cuckoo's Nest: Forced psychiatry in Ohio – Instrument of political oppression? \(2016\)](#)

Optima Specialty Hospital (Lafayette, LA)

- [Federal Inspection Reports \(2015-2016\)](#)

Options Behavioral Health System (Indianapolis, IN)

- [State Inspection Reports \(2015\)](#)
- [Federal Inspection Reports \(2014-2016\)](#)

Pacific Grove Hospital (Riverside, CA)

- [Federal Inspection Report \(2016\)](#)
- [State Inspection Reports \(2015-2018\)](#)
- [Whistleblower Lawsuit \(2017\)](#)

Park Royal Hospital (Fort Myers, FL).

- [State Inspection Reports \(2014-2018\)](#)
- [Federal Inspection Reports \(2014-2018\)](#)
- [Patient Lawsuit \(2014\)](#)
- [Patient Sues Park Royal Hospital for Alleged Sex Abuse \(2017\)](#)
- [Park Royal Hospital patient care deficiencies highlighted in federal inspection report \(2017\)](#)
- [Park Royal Hospital, Fort Myers' only psychiatric hospital, gets a new leader \(2018\)](#)
- [How a Fort Myers mental hospital missed warning signs about employee who sexually assaulted patients \(2015\)](#)
- [Park Royal Hospital patient reports sex crime after finding used condom inside her, according to Lee sheriff report \(2018\)](#)

Parkersburg Treatment Center (Parkersburg, WV)

- [State Inspection Reports \(2017\)](#)

Piney Ridge Center (Fayetteville, AK)

- [Former Piney Ridge Patient: “It’s More Like a Kid’s Fighting Ring” \(2016\)](#)

Pocono Mountain Recovery Center (Henryville, PA)

- [State Inspection Reports \(2016-2018\)](#)

Pottstown Comprehensive Treatment Center (Pottstown, PA)

- [State Inspection Reports \(2015-2017\)](#)

Red River Hospital (Wichita Falls, TX)

- [Federal Inspection Reports \(2013-2018\)](#)
- [Whistleblower Lawsuit \(2013\)](#)
- [Company named in another lawsuit \(2015\)](#)
- [Medicare funding termination date extended for Red River Regional Hospital \(2014\)](#)

Resource Treatment Center (Indianapolis, IN)

- [Former Employee: Staff at youth psychiatric facility encouraged fights; were violent with kids \(2018\)](#)
- [Nine Teenagers Arrested During Riot at Juvenile Facility \(2018\)](#)
- [Indianapolis neighbors, police say kids are escaping a psychiatric treatment center \(2017\)](#)

River Shore Comprehensive Treatment Center (Milwaukee, WI)

- [State Inspection Reports \(2015-2017\)](#)

Riverview Behavioral Health (Texarkana, AR)

- [Federal Inspection Report \(2014\)](#)

RiverWoods Behavioral Health System (Riverdale, GA)

- [Federal Inspection Reports \(2017\)](#)
- [Patient lawsuit \(2018\)](#)

Rolling Hills Hospital (Ada, OK)

- [Federal Inspection Reports \(2015-2017\)](#)
- [Patient Lawsuit \(12/27/2017\)](#)
- [Patient Lawsuit \(12/14/17\)](#)

San Jose Behavioral Health (San Jose, CA)

- [Federal Inspection Reports \(2017-2018\)](#)
- [State Inspection Reports \(2017-2018\)](#)

Seven Hills Hospital (Henderson, NV)

- [State Inspection Reports \(2014-2018\)](#)
- [Mack Giles vs Seven Hills Hospital \(2016\)](#)
- [Ryan Pitterle vs Seven Hills Hospital \(2016\)](#)
- [Michelle Jackson vs Seven Hills Hospital \(2016\)](#)
- [Cynthia McArdle vs Seven Hills Hospital \(2017\)](#)
- [Paul Fulgoni vs James Vilt, M.D. \(2013\)](#)
- [Tonya Otis vs Seven Hills Hospital \(2016\)](#)

Sierra Tucson (Tucson, AZ)

- [Sierra Tucson State Inspections \(2015-2018\)](#)
- [Sierra Tucson fined over deficiencies in psychiatric care \(2016\)](#)
- [Lecce v. Sierra Tucson \(2015\)](#)

Sonora Behavioral Health Hospital (Tucson, AZ)

- [Sonora Behavioral Health Hospital Federal Inspections \(2012-2016\)](#)
- [Sonora Behavioral Health Hospital State Inspections \(2016-2018\)](#)
- [KOLD INVESTIGATES: Hospital in jeopardy \(2018\)](#)
- [Tucson hospital reaches settlement with family of woman who committed suicide \(2018\)](#)
- [KOLD INVESTIGATES: Hospital in jeopardy September 2018 Update \(2018\)](#)
- [Kari David v Marion Douglass \(2017\)](#)
- [Kevin Moon v Acadia Healthcare \(2016\)](#)

Southwood Psychiatric Hospital (Pittsburgh, PA)

- [State Inspection Reports \(2015-2018\)](#)
- [Patient Lawsuit \(2018\)](#)

StoneCrest Center (Detroit, MI)

- [Federal Inspection Reports \(2014-2017\)](#)

SUWS of the Carolinas (Old Fort, NC)

- [State Inspection Reports \(2018\)](#)

Ten Lakes Center (Dennison, OH)

- [Federal Inspection Reports \(2014-2015\)](#)
- [Whistleblower Lawsuit \(2018\)](#)

The Refuge – A Healing Place (Ocklawaha, FL)

- [State Inspection Reports \(2017\)](#)
- [Whistleblower Lawsuit \(2016\)](#)

Timberline Knolls (Lemont, IL)

- [Timberline Knolls wrongful death suit \(2018\)](#)
- [Timberline Knolls patient attack \(2015\)](#)
- [Lemont, Illinois – Counselor Arrested For Sexually Assaulting Patient During Therapy Appointments At Timberline Knolls \(2018\)](#)
- [Lemont counselor charged with sexually assaulting patient during therapy sessions \(2018\)](#)

Valley Behavioral Health System (Barling, AR)

- [Federal Inspection Reports \(2015-2016\)](#)
- [Lawsuit Accuses Valley Behavioral Health Of Negligence In On-Site Rape \(2018\)](#)
- [Negligence trial stemming from Sebastian County child rape case pushed to October \(2018\)](#)
- [Child Rape Case Docket \(2018\)](#)

Vantage Point Behavioral Health System (Fayetteville, AR)

- [Federal Inspection Report \(2014\)](#)

Vermilion Behavioral Health Systems (Lafayette, LA)

- [Federal Inspection Reports \(2015-2016\)](#)

Watsontown Comprehensive Treatment Center (Watsontown, PA)

- [State Inspection Reports \(2015-2017\)](#)

Waukesha Comprehensive Treatment Center (Waukesha, WI)

- [State Inspection Reports \(2017\)](#)

Wausau Comprehensive Treatment Center (Wausau, WI)

- [State Inspection Reports \(2016-2018\)](#)

West Milwaukee Comprehensive Treatment Center (West Milwaukee, WI)

- [State Inspection Report \(2016\)](#)

Wheeling Treatment Center (Triadelphia, WV)

- [State Inspection Report \(2017\)](#)

White Deer Run (15 Facilities in Pennsylvania)

- [State Inspection Reports \(2015-2018\)](#)
- [Whistleblower lawsuit \(2016\)](#)

Williamson Treatment Center (Williamson, WV)

- [State Inspection Report \(2016\)](#)

Wilmington Treatment Center (Wilmington, NC)

- [Federal Inspection Reports \(2014-2017\)](#)

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NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	
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{A 000}	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT An on-site follow-up visit was conducted on March 7 - 10, 2017 by Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Joy Williams, RN, BSN, and Alex Giel, REHS, PHA. The Fire Life Safety (F/LS) follow-up visit was conducted on March 7, 2017 by Washington State Patrol Deputy Fire Marshal Don West. During the survey, surveyors also assessed issues related to the following Medicare complaints: #71391; #71515; and #71516. This visit was to verify correction of Condition-level deficiencies found during the hospital complaint survey on 12/12-16/2016 and 12/19-21/2016 in which the facility was found not in compliance with: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights 42 CFR 482.21 Quality Assessment and Performance Improvement 42 CFR 482.25 Pharmaceutical Services 42 CFR 482.41 Physical Environmental During the course of the follow-up visit, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the serious of the findings. This resulted in the	{A 000}	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 000}	<p>Continued From page 1</p> <p>declaration of IMMEDIATE JEOPARDY in the following area:</p> <p>Failure to conduct effective security procedures when wanding newly admitted patients for identification of hazards associated with danger to self and others (3/9/2017 at 2:45 PM).</p> <p>Removal of the state of IMMEDIATE JEOPARDY was verified on 3/10/2017 at 2:10 PM by Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN, Alex Giel, REHS, PHA, and Joy Williams, RN, BSN.</p> <p>The hospital remains NOT IN COMPLIANCE with Medicare Hospital Conditions for Participation for:</p> <p>42 CFR 482.12 Governing Body</p> <p>42 CFR 482.13 Patient Rights</p> <p>Shell #27QV12</p>	{A 000}		
{A 043}	<p>482.12 GOVERNING BODY</p> <p>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...</p> <p>This Condition is not met as evidenced by:</p> <p>Based on observation, interviews, and document reviews, the hospital failed to meet the requirements at 42 CFR 482.12 Condition of Participation for Governing Body.</p>	{A 043}	<p>A043 482.12 - Governing Body</p> <p>Immediately following the March 10, 2017 exit summation, the CEO, Governing Board Member, Chief Nursing Officer/Chief Operating Officer, PI/Risk Manager, Director of Clinical services and Directors of Nursing reviewed the findings and began formulation of a plan of correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO/Designee who along with the Medical Director is a member of the Governing Board. The CEO currently conducts a daily Leadership Meeting which includes reporting of levels of observation, unusual occurrences, results of unit rounds and any required</p>	

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{A 043}	<p>Continued From page 2</p> <p>Failure to meet patient rights risks an unsafe healthcare environment for patients, visitors, and staff.</p> <p>Findings:</p> <p>1. The Governing Body failed to effectively manage the functioning of the hospital to protect patients from harm as evidenced by the IMMEDIATE JEOPARDY condition identified on 3/9/2017 for failure to ensure patients receive care in an environment in which the safety and well-being of patients are assured.</p> <p>2. Failure to conduct effective safety and security procedures for identification of hazards associated with danger to self and others.</p> <p>Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights, the Condition of Participation for Governing Body was NOT MET.</p> <p>Cross-Reference: Tags A0115</p>	{A 043}	<p>corrective actions. The CEO/Designee is responsible for reporting the results of corrective actions and use of monitoring systems to the full Governing Board.</p> <p>The Performance Improvement Committee will implement increased monitoring for any items that do not meet the thresholds that have been established by the Committee. The increased monitoring will continue until compliance is obtained and sustained for two reporting periods.</p> <p>See A115, A144, A164 and A286</p>
{A 115}	<p>482.13 PATIENT RIGHTS</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This Condition is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to protect and promote patient rights.</p> <p>Failure to protect and promote each patient's rights risk the patient's loss of personal freedom,</p>	{A 115}	<p>A115 482.13 - Patient Rights</p> <p>See A144 and A164</p>

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{A 115}	<p>Continued From page 3 privacy, dignity, and psychological harm.</p> <p>Findings:</p> <ul style="list-style-type: none"> 1. Failure to ensure patients receive care in a safe setting which safeguards vulnerable individuals from self-harm and harm from others. 2. Failure to utilize the least restrictive alternative when using seclusion and restraints. <p>The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights.</p> <p>Due to the scope and severity of deficiencies under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET.</p> <p>Cross Reference: Tags A0144, A0164</p>		{A 115}	
A 144	<p>482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This Standard is not met as evidenced by:</p> <p>ITEM #1 SECURITY PROCEDURES AND IDENTIFICATION OF HAZARDS</p> <p>Based on observations, review of manufacturer's instructions for use, and review of hospital policy and procedures, hospital staff members failed to follow manufacturer's instructions when using the hand held metal detector.</p> <p>Failure to ensure that staff are trained and skill competency verified to operate the hand-held</p>		A 144	<p>A144 482.13(c)(2) - Patient Rights: Care in a Safe Setting</p> <p><i>Security Procedures and Identification of Hazards</i></p> <p>Corrective Action:</p> <p>All staff responsible for wanding patients have been retrained on (1)the requirement to wand all individuals admitted to the hospital, (2)the requirement to wand based on manufacturer recommendations and "Wanding - Use of Hand-Held Metal Detector Wand" and (3)requirement to document completion of wanding on Nursing Communication Hand-Off form. Only staff members that have validated competency have been allowed to perform wanding procedures as of March 9, 2017.</p>

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A 144	<p>Continued From page 4</p> <p>metal detector correctly puts patients, staff, and visitors at risk for contraband and other dangerous hazards entering the facility posing a serious threat which may result in injury or death.</p> <p>Reference: Garrett Metal Detector Super Scanner User Manual.</p> <p>Findings:</p> <p>1. The hospital's policy and procedure titled "Wanding - Use of Hand-Held Metal Detector Wand" (Reviewed/2017) stated in part, "All patients will be wanded prior to or immediately upon arriving on an inpatient unit". The section titled "Procedure" read in part: "Staff should not allow the scanee to influence them as to what is actually causing an alarm. For instance, if the detector denotes the presence of a suspicious item under a shirt sleeve, do not fail to completely investigate the source of the alarm even though the scanee assures you that [it] is just his/her watch." Page 4 of the hospital policy illustrates the proper technique and procedure to use when operating the wand; wanding from the front to the back and ending with the underfoot of the individual.</p> <p>The user manual for the Garrett Metal Detector Super Scanner under the section titled "Components/Function" (pp 5-6) read in part: "Interface Elimination Button- The detector is factory set for maximum sensitivity to detect the smallest of items. The high level of sensitivity may produce alarms when approaching a floor containing rebar. Press and hold this button to decrease sensitivity to a level that does not respond to the rebar. Release button and detector returns to normal sensitivity."</p>		A 144	<p>Continued from page 4</p> <p>Monitoring Plan: The Directors of Nursing and Director of Intake or Designee will be responsible for random weekly audits of staff performing wanding. Any deficiencies in the wanding procedure will be identified and staff members retrained on the spot.</p> <p>The Directors of Nursing will perform 30 random chart audits of the Nursing Communication Hand-Off form.</p> <p>Any adverse findings will be reported in the Leadership meeting daily and to Governing Board weekly until 100% compliance has been attained for one month. Upon attainment of 100% compliance, monitoring will be reported monthly to the PI Committee and quarterly to the Medical Executive Committee and Governing Board.</p> <p>Persons Responsible: CEO Directors of Nursing Director of Intake PI/Risk Manager</p>

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A 144	<p>Continued From page 5</p> <p>2. On 3/7/2017 between 8:00 PM and 8:28 PM, Surveyor #1 requested a certified nurse's aide (CNA) (Staff Member #2) to demonstrate the use of the hand-held metal detector. During the observation, the CNA turned the metal detector on and the metal detector appeared to be malfunctioning with the surveyor noting that all LED lights were flashing on and off. Staff Member #2 pushed a button on the side of the metal detector and the flashing LED lights shut off except for a single green light. The CNA then proceeded to scan the surveyor while continuously holding (depressing) the side button.</p> <p>Staff Member #2 acknowledged in a follow-up interview with Surveyor #1 that he/she was unaware of the side button's function or purpose.</p> <p>3. On 3/8/2017 at 9:00 AM, Surveyor #1 interviewed the Director of Intake Personnel (Staff Member #4) about the use of hand-held metal detectors and training of personnel. S/he confirmed the metal detector used on 3/7/2017 by Staff Member #2 had malfunctioned and the battery had been replaced. The hospital did not have a system in place to check the battery status of the hospital's eight metal detectors.</p> <p>4. On 3/10/2017 between 11:00 AM and 11:45 AM, Surveyor #1 observed an Intake Personnel staff member (Staff Member #3) demonstrate the use of the hand-held metal detector wand. During the observation, Staff Member #3 pushed the side button (interference elimination button) and proceeded to wand the front of the patient. The metal detector beeped and a red light flashed when the wand was located near the patient's feet. Staff Member #3 asked the patient (Patient #5) if they had anything in his/her socks. Patient #5 stated "no". Staff Member #3 continued the</p>		A 144	

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A 144	<p>Continued From page 6</p> <p>wanding procedure to include both sides of the patient (left and right). Staff Member #3 did not wand the backside (posterior aspect) of the patient as required by hospital policy. The staff member failed to wand the underside of the patient's feet or investigate further the source of the beeping as required by hospital policy.</p> <p>5. On 3/10/2017 at 2:30 PM, Surveyor #1 reviewed eight medical records and the "Intake to Nursing Communication Hand-Off" forms and noted the following:</p> <ul style="list-style-type: none"> a. Four of eight records reviewed were not marked "Yes" or "No" to document and confirm the patient had been wanded. b. One of eight records reviewed was marked "No" reflecting that the patient had not been wanded. c. Three of the eight records reviewed were marked "Yes" indicating the patient had been wanded on admission. Upon further review, the surveyor found: <ul style="list-style-type: none"> 1. Patient #3 had a metal "X-Acto: blade" found after the patient had done harm to self by cutting themselves. The record indicated the patient acknowledged hiding the metal blade in his/her sock. 2. Patient #6 had a cellular phone found during the skin/clothing check by the nursing staff upon arrival on the unit. 3. Patient #7 had a cellular phone discovered on the day of discharge after a five day hospital stay. 	A 144		

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A 144	<p>Continued From page 7</p> <p>ITEM #2 LINE OF SIGHT MONITORING</p> <p>Based on record review and review of hospital policy and procedures, the hospital failed to ensure that patients on "Line of Sight" (LOS) observation were kept safe from self-harm or injury from other patients.</p> <p>Failure to protect patients from self-harm and harm by other patients may lead to serious injury or death.</p> <p>Findings:</p> <p>1. The hospital's policy and procedure titled, "Patient Observation"(Policy # PC.P.300; Reviewed 1/2017) stated in part, ". . .III. Levels of Observation. . . B. Line of Sight. The patient will be kept within eyesight and accessible at all times, day and night. Tools or instruments that could be used to harm themselves or others should be removed. This level of observation is required when the patient could, at any time, make an attempt to harm themselves or others. Positive engagement with the patient is an essential aspect of this level of observation."</p> <p>The hospital policy and procedure titled, "Patient Rights and Responsibilities" (Policy # ADM.P.300; Reviewed 1/2017) stated in part: ". . . Procedure . . . B. The list of patient rights shall include but are not limited to the following: . . . 5. The right to receive care in a safe setting."</p> <p>2. Patient #3 was an 18 year-old admitted on 2/24/2017 for treatment of depression with suicidal ideation. The patient received a score of 40 on the Suicide Assessment scale which was completed on admission. A review of the overall risk level scoring tool indicated that medium risk</p>	A 144	<p><i>Line of Sight Monitoring</i></p> <p>Corrective Action: Policy PC.P.300was reviewed and revised to (1)clarify that LOS monitoring be assigned to a specific staff member, (2)clarify that the patient must be visible to the assigned staff member at all times, (3)the staff member must take action to prevent potential for patient to harm self or others, and (4)staff must document efforts to prevent harm in the patient record. Reeducation was initiated for all staff responsible for monitoring observation levels of patients' regarding the changes to the policy. RNs were reeducated on their ability to increase a patient's level of observation without a physician order and all staff performing observations were reeducation on the risk factors for each level of precaution.</p> <p>Monitoring Plan: The Directors of Nursing/Designee will conduct rounds each shift on each unit to ensure monitoring is performed as ordered. Failure to perform monitoring as expected will be immediately addressed. Results of observations will be reported daily in the Leadership meeting and weekly to the Governing Board until monitoring is maintained at 100% for one month. Upon attainment of 100% compliance, results will be reported monthly to the PI Committee and quarterly to Medical Executive Committee and Governing Board.</p> <p>Persons Responsible: CEO Directors of Nursing PI/Risk Manager</p>	

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A 144	<p>Continued From page 8</p> <p>is classified as a score between 25 and 41. Other than the routine every 15 minute checks that are completed for all patients on the unit, no special observation status was assigned until after the physician had examined the patient on the following day (2/25/2017) after which the patient was placed on line of sight (LOS).</p> <p>3. On 2/27/2017 at 10:00 PM, a Registered Nurse (RN) (Staff Member #7) entered a note into the patient's medical record stating that the RN had examined the patient and found multiple cuts on her/his left wrist and arm. The RN notified the patient's physician. A telephone order documented by the RN on 2/27/2017 at 9:30 PM stated that the patient was on LOS observation status and that the patient was responsible for remaining in LOS of assigned staff. The patient's physician had ordered LOS observation status earlier in the day at 2:25 PM as well. The RN phone call to the physician about her/his concerns related to the patient's self-harm did not result in an order for increased monitoring of the patient.</p> <p>4. Review of a physician (Staff Member #9) note dated 3/2/2017 at 1:00 PM showed the physician assessed the patient to have an increased suicide risk. The physician ordered increased staff monitoring of the patient. The physician's order dated 3/2/2017 at 10:45 AM stated "LOS Q [every] 5-minute checks for 24 hours."</p> <p>5. According to documentation, on 3/2/2017 around 10:00 PM, a licensed nurse (Staff Member #8) found that Patient #3 was bleeding in the area of her/his left hand/wrist area. The patient was noted to be sitting on the floor with a blanket covering her/his arm. Initially, Patient #3 stated she/he cut themselves using a pencil.</p>	A 144		

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A 144	<p>Continued From page 9</p> <p>After further questioning, it was discovered that the patient had used a metal blade [X-Acto blade]. The patient reported that she/he kept the blade hidden in her/his sock.</p> <p>6. Review of documentation dated 3/2/2017 at 11:00 PM, following the blade cutting incident, revealed that staff felt the patient should have been in 1:1 observation status because while the patient was in LOS of staff and on every 5 minute checks the incident still occurred.</p> <p>7. An interview with a RN (Staff Member #7) on 3/8/2017 at 3:20 PM with Surveyor #2 showed that she/he felt that Patient #3 should have been on 1:1 observation status as the patient had a history of grabbing pencils and using them to harm herself/himself even though she/he was on LOS observation status. Staff Member #7 also reported that Patient #3 harmed themselves with a metal blade while on LOS observation status with every 5 minute checks.</p> <p>8. An interview with the Director of the Adult Psychiatric Unit (Staff Member #10) on 3/9/2017 at 10:40 AM confirmed the incident related to Patient #3. Staff Member #10 revealed that she/he was unsure how Patient #3 came to be in possession of such a dangerous object. Staff Member #10 stated that Patient #3 told staff that she/he brought the blade from home.</p> <p>9. On 3/09/2017 at 10:00 AM, Surveyor #4 reviewed the inpatient record of Patient #4. S/he was admitted on 2/13/2017 due to concerns that the patient might harm themselves. Patient #4 was initially placed on 1:1 observation from 2/13/2017 to 2/18/2017, and then was placed on LOS observation for safety. The patient remained on LOS observation until 3/8/2017. An</p>	A 144		

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A 144	<p>Continued From page 10</p> <p>entry in the medical record by a registered nurse (Staff Member #5) dated 3/7/2017 at 5:37 PM documented "Pt. A&O (alert and oriented) x3. Mood is anxious and restless. Pacing about unit. Approached nurse with blood streaming down R (right) forearm from self-inflicted injury." The self-harm injury sustained by Patient #4 occurred while the patient was ordered for LOS. No other documentation in the medical record was found to indicate the hospital staff attempted to stop the patient from harming themselves prior to the patient presenting themselves to the nursing staff.</p> <p>10. On 3/9/2017 at 9:15 AM, Surveyor #3 reviewed the medical records of three patients who were involved in a total of eight patient on patient assault incidents of which five occurred while on LOS monitoring. The surveyor noted the following:</p> <p>a. On 2/25/2017 at 6:15 AM, Patient #8 while on LOS monitoring was noted in the record to be "exit seeking, frequently trying to open doors . . . Pt [patient] is observed wandering into peers bedroom & taking their belongs. Staff stated that pt. was observed punching a much larger peer who assaulted him back. Staff was able to break up the argument & redirect pt's to different locations."</p> <p>b. On 2/11/2017 at 9:45 PM, Patient #2 while on LOS monitoring was noted in the record as "Patient threw a punch and knocked . . . patient to the ground . . . Police officers arrived in unit [to] investigate the case. . . Patient medicated PRN [as needed] meds. Remain in room for a while until the second patient transferred for safety".</p> <p>11. On 3/7/2017 at 9:15 AM, Surveyor #3 interviewed a registered nurse (Staff Member #6)</p>	A 144		

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A 144	<p>Continued From page 11</p> <p>about the different levels of observation and the difference between them. The nurse indicated that LOS is similar to the 15 minute checks with the entire staff and no one person responsible for the monitoring. Staff Member #6 acknowledged that only when a patient is ordered for 1:1 monitoring is a specific individual assigned to monitor the patient.</p> <p>12. An interview with the Director of Quality and Risk (Staff Member #11) with Surveyor #2 revealed that the facility was not collecting data on the use and effectiveness of levels of observation (i.e. LOS, 1:1) of patients. He/she also stated that there were no current improvement projects concerning LOS and 1:1 patient monitoring.</p>	A 144		
{A 164}	<p>482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.</p> <p>This Standard is not met as evidenced by:</p> <p>Based on record review and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying simultaneously both restraints and seclusion for 3 of 6 patients reviewed. (Patients #1, #2, #3).</p> <p>Failure to utilize or consider less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity.</p>	{A 164}	<p>A164 482.13(e)(2) – Patient Rights: Restraint or Seclusion</p> <p><u><i>Utilize least restrictive alternative when using restraint or seclusion</i></u></p> <p>Corrective Action: Policy PC.R.100 "Seclusion and Physical & Mechanical Restraint" was reviewed on March 10, 2017 and providers and staff were reeducated regarding the requirement to utilize and document the utilization of the least restrictive alternative when using restraints or seclusion.</p>	All corrective actions will be completed no later than April 28, 2017

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{A 164}	<p>Continued From page 12</p> <p>Findings:</p> <p>1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Reviewed 1/2017; Policy # PC.R.100) under the section "Policy" read in part: "Seclusion and restraints may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others after less-restrictive interventions are ineffective or ruled-out . . . "</p> <p>The section titled "Patient Rights" read in part: "Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. The type of technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm."</p> <p>2. On 3/8/2017 at 9:15 AM, Surveyors #3 and #4 reviewed the records of five patients who were placed in either seclusion or restraints during their hospital stay and noted the following:</p> <p>a. Patient #1 was placed in 4-point restraints and seclusion simultaneously by hospital staff on 2/9/2017 at 7:45 PM. Subsequently, Patient #1 was released from restraints at 9:15 PM and from seclusion at 10:45 PM. No documentation indicating that a less restrictive alternative had been considered or attempted first prior to the simultaneous application of both physical restraints and seclusion could be found.</p> <p>b. Patient #2 was placed in 4-point restraints and seclusion simultaneously by hospital staff on</p>	{A 164}	<p>Monitoring Plan: The Directors of Nursing/Designee will perform audits on each incident of restraint or seclusion. Failure to adhere to PC.R.100 will be immediately addressed with staff involved in the incident. Results of the audits will be reported daily in Leadership meeting, and weekly to the Governing Board until monitoring is maintained at 100% for one month. Upon attainment of 100% monitoring, results of audits will continue to be reported in Leadership but will be reported monthly to the PI Committee and quarterly to Medical Executive Committee and Governing Board.</p> <p>Persons Responsible: CEO Directors of Nursing Director of Intake PI/Risk Manager</p>

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{A 164}	<p>Continued From page 13</p> <p>2/25/2017 at 6:00 PM. Subsequently, Patient #2 was released from restraints at 9:00 PM and from seclusion at 9:45 PM. No documentation indicating that a less restrictive alternative had been considered or attempted first prior to the simultaneous application of both physical restraints and seclusion could be found.</p> <p>3. During the survey, Surveyor #2 toured the Adult Psychiatric Unit 2 West and reviewed the medical record of Patient #3. The surveyor noted the patient was ordered for both seclusion and 4-point restraints simultaneously on 3/2/2017, 3/3/2017, and 3/6/2017 respectively. No documentation could be located in the medical record to indicate a less restrictive technique (either seclusion or restraint used alone) was attempted prior to the simultaneous application of both physical restraints and seclusion.</p>		{A 164}	A286 482.21(a), (c)(2), E3 – Patient Safety <u>Program Scope, Activities and Executive Responsibilities</u> <u>Corrective Action:</u> PI/RM was reeducated on the facility Performance Plan on March 29, 2017 which includes the objectives to: (1)achieve an effective reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes (2)providing an effective, planned, systematic mechanism to design, measure, assess and improve the performance of the facility (3)to facilitate a proactive approach toward continuous quality improvement and evaluate actions taken to assure that desired results are achieved and sustained (4)to promote communication and reporting of performance improvement activities by and between departments, administration, medical staff, Governing Board and others as deemed necessary.
(A 286)	<p>482.21(a), (c)(2), (e)(3) PATIENT SAFETY</p> <p>(a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...</p> <p>(c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.</p> <p>(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and</p>		(A 286)	All corrective actions will be completed no later than April 28, 2017

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{A 286}	<p>Continued From page 14</p> <p>responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...</p> <p>(3) That clear expectations for safety are established.</p> <p> This Standard is not met as evidenced by: Based on interview, record review and review of policy and procedure, the hospital failed to track and document the staff response to a patient's cardiac arrest event as required by hospital policy and procedure.</p> <p>Failure to document a patient's cardiac arrest event decreases the quality of the information the hospital can provide for ongoing treatment of the patient and leaves the hospital unable to evaluate the effectiveness of emergency response for quality improvement purposes.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The hospital's policy and procedure titled "Code Blue" (Policy #PC.C.100; Reviewed 1/2017) stated that a patient cardiac arrest should be documented on the Code Blue Record and placed in the patient's medical record. 2. Patient #9 was a 49 year-old admitted on 12/19/2016 for treatment of alcohol use disorder. Patient #9 required treatment for alcohol withdrawal and was admitted to the detoxification unit. On 12/21/2016 at 12:54 PM the patient was found unresponsive and cyanotic (bluish discoloration of the skin). At the same time, Staff called a Code Blue (a code used in hospitals for 		{A 286}	<p>Monitoring Plan: Unusual occurrences will be reported daily in Leadership, weekly to Governing Board and investigated by the PI/RM. Incidents will be tracked, trended and reported by PI/RM along with plans for improvement monthly to PI Committee and quarterly to Medical Executive Committee and Governing Board.</p> <p>Persons Responsible: CEO PI/Risk Manager</p>

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{A 286}	<p>Continued From page 15 medical emergencies) and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 1:10 PM and continued administering CPR until the patient was pronounced dead at 1:40 PM.</p> <p>Review of Patient #9's medical record revealed that there was no detailed record (Code blue Record) of the staff response to the patient's cardiac arrest.</p> <p>3. An interview with the Chief Operating Officer (Staff Member #12) on 3/8/2017 at 10:10 AM confirmed these findings.</p>	{A 286}	<p>A286 482.21(a), (c)(2), E3 – Patient Safety</p> <p><u>Code Blue</u></p> <p><u>Corrective Action:</u> PC.C.100 "Code Blue" was reviewed and all nursing staff retrained regarding documentation requirements and forms to be utilized. Going forward the hospital will conduct annual mock Code Blue drills.</p> <p><u>Monitoring Plan:</u> All Code Blue incidents will be reviewed by PI/RM and a staff debrief conducted post incident to ensure documentation requirements have been met. Adverse findings will be reported in Leadership daily and results of investigations, action plans and chart audits will be reported monthly to PI Committee and quarterly to Medical Executive Committee and Governing Board.</p> <p><u>Persons Responsible:</u> CEO PI/Risk Manager</p>	All corrective actions will be completed no later than April 28, 2017



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Summary

We are short Acadia Healthcare (NASDAQ: ACHC) because the company has concealed widespread patient abuse and neglect that results from pervasive understaffing at its facilities. At Acadia, cutting staffing costs to the bone is the "secret sauce" used by management to inflate short term profits. Acadia's existence makes the world a worse place because its business model depends on acquiring new facilities and then degrading care, a losing proposition that victimizes patients. We believe the fundamental problem for investors is that Acadia's slash and burn approach to behavioral healthcare is inherently unsustainable and increasingly at risk of unraveling.

CEO Joey Jacobs and his management team first used this recipe at Psychiatric Solutions (PSI) a decade ago, where investors sued for fraud alleging that Jacobs had "*downplayed the alarming incidents of abuse, neglect, and even death*" at company facilities, ultimately winning a **\$65 million settlement**. After selling PSI to competitor UHS in 2010 amidst regulatory investigations, Jacobs reassembled his PSI executive team at Acadia to replicate this approach. Once again, we believe Jacobs has misrepresented the true nature of his company to investors.

Over several months, we gathered and reviewed thousands of pages of public documents including over **600 state and federal inspection reports** as well as court records, media reports, lawsuits, and police records. We found that numerous patients, including children and teenagers, have died due to alleged negligence or malpractice at Acadia facilities. We found recurring reports of sexual abuse and physical assaults on vulnerable patients that have allegedly been

perpetrated by Acadia employees or unmonitored patients. We found repeated instances of patient neglect or deficient care linked directly to staffing problems at Acadia facilities. We found a pattern of whistleblower allegations made by former employees who say Acadia retaliated against them after they reported fraud or misconduct.

Acadia's undisclosed problems are not isolated to just a few bad facilities or a handful of rogue employees. We found indications of understaffing or deficient care at over 75 Acadia facilities in 24 states. Not only did we uncover problems at the majority of Acadia's U.S. inpatient hospitals, which in aggregate **generate 43%** of the company's U.S. revenue, but we also flagged significant issues within Acadia's national network of outpatient addiction facilities. We have posted extensive source documents at www.acadiaexposed.com, where we will individually profile 30 of Acadia's most problematic facilities in a series of additional releases. Some of these facilities are also reportedly under government investigation, have received patient referral holds, or are being permanently closed.

Acadia's true business model is premised on borrowing billions of dollars to acquire behavioral health facilities, then wringing out profits by cutting staffing expenditures while increasing beds. Underspending on staffing temporarily juices profits, because it's the company's largest expense, but it leads to chaos, violence, and deficient care since many patients are vulnerable or dangerous and need substantial direct attention. That's why government inspections have repeatedly attributed patient death and neglect at Acadia facilities to problems with both the quantity and quality of staff.

Up until now, Acadia was able to conceal the extent of its problems because most investors hadn't connected the dots between the vast number of disparate public documents and local news reports that repeatedly detail deaths and assaults at problematic Acadia facilities across the country. Also, many of Acadia's victims are young, disabled, or suffer from serious disorders that makes it difficult for them to sue the company or publicize what happened to them. Now that the truth has emerged, we anticipate that Jacobs will attempt to falsely depict these problems as isolated and sensationalized or the

product of past issues or difficult patients – this is exactly what he tried to do after journalists exposed similar problems at PSI.

The truth coming out hurts Acadia because it contradicts Jacob's claims and leads to increased public scrutiny. The stock price of competitor American Addiction Centers has lost nearly 75% of its value since a short seller [reported](#) that the company was covering up patient deaths. Former employees, including that company's President, were [criminally indicted](#) by the State of California for second degree murder in 2015 for the death of a patient (the murder charge was later dismissed). At Acadia, not only are there undisclosed criminal indictments and convictions of former employees for the death or assault of patients, but we found allegations that Acadia has:

- Destroyed evidence
- Falsified documents
- Duped regulators during audits
- Covered up incidents of patient abuse
- Submitted fictitious billings to the government
- Failed to disclose regulatory investigations involving certain facilities
- Retaliated against multiple whistleblowers

As undisclosed problems have mounted, Acadia's four top officers [dumped](#) over [\\$40 million](#) worth of stock last year—with Jacobs divesting half of his stake and later [purchasing a portion](#) of the Nashville Predators professional hockey team. Acadia's top five officers have received more than \$63 million in compensation over the past three fiscal years under the watch of a Compensation Chairman, [Wade Miquelon](#), who [was charged](#) by the SEC last month for “misleading investors” during his tenure as Walgreens CFO.

We believe Acadia's profits are largely fleeting. History demonstrates that roll-up business models like Acadia [unravel](#) when the underlying financial engineering driving the reported financials loses momentum. This is precisely what we see starting to happen. Because Acadia's costs have already been cut to the bone, the company has exhausted its primary means of driving profits from

existing facilities. Acadia has missed earnings estimates two of the past four quarters and same facility revenue growth is slowing while facility expenses have started to increase. We believe staffing expenses are likely to increase significantly as scrutiny from the public and regulators intensifies because Acadia will face increased pressure to improve patient care. But Acadia has over \$3.2 Billion in debt it needs to service, which leaves the company little room to weather increased expenses or reduced revenues. We therefore see significant downside potential in Acadia shares.

A video presentation on Acadia Healthcare can be found [here](#).

Systemic Patient Abuse, Neglect, and Understaffing Infects Acadia Facilities Across the Country.

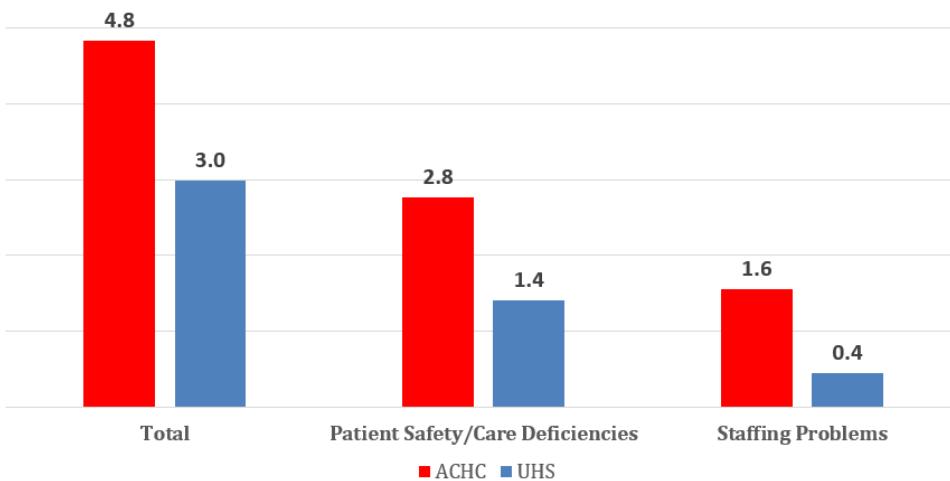
Acadia investors have been led to believe the company is isolated from the fraud and patient care scandals that have historically plagued other publicly traded behavioral health companies such as Psychiatric Solutions (PSI), Universal Health Services (UHS), and American Addiction Centers (AAC). CEO Joey Jacobs has publicly claimed that “everybody wants to be Acadia”, while the sell-side, for example, has touted that *“claims about understaffing typically are focused on ACHC’s competitors”* and *“fraud, abuse in behavioral industry mainly limited to the addiction segment, where ACHC has a small presence”*. But this narrative is simply false.

Because staffing is Acadia’s single largest expense, currently representing roughly 53% of total revenues, we believe that Jacobs and his team have inflated short-term reported profits by cutting staffing expenses at Acadia facilities to unsafe levels. Yet having appropriate staffing, in terms of both quantity and quality of people, is critical because some patients are dangerous to themselves and others, requiring intense supervision and precise administration of treatment. A senior industry executive with over 20 years of experience told us that *“the way to think about it is that if you cut staffing or hire the wrong people, you’re more likely to have an adverse event”*. This is exactly why we believe underspending on staffing makes it so difficult for many Acadia facilities to properly supervise and protect vulnerable patients, much less treat them effectively.

The nexus between understaffing and deficient patient care at Acadia is demonstrated by our analysis of Centers for Medicare & Medicaid Services (“CMS”) inspection reports. Although Acadia [operates](#) 209 behavioral healthcare facilities nationwide, 43% of its US revenue (over \$775 million) comes from acute inpatient facilities. CMS [typically inspects](#) hospitals at least every four years but will conduct more frequent inspections in the event of complaints or problems. We located CMS inspection reports for 31 of the 40 US hospitals listed on Acadia’s website. Federal inspectors uncovered staffing deficiencies at [28 of the 31 Acadia hospitals we reviewed](#), including repeated violations for not having enough nurses or qualified practitioners on hand. Of the 28 hospitals that had staffing deficiencies, [25](#) were also cited by inspectors for having deficiencies related to patient safety or care, including violations involving patient deaths, suicides, elopements (escapes), improper or erroneous administration of medications, improper use of restraints, and physical or sexual assaults. Inspectors also found managerial deficiencies at 27 of the 31 facilities we reviewed, which includes failures to report incidents to law enforcement or even investigate patient abuse allegations, and failures to provide proper oversight or follow or establish appropriate patient safety protocols.

Our analysis indicates that Acadia’s hospitals are also measurably worse than its publicly traded competitor UHS. We compared the results of 70 CMS inspection reports of Acadia facilities from 2015-2017 to 153 CMS inspection reports we found for 58 different UHS behavioral hospitals over the same time period. The Acadia facilities averaged 4.8 violations per inspection, 60% higher than the 3 violations per inspection averaged by the UHS facilities. Our review found that Acadia facilities also received more violations per inspection involving patient safety or care deficiencies (double) and staffing problems (quadruple). We consider this performance especially poor since some UHS facilities have well known problems that have attracted significant [media scrutiny](#) as well as multiple criminal and civil [government investigations](#).

Violations Per Inspection



Source: Internal analysis of CMS inspection data.

The conditions inside Acadia's facilities claim real victims. Examples of undisclosed incidents include:

Note: This report references numerous lawsuits, regulatory documents, and criminal proceedings. You should assume that Acadia or the referenced defendants deny all allegations. Some of the referenced lawsuits have been settled, dismissed, or removed.

- A five-year-old boy [was killed](#) in June 2017 at Acadia's Ascent Children's, a chain of youth facilities in Arkansas. Staffers left the boy inside a hot van with a disabled safety alarm, resulting in felony manslaughter [indictments](#) of four former Acadia employees. This month, [the facility abruptly announced it would permanently close](#) all of its [seven facilities](#). State officials had launched an [additional investigation](#) in December into incidents of alleged child maltreatment at the center.
- Police are [investigating](#) two recent patient deaths and a [sexual assault](#) at Acadia's Park Royal Hospital in Florida, according to a February 2018 media report. [Federal inspectors](#) have flagged patient safety issues at the hospital, which has a pattern of patient abuse that has already seen one former Acadia employee [imprisoned](#) for raping 11 patients.

- Patient referrals to Acadia's Ohio Hospital for Psychiatry were **temporarily halted** in May 2018, after patient safety and staffing issues were revealed on [a website](#) created by an area rights group. A sexual assault allegedly perpetrated by an Acadia nurse with a history of disciplinary actions is the latest following what a local news outlet **reported** as "years of complaints, state investigations and violations of safety and care standards".
- Acadia staff members allegedly assaulted children and "would encourage kids to fight for their entertainment" [according](#) to a February 2018 local news investigation into Acadia's Resource Residential youth facility in Indiana. The Indiana Department of Child Services placed a referral hold at the facility in April 2018, according to a local [news report](#), meaning that they will not send any more kids to the facility.
- In June 2018, CMS inspectors declared **Immediate Jeopardy**, commonly interpreted as a "**crisis situation**", at Acadia's Lakeland Behavioral hospital after CMS directed an unannounced inspection that found "the facility failed to protect two patients from sexual misconduct". Inspectors had previously declared Immediate Jeopardy [in 2017](#) after finding the facility failed to prevent patient assaults.
- Federal inspectors last year discovered that 26 patient deaths went unreported to the governing body of Acadia's Rolling Hills Hospital in Oklahoma in 2016 alone. According to a [lawsuit](#), reports of sexual assaults against young patients triggered government investigations "which resulted in the removal of all DHS [Oklahoma Department of Human Services] children" from the premises.
- At Acadia Montana, [state inspectors](#) documented "128 patient assaults" that occurred during a 13 week review period in 2016. According to inspectors, "Staff reported the facility is understaffed" and one resident reported that staffers watch porn in front of the kids.
- Multiple instances of **child abuse** by staff at Acadia's Capstone Academy in Michigan have been substantiated by state child welfare investigators. We obtained a December 2017 letter (see [page 41](#)) to the facility from the Michigan Department of Health and Human Services which demands,

in bold print, "an explanation why previous corrective action plans have not obtained and maintained compliance for rules found in repeat noncompliance".

- After a vulnerable child was assaulted by an Acadia staffer at Sonora Behavioral in Arizona, **federal inspectors** found that the facility failed to report the incident to the parents or police in 2016. A string of young patients have died at the facility and inspection reports detail numerous **other violations** including understaffing, medication errors, and failures involving patient injuries.
- Two patients died due to allegedly being improperly treated with dangerous medications at Acadia's Seven Hills Hospital in Nevada, according to two wrongful death suits ([here](#), [here](#)). The doctor accused of the misconduct is still practicing at the hospital.
- Arkansas regulators reportedly opened an **investigation** into Acadia's Piney Ridge Treatment Center in 2016 after **parents and former patients** told local reporters the facility actually operates "more like a kid's fighting ring". A former facility staffer **was arrested** in April 2018 and charged with one felony count of engaging children in sexually explicit conduct. Former employees told a local news stations that Piney Ridge **overlooked** the misconduct and had attempted to "sweep it under the rug".
- Undercover footage of patient brutality at an Acadia facility in the UK **was aired** on *Dispatches* in February 2018 including evidence of **severe understaffing** and improper safety practices.
- A teenage girl was **violently raped** by another resident at Acadia's Valley Behavioral facility in Arkansas because of low staffing at the facility, according to a negligence suit filed in 2016 against Acadia. A 10 year old patient **was raped** in the presence of a van driver who has subsequently pleaded guilty to a felony, according to a **lawsuit** filed against Acadia and the van company that is reportedly headed to trial in late 2018.
- A **malpractice suit** filed in 2017 states that "a detective threatened to shut down the Longleaf Hospital", an Acadia facility in Louisiana, after an adolescent patient was

assaulted by Acadia representatives who then “obstructed and prevented several law enforcement officers from entering the facility”.

- Violations surrounding a patient’s **death** and incidents of abuse and neglect are highlighted in a series of recent **federal inspections** of Acadia’s Cross Creek Hospital in Texas.
- Inspectors found that a patient who staff “failed to monitor” **died** after a series of falls at Acadia’s StoneCrest Center. **Federal inspectors** were told by a patient that “all the staff were sleeping, even the nurse” and uncovered numerous patient safety deficiencies including “unmet care needs”. They also found indications that patients were “coerced into taking medications or receiving treatment that they did not agree to” by the nurses.
- Two patients committed suicide in a **five day period** last year at Acadia’s Belmont Behavioral Hospital, according to a **state inspection** and a **lawsuit** that blames understaffing.
- In addition to instances of abuse, **federal inspectors** report that senior citizens failed to receive basic care such as baths and wound treatment at Acadia’s Delta Medical Center.

Our investigation also found problems within Acadia’s national network of addiction centers, treatment clinics, and residential facilities. Acadia is soliciting taxpayer funds by promoting itself as a solution to America’s Opioid addiction crisis. Jacobs has told investors that “we have *lobbyists in every state, working with states and communicating our position on how we think this money [opiate crisis funding] should be used*”. But our analysis of inspection reports for outpatient facilities in various states indicates that Acadia is providing deficient care to many of these patients. To illustrate this point, we reviewed inspection reports for 36 Acadia addiction facilities in Pennsylvania, which we chose to sample because Acadia **derives 7%** of its total revenue from Pennsylvania, more than any other state. Pennsylvania inspectors uncovered 542 violations at these Acadia addiction centers since 2015 including **deficiencies related to patient safety, treatment, and/or staffing at 97% the locations**. Not only did inspectors find that patients often lack basic treatment, but Acadia invests so little in some of these

facilities that that inspectors found locations infested with rodents, mold, and even bullet holes in the windows.

Slash & Burn: The True Nature of Acadia's Business Model

Acadia's CEO Joey Jacobs and his management team previously ran PSI which pursued a roll-up strategy focused on aggressively cutting costs at acquired facilities. *ProPublica* and the *LA Times* published an investigative series on PSI a decade ago [which exposed](#) patient deaths, assaults, and how "*poor patient supervision, understaffing and inadequate worker training have led to instances of chaos and brutality*".

The Department of Justice and other regulators opened [investigations](#) into PSI and at least four whistleblowers filed lawsuits alleging misconduct or fraud at the company. PSI investors [sued](#) Jacobs and the company for fraud in 2009 alleging that Jacobs had "*downplayed the alarming incidents of abuse, neglect, and even death*" at company facilities because PSI had become "*addicted to debt*" and needed to cover up its operating problems:

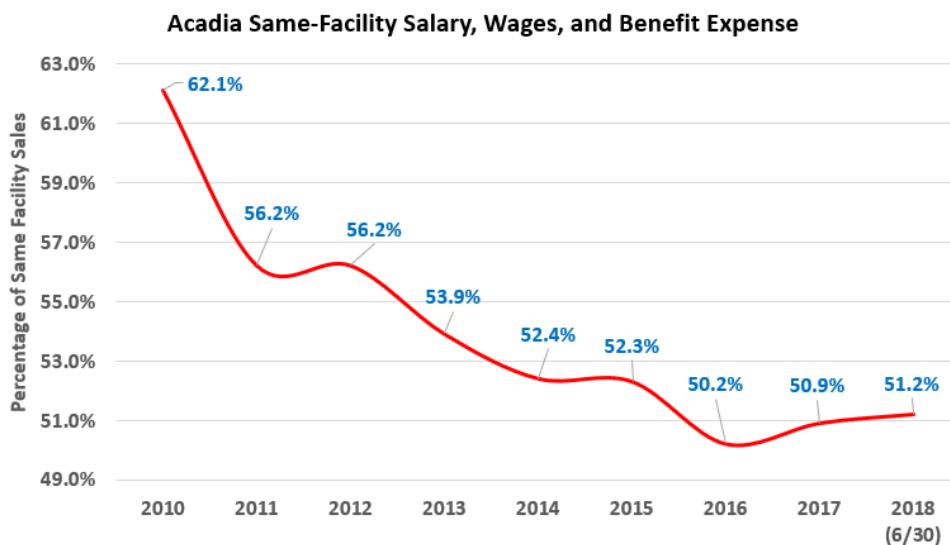
6. Reduced staffing and lower expenditures on patient care led to repeated and systemic problems with both the quality of care being provided to patients and their safety while housed at PSI facilities. Repeated incidents of sexual abuse and physical attacks on children perpetrated by unmonitored patients occurred at PSI facilities across the country, as did numerous suicide attempts by at-risk teenagers who were not properly monitored by overtaxed nurses and facility staff. Unable to cope with the increased patient load, some PSI facilities resorted to the excessive use of "chemical restraints," deliberately overmedicating the most troublesome youths consigned to their care.

Above: Civil Action [No. 3:09-cv-00882-WJH](#). The suit was settled by UHS for \$65 million without admitting guilt, Jacobs and PSI denied the allegations.

After selling PSI to UHS in 2010, Joey Jacobs founded Acadia in 2011 with five other former PSI executives. Jacobs has replicated PSI's roll-up strategy at Acadia, thus far acquiring over \$5 Billion worth of behavioral healthcare facilities while hiring certain former

PSI lieutenants to run and oversee them. Like PSI, our research demonstrates that cutting staffing expenses is the heart of Acadia's business model.

Acadia's financials show that the company's staffing expenditures have declined sharply over the past eight years. Acadia's reported same-facility salary, wages, and benefits ("SWB") expressed as a percentage of revenue, essentially an "apples to apples" comparison of facility level staffing expenditures, has declined from 62.1% of sales in 2010 to 51.2% in June 2018. SWB expenses had declined 6 of the past 8 years, but began to increase slightly in 2017 and so far this year.



Source: data from Acadia SEC Filings

Staffing problems at Acadia are consistently detailed in CMS inspection reports. CMS requires staffing to be based on the needs, or "acuity," of the patient population. More staff per patient is required when the facility has more patients requiring intense, at times one-on-one, care than others. For instance, the Behavioral Health Executive explains that facility policies typically call for checks on suicidal or dangerous patients at least every 15 minutes and "*the failure could be that you haven't hired enough staff to do the check*". **Federal inspectors have repeatedly attributed patient deaths to Acadia's failures to properly perform such checks:**

1. The Progress Notes dated 7/11/16 at 7:45 p.m. indicated Patient #3 was found by the roommate hanging from a bathroom door by a sheet tied around the neck.

Orders dated 7/9/16 at 11:09 a.m. and signed by the nurse practitioner included directions to maintain Patient #3 on line of sight observation status.

An interview was conducted with the Risk Manager on 8/11/16 at 2:35 p.m. The Risk Manager indicated she reviewed video tapes showing Patient #3 on the evening of 7/11/16. The Risk Manager indicated there were no staff members within line of sight of Patient #3. She confirmed the finding the staff failed to ensure Patient #3 was maintained on line of sight observation status as ordered for safety.

Source: CMS Inspection of North Tampa

Staff #34 stated, during interview conducted on 01/20/16 at 5:20 P.M., that Staff #29, an RN, was responsible for the 5 minute observations of Patient #1 which were not done prior to the suicide.

Staff #16 acknowledged, during interview conducted on 01/26/16 at 10:00 A.M., that Staff #29, an RN had left the unit to get coffee at the time Patient #1 hanged herself on the unit.

Source: CMS Inspection of Sonora

The hospital nursing staff failed to ensure every 15 minutes checks where done on all patients who needed these checks to ensure a safe environment. There was no systematic way to ensure the checks were performed in an accurate and timely manner. The hospital nursing staff failed to ensure 15-minutes checks were completed in accordance with hospital procedures to monitor patient safety, prevent self-harm and the death for Patient #1. The mental health technicians (MHT) failure to implement the hospital's 15-minute check system, including the nursing staff pulling MHT from conducting the 15-minute checks, resulted in Patient #1's suicide attempt on 11/4/14 and death on 11/5/14.

Source: CMS Inspection of Park Royal

Inspectors have also repeatedly found that Acadia facilities simply don't have enough nurses or staff to properly care for patients. For instance, after inspectors found Acadia's Options Behavioral did not come close to meeting the required 1:6 licensed nurse to patient ratio in 2017, the Director of Nursing admitted that "she was aware of the short staff and the management was also fully aware regarding the short staff issue".

Review of the hospital's staffing assignment and the census from 11/1/17 to 12/31/17, indicated the licensed nurse-to-patient ratio did not meet 1:6.

The night shift assignment and the census, dated 11/12/17, were reviewed. In Unit A, the census was 20, one RN worked, and the ratio was 1:20. In Unit B, the census was 16, two RNs worked, and the ratio was 1:8. In Unit C, the census was 22, one licensed vocational nurse (LVN) worked, and the ratio was 1:22. In Unit D, the census was 16, one RN worked, and the ratio was 1:16.

During an interview on 1/4/18 at 1:40 p.m., the DON stated for the licensed nurse-to-patient ratio, the ratio 1:6 was the ideal ratio and the usual ratio was 1:8 or 1:9. She stated she was aware of the short staff and the management was also fully aware regarding the short staff issue.

Source: CMS Inspection of Options Behavioral

During an April 2018 CMS inspection of Acadia's Cedar Crest Hospital in Texas, inspectors found that "units were not staffed to facility staffing standards, often resulting in injuries to both patients and staff as well as patient elopements". Staff members told the inspectors that "**it's terrible here. There's no staff. It's not safe**", "**we have begged for help**", "**there's never enough staff to take care of the patients**". Another staff member explained that "**it's outrageous... patients physically intervene because we don't have enough staff on the unit. Sometimes interns are used as subs for staff coverage... sometimes we breakdown and cry... The CEO knows what is going on in this hospital. He knows we are understaffed**".

28422 The facility failed to provide a sufficient number of licensed and unlicensed staff present to provide appropriate and safe patient care. * Units were not staffed to facility staffing standards, often resulting in injuries to both patients and staff as well as patient elopement. An inadequate number of staff was provided to observe and carry out physician's orders regarding patient's precaution/observation levels (line of sight and 1:1 patient observation (cross refer to A0392). * The if they could remember the most amount of patients they were responsible for, they stated, "All together 15 girls with 6 LOS." When asked if they had to watch a 1:1 with other patients at the same time, they stated, "Multiple times. Once I had one 1:1 with 8 to 12 other patients. **It's terrible here. There's no staff. It's not safe ... We're always short staffed. It's stressful.**" In an interview with staff #D-28 on 4/10/18 when two MHTs. **It's outrageous, there is always a fire that needs to be put out. Patients physically intervene because we don't have enough staff on the unit. Sometimes interns are used as subs for staff coverage.** The interns are here to learn they shouldn't have to cover the unit because we are short staffed. Psychosocial assessments are due, groups, and patient discharges, everyone is over worked. **Sometimes we breakdown and cry, we and make sure the patients don't see us. It's difficult to stay in compliance when you are having to put out fires. The CEO knows what is going on in this hospital. He knows we are understaffed. I've told him our staff are burnt out to the hilt and they are super stretched. I'm also**

Source: CMS Cedar Crest Inspection

Acadia also appears to increase profits by crowding more beds into facilities without adding enough staff. For example, the CEO of Acadia's Longleaf Hospital admitted to inspectors he "**was aware of the 'broken system' of the hospital**". Longleaf's Medical Director told inspectors that "it became difficult to staff" the facility because "since the current owners [Acadia] acquired the hospital, they have grown and increased beds by 24. As soon as more beds became available, there was more pressure to admit more patients". When inspectors asked a nurse if patient safety incidents at the hospital are connected to inadequate staffing, she stated "**it's absolutely horrendous, they put people on the schedule they know won't show up,**

people who aren't even there". Inspectors also found instances of alleged patient abuse and wrote that Longleaf "provided the **opportunity for alleged perpetrators to continue to provide direct patient care**". When inspectors spoke with the facility's risk manager she "indicated she 'could cry right now'...she had only been in the position manager of Risk Manager for 5 months and had a 3 day training with corporate staff".

In an interview on 10/08/15 at 1:10 p.m., S2DON indicated the hospital did not have a policy that addressed the staff to patient ratio.

In an interview on 10/09/15 at 11:00 a.m., S29CEO indicated the staff to patient ratio should be 1 staff to 6 patients.

In a telephone interview on 10/13/15 at 2:05 p.m., S12LPN indicated she was working the Boys' Unit on 10/02/15 when Patient #2 attempted suicide by hanging himself with a television cord wrapped around his neck while not directly observed by staff. She indicated when she came to work on 10/02/15 at 2:00 p.m., the day shift had been so busy they had not completed their nursing notes for the day shift. She further indicated at the time there were 5 patients waiting to be admitted, and they didn't have enough MHTs to handle the census. S12LPN indicated by the time she arrived, only one MHT had shown up for the 3:00 p.m. to 11:00 p.m. shift, with 28 patients present, 2 boys waiting to be admitted, and 5 more patients to come for admission. S12LPN indicated when she met with Patient #2's father at the start of her shift (before the event occurred), his father told her that Patient #2 reported to him that the "staff leaves us unattended and ya'll don't have enough people watching us, so I'm scared of the other pts. (patients)." When asked if she thought the sentinel event was related to inadequate staffing, S12LPN indicated "it's absolutely horrendous. They put people on the schedule who they know won't show up people who aren't even there." She further indicated S15Staffing said "it looks good on paper."

In an interview on 10/13/15 at 1:25 p.m., S32LPN indicated "sometimes" there's a problem with staffing when there's not enough MHTs to cover the unit.

In an interview on 10/14/15 at 3:00 p.m., S28MD indicated he was the hospital's Medical Director. He indicated management counts nursing in the staffing ratio and shouldn't, because the nurses have other responsibilities and rely on the MHTs to observe patients. He further indicated he was aware he's responsible for the quality of care at the hospital, but he can only advise and cannot implement any action. S28MD indicated since the current owners acquired the hospital on [DATE], they have grown and increased beds by 24 beds. As soon as more beds became available, the was more pressure to admit more patients, and there were heavier admission days with a census above 70 patients. He indicated it became difficult for staff with 14 to 16 admissions not being unusual for a Friday. He further indicated he didn't know if the staff was increased to accommodate this growth.

- i) Failing to ensure all patients were free from all forms of abuse, the alleged reported incidents of abuse were reported immediately and thoroughly investigated, and that patients were protected from abuse during the investigation by allowing the alleged perpetrators to continue to work before the investigation was complete for 3 (#3, #4, #5) of 3 patient records reviewed for allegations of abuse from a total sample of 10 patients. This failed practice provided the opportunity for alleged perpetrators to continue to provide direct patient care for any patient currently admitted to the hospital as well as any future admitted patients.

Source: CMS Inspection of Longleaf

At Harbor Oaks, an Acadia facility in Michigan, former employees say that **Acadia deceived regulators by increasing staffing levels immediately prior to audits before quickly reducing it again after the inspectors left**. A detailed recent investigation of Harbor Oaks aired by WXYZ News in Detroit featured interviews with four former employees who described how Acadia understaffed the facility to maximize profits. The WXYZ investigation detailed multiple alleged instances of patient neglect and violence, including "scores" of police reports regarding physical and sexual assaults as well as 76 OHSA reports of workplace violence. One whistleblower says that she was tasked with overseeing 32 patients by herself and sustained severe injuries after being attacked by a large patient.

Ex-employees: Metro Detroit psych hospital so understaffed it's dangerous



BY: Ross Jones

POSTED: 10:58 PM, Sep 14, 2017

UPDATED: 5:40 PM, Jun 18, 2018



Inspections we reviewed also repeatedly suggest that Acadia has limited the availability of medical professionals or hired unqualified or improperly trained staff, further degrading patient care. This is a serious issue because patients suffering from psychological disorders or addiction often require skilled and personalized care to get better. A former senior employee of CRC Healthcare we spoke with explained that after Acadia acquired the company in 2015, Jacobs and his team cut millions in costs by gutting successful corporate programs specifically designed to track and improve patient outcomes:



When Acadia acquired us, they dumped it all... In service of the bottom line, they decided to let all the clinical work that we had done go... Do I think the quality of care has gone down in many of the facilities there? I absolutely do. Do I think the outcomes aren't as good as they were? I absolutely do.

For example, after multiple young patients died at Acadia's Sonora Behavioral, inspectors found that the only Acadia staff person working in the unit during one of these deaths "was not qualified" and "his/her only documented prior employment was as a 'driver'" (below). A local news investigation from May 2018 identified other **staffing problems** including "*a nurse without a valid license to work in Arizona, a behavioral health technician who assaulted a child patient, and a nurse accused of being drunk on the job*".

No RN was covering the patients on the Catalina Unit, when Pt # 1 committed suicide by hanging.

A BHT assigned to provide supervision and observation of patients on the Catalina Unit on the shift when Pt # 1 committed suicide, had no documented competence to care for psychiatric patients and his/her only documented prior employment experience was as a "driver."

Staff #15 acknowledged, during interview conducted on 01-26-16 at 1:30 P.M., that Staff #12, the BHT assigned to Patient #1 prior to her suicide attempt, was not qualified to be a BHT.

Source: CMS inspection of Sonora Behavioral

In February, a former nurse at Acadia's Resource Residential told a local news outlet **investigating problems** at the youth facility that "*the majority of the employees are young and vastly underqualified*". She also said she was aware of misconduct including a "*male staff member who engaged in sexual activity with the female residents*":

Sarah struggled with whether to talk with us, because she still respects some of the people who work at Resource, but she says a majority of the employees are young and vastly underqualified to work with kids struggling with major mental health issues.

"The staff members would encourage the kids to fight for their entertainment," she said. "They started making concessions, bringing in outside food, doing things they shouldn't have been doing for the kids and that in turn would create drama. There was one incident where I was told a staff member had brought marijuana onto a unit."

Sarah said she witnessed several incidents where staff members were violent with the kids - and she's told us she is aware of a male staff member who engaged in sexual activity with female residents.

Similarly, a whistleblower suit ([here](#)) filed in August 2017 by the former Human Resources Director of Acadia's Pacific Grove Hospital. The suit alleges that she was fired after reporting "unsafe and illegal practices within the hospital" including staff operating without requisite training, licensure, or background checks. We note that federal inspectors **declared** an immediate jeopardy situation at Pacific Grove in 2016 after finding problems impacting the "*safety of patients related to unsafe use of restraints and seclusion*".

Staffing was so thin at Acadia's Fashion Valley Treatment Center in California "that non-medical personnel such as the secretary were making treatment decisions", according to allegations made in a different whistleblower suit filed in May 2018 by a former nurse ([here](#)). The nurse explains that serious problems began to surface after Acadia began to slash the staffing at the facility while cutting corners "because Acadia wanted to increase their total number of patients and reach their quotas". The suit also says that chaos ensued causing patients to become increasingly frustrated and violent while "*Clinical and Regional Directors would make the nurses back date patients intake and other forms*". The nurse says she reported her concerns to Acadia's corporate office, but the company retaliated in "an attempt to silence" her before she was terminated. Similar allegations were made in an additional whistleblower suit ([here](#)) filed in September by a former Fashion Valley counselor who also says she was fired after reporting "*unlawful and/or unethical conduct with respect to patient treatment*" as well as "practices to inflate the patient and/or billing figures".

22. During a normal holiday period intakes increase due to clients seeking help before seeing relatives. Clinical and Regional Directors would make the nurses back date patients intake, and other forms. Nurses were encouraged to rush patients' paper work, to side step doctors and blood tests to get patients admitted quickly.

23. Acadia Health Care allowed the intake process to be so rushed that non-medical personnel such as the secretary were making treatment decisions and placing patients in different treatment programs. Acadia Health Care failed to write down the intake procedure anywhere, the

[Endres vs Acadia Healthcare Company \(2018\)](#)

At Acadia's Vermillion Behavioral inspectors noted "psychiatrists failing to participate in the patient's treatment team as stipulated in the by-laws". A psychiatrist told inspectors that even though patients were being admitted under her name, in reality, "*she had very little oversight at this hospital*". An Acadia nurse explained that "*patients are admitted under [the psychiatrist's] services, but she [the nurse] treats them*".

- 2) psychiatrists failing to participate in the patient's treatment team as stipulated in the by-laws for 4 of 4 (#3, #6, #7, #8)
sampled patients reviewed for treatment planning.

Findings:

1) Nurse practitioners conducting history and physical (H&P) assessments and medical consults when medical staff bylaws required H&P assessments and medical consults be done by physicians:

Review of the clinical record for Patient #3 revealed the patient was a [AGE] year old female admitted to the services of S5Psychiatrist on the acute psychiatric unit on 04/20/15 with a diagnosis of Schizoaffective Disorder. The patient was discharged on [DATE].

Review of the record revealed no documented evidence that S5Psychiatrist had seen, evaluated or examined Patient #3 during her hospital stay, or was a member of the treatment team. Review of the record revealed all orders, progress notes, and the psychiatric evaluation were documented by S4APRN.

In an interview on 05/28/15 at 8:10 a.m. with S5Psychiatrist confirmed that only the nurse practitioner saw Patient #3.

S5Psychiatrist stated she had very little oversight at this hospital. S5Psychiatrist confirmed she did not consult with S4APRN on Patient #3. She stated she was not involved in her treatment team. S5Psychiatrist confirmed she had never evaluated Patient #3, even in the clinic.

In an interview on 05/28/15 at 8:34 a.m. with S4APRN, there was no documentation of any collaboration with S5Psychiatrist. S4APRN confirmed the patient was not seen or evaluated by a physician, only by a nurse practitioner. She stated if the patient was an uncomplicated patient she could evaluate, treat, and discharge the patient without any consultation with S5Psychiatrist.

She stated patients are admitted under S5Psychiatrist's services, but she treats them.

Source: CMS Inspection of Vermillion Behavioral

As previously mentioned, Federal inspectors last year discovered that 26 patient deaths went unreported to the governing body of Acadia's Rolling Hills Hospital in Oklahoma in 2016 alone. The Senior Industry Executive told us this is "a huge problem, that's mind-boggling". The inspectors also found that "*the hospital failed to ensure a registered nurse (RN) supervised and evaluated the nursing care for each patient...this occurred in 28 of 28 open and closed medical records reviewed*". In total, inspectors have documented 64 separate violations at this facility since Acadia first acquired it in 2012, including "failed practices" related to patient care, staffing, and even failures to investigate allegations of patient abuse.

Based on record review and interview, data regarding patient deaths was not being reported to the Governing Body for oversight.

Findings:

A document titled "Patient Deaths 2016" showed 26 deaths for 2016. There was no documentation to show this information was provided to the Governing Body.

During an interview with Staff A on 05/10/17 at 11:21 am, Staff A acknowledged the deaths were not reported to the Governing Body for oversight.

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

Tag No:
A0145

Based on review of hospital documents and interviews with hospital staff, the hospital failed to protect the patients from neglect. This occurred in one of six (# 8) patient medical records reviewed that had wounds.

Source: CMS Inspection of Rolling Hills

Two different lawsuits ([here](#), [here](#)) were filed in December 2017 against Acadia by guardians of former Rolling Hills patients, one of whom allegedly suffered permanent brain damage after being violently assaulted at the hospital. The other suit describes how a boy was raped by another patient who had a history of alleged assaults (and has subsequently [pled guilty](#)) at an affiliated group home owned and operated by Acadia. The suit alleges that "**Acadia ordered its employees to remove security cameras and to destroy video surveillance footage**", failed to report the incident to police, and ejected a state case worker from the premises. Also, according to the lawsuit, additional reports of sexual assaults triggered government investigations "which resulted in the removal of all DHS [Oklahoma Department of Human Services] children" from the premises. Area media reports confirm that this Acadia facility has indeed been closed.

20) That after receiving reports of sexual assaults by Cato Mashburn, Defendants Rolling Hills and Arcadia assigned Cato Mashburn to be J.D.L.'s roommate.

21) After receiving additional reports of sexual assault, Defendants Rolling Hills and Arcadia ordered its employees to remove security cameras and to destroy video surveillance footage.

22) Defendants Rolling Hills and Arcadia also ejected/removed from the premises a DHS caseworker who was making inquiry into the reported assaults.

23) After multiple additional reported sexual assaults, to Defendant Rolling Hills, the City of Ada Police Department, CASA, and to the District Court of Pontotoc County, Defendant DHS undertook an investigation, which resulted in the removal of all DHS children from the Cypress Adolescent Group Home in July 2015.

[Joshua Edwards vs Rolling Hills Hospital \(2017\)](#)

Acadia facilities often treat children and teens, many of whom have been placed under Acadia's care after incidents of abuse by their former caregivers. But we found evidence of violence, abuse, and neglect at Acadia youth facilities driven by staffing problems, including previously mentioned episodes at Ascent Children's, Capstone Academy (Detroit Behavioral), Piney Ridge, and Resource Residential. At Acadia Montana, state inspectors documented "**128 patient assaults** and 26 incidents of residents causing property damage occurring during this 13 week review period" in 2016. This followed a 2015 "statement of deficiency report citing the facility is not providing a safe environment" issued by the department after inspectors reported "*the facility has had 132 patient assaults*" during that 13 week review period. The inspectors wrote "*the facility failed to implement significant changes in programming in order to ensure patient safety and reduce the number of serious incidents as indicated in the plan of correction*". According to inspectors "*youth reported not feeling safe in the facility due to physical assaults by peers and lack of staff intervention*" and "**Staff reported the facility is understaffed**". One resident reported that staff even **watch porn in front of the kids**.

Inspector Notes: The surveyor's record review of incident reports from January 014, 2016 to March 31, 2016. The surveyor's interview of residents on April 13, 2016 and on-site inspections on April 13, 2016 and April 18, 2016 and May 26, 2016. FINDINGS: (1) **The facility is not providing a safe environment for residents.** The facility has had 128 patient assaults and 26 incidents of residents causing property damage occurring during this 13 week review period. Repeat Deficiency. On 10/08/2016 the department received a complaint stating that the facility is out of control and that a resident had crawled into the ceiling and was pouring glycol out of the buckets in the ceiling onto staff members below. On December 10, 2015 the department issued a statement of deficiency report citing the facility is not providing a safe environment for residents. The facility has had 132 patient assaults and 39 incidents of resident causing property damage occur during a 13 week period. The facility submitted an acceptable plan of correction on December 28, 2015. The plan of correction states: Our goal is to minimize any number of serious incidents resulting in injury; as a result we developed an Adolescent Behavioral Modification Program and trained staff on October 12, 2015. **The facility failed to implement significant changes in programming in order to ensure patient safety and reduce the number of serious incident as indicated in the Plan of Correction submitted to the Department on December 28, 2016.** (2) On April 13, 2016 and May 26, 2016 the department conducted complaint investigations and interviewed 9 youth and 6 staff. **Youth reported not feeling safe in the facility due to physical assaults by peers and lack of staff intervention. Staff reported the facility is understaffed.** the cafe hall to let another resident go the gym to join the group. 02/16/16- staff made the resident go outside from the children's unit without shoes on because he had been acting out on the unit, the resident reported that the staff made him stay outside and would not allow him to come back inside for an extended period of time. 02/18/2016- resident reported to her therapist that **staff had their cell phones on the unit and it had porn on it and were showing other staff the porn and the resident saw it.** The resident also reported that the same staff had told the resident she was going to adopt the resident, but told the resident not to tell as she (the staff) could lose her job. 02/20/2016- Staff was observed on the preadolescent unit dragging one of the residents down the hall by her feet as a way to intervene with the aggressive resident.

Source: Acadia Montana Inspection Report

We also found indications that overtaxed Acadia medical providers resort to using **chemical restraints**—i.e. deliberately overmedicating patients for the convenience of Acadia's staff. For example, a state inspection of Acadia's Options Behavioral “*determined that the on-call physician wrote orders for chemical restraints in conflict with the facility policy that restricted this practice*”. Federal inspectors also found that this facility “*failed to have adequate numbers of licensed registered nurses to provide nursing care*”.

Department determined that the on-call physician wrote orders for chemical restraints in conflict with hospital policy that restricted this practice. This deficient practice violated

VIOLATION: STAFFING AND DELIVERY OF CARE

Tag No:
A0392

Based on review of hospital policy/procedure, hospital documents, medical records and interviews, it was determined that the **nursing service failed to have adequate numbers of licensed registered nurses to provide the nursing care required by all patients**, as evidenced by:

Source: Options Behavioral Inspection Reports ([Here](#), [Here](#))

This practice appears to have been going on for some time. At Acadia's Red River Hospital in Texas, a whistleblower suit filed by a former employee in 2012 alleges that patients were neglected and references a recording of an elderly patient left strapped to a chair for an entire 12-hour shift while being periodically injected with sedatives by Acadia staff. According to the suit, the neglect was the product of an allegedly fraudulent campaign to get more elderly Medicare patients in the door to increase revenues for Acadia even though the facility didn't have the resources to properly treat the patients.

51. The recording started at the beginning of a 12-hour shift in the PCU, and showed an elderly patient who appeared sedated strapped to a "Broda Chair" in the corner of the room. Throughout the entire duration of the 12-hour shift on the video, the elderly patient was ignored and neglected by nurses and medical staff. After 12 continuous hours of neglect, without receiving any treatment, care, or attention, the elderly patient tried to raise his hand for help. Shortly thereafter, a nurse walks directly toward the patient, lifts his gown, and gives him a shot (which apparently further sedated him) causing the patient to fall asleep and/or become unconscious again strapped to the chair.

Source: [Yvonne Downs v. Red River Hospital \(2013\)](#) Afterwards, Red River allegedly implemented a new video retention policy, only retaining the most recent 14 days of footage.

Other allegations of fraud at Acadia include:

- A whistleblower suit filed in June 2018 by a former nurse at Acadia's North Tampa Behavioral Health Hospital. The nurse says she was directed "to falsify medical documents" and was fired after reporting "inadequate staffing, patient safety, employee safety".

9. Plaintiff engaged in a protected activity, as defined by the Florida Whistleblower's Act, when she objected to Defendant's unsafe and dangerous working conditions that involved the safety of Defendant's patients and said safety and concerns constituted violations of law, rule and/or regulation as such were violations of laws, rules and regulations under Florida law. Specifically, Plaintiff objected to Defendant's violations of law, which included, but was not limited to Defendant failing to adhere to the legal and professional standards of care for patient needs, falsifying and/or attempting to falsify and/or directing Plaintiff to falsify patient records and disregarding the rights of Baker acted patients who are entitled to receive the services suited to his or her needs as a matter of law.

Source: [Young vs. North Tampa Behavioral Health \(2018\)](#)

- A former employee at Acadia's Millcreek facility "was terminated after making her supervisor aware of multiple acts of Medicaid fraud", according to allegations in a lawsuit filed

by a former employee in 2017. ([Madeline McNease vs Acadia Healthcare Company Inc.](#))

- A 2015 whistleblower suit states that Cedar Crest was billing Medicare, Tricare, and private insurers for phantom services. The whistleblower alleged that the hospital falsified patient records before state audits and experienced retaliation after reporting the malfeasance to Acadia's corporate compliance department.

19. On or about February 17, 2015, plaintiff reported to O'Shaughnessy and Marsh that defendant was **billing Medicare, Tricare, and other insurors for services which had not been provided by defendant or which had not been provided by licensed professionals, as billed.**

20. On or about March 15, 2015, plaintiff reported to Acadia's Corporate Compliance Office the information contained in paragraph 19, together with a report that Marsh and members of his staff **altered patient records in advance of an audit of defendant by the State of Texas.**

[Russell vs HMIH Cedar Crest \(2015\)](#)

We See Substantial Downside Potential in Acadia Shares

Acadia's business model is premised on borrowing billions of dollars to acquire behavioral health facilities, then wringing out profits by cutting staffing and patient care expenditures while adding beds. The fundamental problem, in our opinion, is that this model is inherently unsustainable because it depends on degrading patient care- a losing proposition. The consequences of Jacob's slash and burn approach to behavioral healthcare, which has caused many of the problems we found at Acadia facilities across the country, now appear to be spilling over into Acadia's financials.

The true nature of Acadia's business practices finally coming to light hurts the company because it contradicts management's public

claims and increases public scrutiny. The former UHS facility CEO told us that after Buzzfeed [published](#) articles exposing patient safety issues at UHS, there was an “*immediate impact*” and “*Once an article like that goes out, first of all, any provider in the local market won’t hardly dare send you a patient, because they don’t want to be associated with it.*” Loved ones also become less likely to send family members to facilities associated with patient safety scandals or misconduct. This dynamic already appears to have begun at Acadia’s Ohio Hospital of Psychiatry, where referrals were [temporarily halted](#) earlier this year after an area rights group released a [report](#). Similarly, the Indiana Department of Child Services placed a [referral hold](#) at Acadia’s Resource Residential youth facility in April 2018, meaning that they will not send any more kids to the facility.

Based on the recurring problems in inspection reports we reviewed, we find it likely that state and federal regulators have already begun to scrutinize Acadia’s business practices. The former UHS facility CEO also explained that increased inspections, investigations, and potential fines or facility closures is why “*It’s a painful sentence once you’re on the [regulatory] radar. Plus, it’s worth the extra bodies [proper staffing] to stay off the radar, it’s worth it.*” AAC’s stock price has lost 75% of its value since news of criminal indictments broke, while UHS has [closed](#) over 20 facilities since 2011 amidst myriad government investigations. Just this month, Acadia’s Ascent Children’s announced that it would permanently close all seven of its facilities after Arkansas regulators opened an investigation into child maltreatment and four former employees were criminally indicted for the death of a young boy.

Furthermore, the Department of Justice and other regulators have historically charged operators for billing for deficient care ([here](#), [here](#), [here](#)), which strikes us as a particularly acute risk for Acadia given that multiple whistleblowers have accused the company of fraudulent practices.

We believe Acadia’s profits are largely fleeting. Since Acadia’s costs have already been cut to the bone, the company has exhausted its primary means of driving profits from existing facilities. As scrutiny from the public and regulators intensifies, we believe Acadia will

likely be pressured to improve patient care, driving up operating costs significantly. This dynamic already appears to have started.

Acadia has missed earnings estimates two of the past four quarters and same facility revenue growth is slowing while facility expenses have started to increase. We estimate that Acadia will need to increase staffing expenditures by at least 10-20% to improve patient care, which would cost Acadia approximately \$150 to \$300 million in incremental annual expenses and reduce reported EBITDA by 25-50%. For context, we spoke to the CEO of a privately-owned facility who has over a decade of experience, including at UHS. The Private Facility CEO estimates that his current facility has 40 to 50% more staff relative to patients than the former PSI facility he managed at UHS (which we believe approximates the staffing levels at Acadia). Unsurprisingly, he believes the patient care at his facility is much improved and patient safety issues are now limited because he has more staff than before.

Acadia has little room to weather increased expenses or reduced revenues because it has over \$3.2 billion in debt it needs to service. Leverage stands at more than 5x Debt/EBITDA, already at the high end of Jacob's stated objective of "operating not much higher than the 5 times [Debt/EBITDA]". Acadia is also significantly more levered than PSI was, which was operating at approximately 3.7x Debt/EBITDA in 2009 according to Bloomberg data.

We therefore see substantial downside potential in Acadia shares.

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