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STATE OF MAINE
KENNEBEC, ss.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-088

PAUL BATES, et al.,

Plaintiffs

v.

COMMISSIONER,
DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

Defendants

COURT MASTER'S PROGRESS
REPORT PURSUANT TO
PARAGRAPH 299

The following report covers the period from August 1, 2015 to January 31, 2016.

Riverview Psychiatric Center

Since the representatives of the Department and Riverview appeared before this Court to present their plan of correction in response to the site visit report of Elizabeth Jones dated November 3, 2014, a second site visit occurred on September 22-24, 2015. This follow up visit was conducted by Ms. Jones for the purpose of evaluating whether the actions promised by Riverview's leadership had been implemented in a timely and thorough manner. The report of this visit, submitted October 26, 2015, concluded that the plan of correction had not been accomplished in several respects. Although there is dispute on some of these issues, after conferring with the Court, counsel and representatives of the Department, I have undertaken a further review of the operations of Riverview, together with a two day site visit in the company of the Division of Licensing and Regulatory Services, for the purpose of determining whether formal recommendations could be helpful in facilitating and promoting improvement. I conclude that formal recommendations are in order:

1. I recommend that Riverview implement unit based staffing on a pilot basis in one of the four units on or before April 4, 2016 with implementation on all other units to be completed on or before August 1, 2016.

In its plan of correction submitted to the Court, the Department proposed a move to unit based staffing, accompanied by an acuity based staffing model "with a unit by unit roll-out and full implementation by December 2015." Unit based staffing has not been accomplished and a consulting service for acuity based staffing has been selected but a contract has not yet been finalized. There have been recent changes in nursing leadership and I am encouraged that the new Director of Nursing has the experience, training and intention to implement unit based staffing in the near future. My recommendation is designed to put a timeframe on that effort. The work that is being done on acuity based adjustments to staffing, may eventually bear fruit but it need not delay the implementation of unit based staffing.

2. I recommend that the newly created positions for acuity specialists not be counted for purposes of determining compliance with the staffing ratios for mental health workers required by the Consent Decree. This change is designed to ensure that acuity specialists are assigned to their designated tasks and not used as substitutes for mental health workers.

The position of acuity specialist was created after the fallout developed from the use of correctional officers for dealing with clients who presented more challenging and aggressive behaviors. The position is not referenced in any way in the staffing ratios established by the Consent Decree. As designed by the hospital, acuity specialists have either more education or more experience than mental health workers and they are trained more intensively by the Psychology Department. Their training includes advanced intervention strategies for physical restraint and de-escalation. There are examples in the hospital of acuity specialists intervening effectively with challenging clients. Routinely, however, acuity specialists have been assigned to perform as mental health workers in order for the hospital to deal with unit acuity and to maintain the mental health worker/client ratio of 1 to 6 or 1 to 8. Often, an acuity specialist is counted and assigned to work as a mental health worker. As a result, the higher paid personnel work side by side with mental health workers and their time is devoted to meeting the needs of the clients for assistance in daily living, taking vital signs, escorting clients within the hospital as well as for fresh air breaks and visits to the community. The net result is that the assigned functions of the acuity specialist to prevent challenging behaviors and intervene when necessary are not realized. If the hospital's goal is to eventually move to a single class of mental health worker, it should forthrightly declare that goal and take the budgetary and management steps necessary to accomplish it. The existing confusion over the relative roles of mental health worker and the acuity specialist serves neither the interest of the client, staff nor the hospital.

3. I recommend that an annual review of restrictive practices and the management system being used by the hospital be conducted by a fully independent consultant, with the report of the first review due on or before August 1, 2016. The scope of the review and the selection of the independent consultant to require the approval of the Court Master.

Although Paragraph 188 of the Consent Decree requires a semi-annual examination of restrictive practices by an independent consultant, no such reviews have been conducted in recent years. In response to the recommendation in the Jones Report that the reporting requirements of Paragraph 188 be completed as mandated, the hospital undertook to conduct a review of its management system (MOAB) and its seclusion/restraint practices in 2015. The reports that resulted were unsatisfactory in that they were neither complete nor independent.

4. I recommend that the staffing ratio for mental health workers be adjusted to require the assignment of an additional mental health worker if one to one staffing by a mental health worker is mandated for a client on the unit.

The Consent Decree obligates the hospital to maintain staff "sufficient to carry out the requirements of this Agreement" and then specifies minimum ratios. As a matter of hospital policy, the staffing ratio for mental health workers is not presently adjusted for the first one to

one assignment of a mental health worker for a client on a unit. Thus if a unit has twenty four clients, four mental health workers are required at a minimum. If one worker is assigned to cover one client, the remaining three workers share twenty three clients. Only in the event of a second one to one assignment or a two to one assignment does the hospital adjust the staffing assigned to the balance of the population. The policy creates an exception unrecognized by the Consent Decree and effectively reduces the minimum staffing ratio.

5. I recommend that mental health workers attend treatment team meetings for the clients they work with and that acuity specialists attend whenever appropriate. Current and relevant portions of the treatment plans, such as interventions should be made available to mental health workers.

At present the hospital is experiencing significant turnover in the psychiatric and nursing staff thereby limiting the opportunities for continuity of care and the establishment of trusting relationships. Under such circumstances, the mental health worker is often the one person who knows the client best and yet is not included in the treatment team meetings nor familiarized with the treatment plan that results from that meeting. Although some units currently have a book of treatment plans available for mental health workers, they are not kept current and their use is infrequent. (See Attachment A, statement of deficiencies from licensing survey conducted 1/13/16.)

6. I recommend that unit activity logs be maintained on each unit and that the logs be reviewed at least on a monthly basis to determine whether any limitation in a client's access to treatment, services or outdoor areas has occurred.

In response to the initial Jones report, the hospital adopted as a Quality Improvement Measure the requirement that "Unit activity logs will be reviewed on a monthly basis to determine whether any limitations in a patient's access to treatment or services occurred." In fact, activity logs are not maintained on all units and there is no readily available means of determining the validity of complaints regarding the limitation of outdoor access or other treatment or services occasioned by the staffing shortages that the hospital now experiences.

In addition to the recommendations above, I would note that there are other initiatives underway to address some of the shortcomings in the hospital's execution of its own plan of correction. The most critical issue at present is the need to fill serious staff vacancies that exist in the ranks of direct care workers. At present, the hospital is absorbing these vacancies by the use of overtime and mandated shifts at a level that is not sustainable. The use of overtime varied between 1500 to 2000 hours per month during the last quarter of calendar year 2015. Mandated shifts for nurses increased from eleven in the prior quarter to twenty nine. Mandated shifts for mental health workers increased from 125 to 135 over the same quarters. Staffing shortages affect other aspects of the hospital's operation. For example, only 80% of newly admitted clients were informed of their rights. Only 51% of Level I grievances were responded to in a timely manner, while data was not available for Level II grievances. No institutional reports for forensics clients were submitted in a timely manner, and the annual report to the Commissioner, due in December, regarding all NCR clients has not yet been prepared. Staff training in non-violent communication and motivational interviewing was not conducted during the last two quarters. The incidence of seclusion and restraint remains above the national average. I point

these deficiencies out only to emphasize the seriousness of the staffing shortages in direct care positions.

As of January 19, 2016, the hospital had fifty one total staff vacancies of which forty seven involve direct care. Within that number there are three vacancies for acuity specialists out of a total of twenty authorized, thirteen vacancies for mental health workers out of 124 authorized and twenty three nursing vacancies out of a total of eighty seven authorized. In the five-week period leading up to January 19, the hospital had hired twenty five direct care positions. Acuity specialists accounted for three, nurses accounted for seven and mental health workers accounted for fifteen. One of the acuity specialists hires involved an internal candidate, two of the nurse hires involved an internal candidate and six of the mental health worker hires involved an internal candidate. Thus the net gain leading up to January 19, was sixteen direct care positions. Nursing shortages amounting to 25% of the authorized total is undoubtedly the most pressing problem.

Staffing for psychiatrists and psychiatric providers is adequate in numbers but lacking in continuity. Out of a total of eleven providers, six are engaged long term and five are engaged for terms ranging from six weeks to six months. Continuity of care and the development of trusting relationships is difficult to maintain under such circumstances. The hospital is actively recruiting and I will continue to monitor staff recruitment and retention and the use of overtime and mandated shifts on a weekly basis. The Director of Nursing is currently addressing nursing structure and leadership within the hospital and I will monitor his efforts in that regard. In addition, the Director acknowledges the need for substantial work in the treatment planning process (also referred to in the attached statement of deficiencies) and I shall monitor the efforts of the Superintendent, aided by input from the clinical departments, mental health workers, advocates, peer specialists and clients, to improve the process and the resulting plans. Because I view the current situation as critical, I shall report promptly to the Court if there any developments that seriously affect the quality of client care and I will promptly make further recommendations regarding the management and operation of Riverview if it becomes necessary.

Developments in Community Mental Health

The additional funding for mental health services for the current fiscal year included in the biennial budget has been fully encumbered and allocated across types of service and among providers. The service breakdown is reflected on Attachment B. It should be noted that more than half of the roughly \$5.8 million for persons ineligible for MaineCare has been directed toward community integration, the basic service that is a gateway to other services. As yet, there has been only a modest improvement in the waitlist for community integration, but the additional funding, taken in combination with the Department's efforts to manage the waitlist more aggressively, should yield improvement in the coming months. The Office of Substance Abuse and Mental Health Services (SAMHS) has added a new position to manage the waitlists and is tracking not only the waitlists of each provider, but the amount of additional grant funding that the provider has available, plus the staff to client ratio for the provider's existing staff of caseworkers. Executed effectively, this is a management initiative that should ensure that

existing capacity is optimally used and that the need for additional capacity can be identified. I will continue to monitor service waitlist data in the coming months.

In October, The MaineCare Services Division of the Department proposed amendments to Section 17 of the MaineCare Benefits manual. The amendments would eliminate coverage for persons diagnosed solely with post-traumatic stress disorder or depression not otherwise specified. In addition, the amendments would require an initial face to face intake or assessment within 7 days of referral for community integration services. Although this time frame deviates from the requirements of the Consent Decree, it represents a reasonable effort to improve the management of provider services and should complement the Department's other efforts to eliminate undue delay in service delivery. I have no objection to any of the proposed amendments. A hearing has been held and the comment period has passed. I would expect that the amendments will be promulgated in the near future.

Although the results have not been realized as yet, I am persuaded that the Department is slowly and incrementally improving its ability to manage the provider contracts through which it provides community mental health services such as community integration and ACT services. The Department provides no direct mental health services directly, rather it provides services indirectly through contracts that it maintains with private providers. Thus, the ability to manage contracts effectively is an important measure of SAMHS' performance. There is one area of service, however, that chronically presents problems. When clients at Riverview no longer require hospitalization and are clinically ready for a less restrictive placement, such as a group home or supported apartment, there is often significant delay as the social workers and SAMHS' gatekeepers negotiate with community providers to accept the referral. For example, during the week of January 18, 2016, there were twelve civil clients awaiting placement after being declared clinically ready to leave the hospital. Those twelve, one quarter of the hospital's civil capacity, had been waiting anywhere from fifteen to ninety days for placement. Collectively, they represent 444 days of unnecessary hospitalization at a time when the hospital is struggling with staffing and has other clients waiting for admission. The delays in placement are sometimes occasioned by the fact that there are no vacancies, but even when placements are available unnecessary time is consumed in securing the providers agreement to accept the referral. This practice exists in violation of the Paragraph 277 of the Consent Decree, which provides that the Department's:


contracts with agencies for the provision of mental health services shall require the individuals or agencies to accept referrals of all class members. Once the interdisciplinary team determines that the class member requires specific services, no agency under contract with the (Department) may refuse those services except when, in the case of a residential facility, there are no vacancies, and in the case of other services, the extension of services would cause the agency to exceed pre-established staff/client ratios.

Paragraph 51 provides that agencies under contract shall be subject to sanctions for non-compliance. The enforcement of Paragraph 277 would substantially reduce the delay that Riverview experiences in placing clients in less restrictive settings once clinical readiness has been achieved.

Because SAMHS is currently undergoing reorganization and may need to modify the referral process to accommodate Paragraph 277, it is appropriate to provide a grace period for the implementation of this long-standing but neglected requirement of the Consent Decree.

1. I recommend that commencing July 1, 2016, the Department enforce the provisions of Paragraph 277 and 51 for providers receiving referrals from treatment teams at Riverview for community mental health services for Class Members.

Dated: February 8, 2016



Daniel E. Wathen, Court Master

Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ME20140227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/13/2016
NAME OF PROVIDER OR SUPPLIER RIVERVIEW PSYCHIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 250 ARSENAL ST AUGUSTA, ME 04330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments State Hospital Complaint: ME20977 Riverview Psychiatric Center, an Acute Care Psychiatric Hospital, is not in substantial compliance with State of Maine 10-144 C.M.R. Ch. 112: Rules for the Licensing of Hospitals. Deficiencies were issued during the onsite complaint investigation completed on January 13, 2016.	P 000		
P303	3.1.2 Standards Standards Federal standards and certification requirements A violation of any of the federal standards and certification requirements constitutes a violation of the state of Maine Rules for the Licensing of Hospitals, 10-144 C.M.R. Ch. 112. This Regulation is not met as evidenced by: Based on review of medical records and interviews with key staff, the facility failed to assure that all services ordered were provided consistent with the requirements at 42 C.F.R. §482.61(c)(i); §482.61(c)(i)(iii); §482.61(c)(i)(iv); and §482.61(c)(2). §482.61(c)(i): Based on interview and record review, the facility failed to ensure that the treatment plan and treatment team considered all assessments of patient strengths and disabilities for 1 of 10 records reviewed (Patient C). Finding: The clinical record for Patient C contained a	P303		

Department of Health and Human Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Department of Health and Human Services

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P303	<p>Continued From page 1</p> <p>Psychological Assessment report dated 12/4/15 that stated, "ADL-Occupational skills, primary treatment interventions should be targeted at tolerating distress, controlling anger, and irritability, improving independent living skills, increasing insight into negative behaviors, and identifying motivations for reducing substance abuse." The treatment plans dated 12/15/15 and 1/7/16 as well as the physician progress note dated 1/7/16 lacked evidence that the targeted interventions outlined in the 12/4/15 Psychological Assessment report were implemented or considered. This finding was reviewed with the "Team A" Charge Nurse on 1/12/16 at 10:48 AM who confirmed the finding and indicated it would be the provider's responsibility to review the Psychological Assessment and bring the recommendations to the treatment team. The Charge Nurse stated that she had no recollection of the treatment team discussing the 12/4/15 Psychological Assessment report.</p> <p>§482.61(c)(i)(iii): Based on interview and record review, the facility failed to ensure that the treatment plans used by all applicable staff were consistently updated on 2 of 4 patient units. Additionally, the facility failed to ensure that the treatment plans addressed modality approaches with enough specificity to ensure consistency with the approach and the intended focus of the active treatment for 2 of 10 records reviewed (Patient's C and D).</p> <p>Findings:</p> <p>1. While conducting a staff interview on 1/13/16 at approximately 10:08 AM, on the Upper Saco Unit, the surveyor was told that Mental Health Workers (MHW) are provided with patient</p>	P303		

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P303	<p>Continued From page 2</p> <p>treatment plans in a 3 ring binder at their work station behind the nurses desk. This binder contains a copy of each patient treatment plan which has the interventions relevant to the MHW highlighted for them. The surveyor reviewed the contents of the MHW Treatment plan book with the Charge Nurse on 1/13/16 at 10:10 AM who confirmed that the treatment plans contained in the MHW treatment plan book had not been updated since 10/17/15.</p> <p>2. On 1/13/16 at 1:10 PM, the surveyor reviewed the MHW Treatment Plan book for the Lower Saco Unit with the Treatment Team Coordinator. This book contained patient treatment plans with interventions specific to the MHW highlighted in yellow. The most recent patient treatment plan within this book was dated 12/17/15. The Treatment Team Coordinator confirmed that this book did not contain the most recent treatment plans for the patients currently on the unit.</p> <p>3. The most current treatment plan in effect for Patient C was dated 12/30/15 and contained a psychologist intervention that stated "Psychologist will offer to meet with Patient C two times a week for up to 60 minutes per session." The treatment plan lacked the focus of these meetings or how this treatment modality would assist the patient in meeting short or long term goals. This finding was confirmed with the Charge Nurse on Upper Saco on 1/13/16 at 1:45 PM.</p> <p>§482.61(c)(i)(iv) Based on interview and record review, the facility failed to ensure that all disciplines involved in the patient's treatment were aware of their current responsibilities and particular aspects of the current treatment plan. For 2 of 4 patient treatment units reviewed (Upper and Lower Saco</p>	P303		

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P303	<p>Continued From page 3</p> <p>Units).</p> <p>Findings Include:</p> <p>1. While conducting a staff interview on 1/13/16 at approximately 10:08 AM, on the Upper Saco Unit, the surveyor was told that Mental Health Workers (MHW) do not attend the treatment team meetings and that they are provided with patient treatment plans in a 3 ring binder at their work station behind the nurses desk. The surveyor reviewed these books on both Upper and Lower Saco Units and found that they both contained outdated treatment plans. On 1/13/16 at 2:05 PM, during an interview with the Registered Nurse Manager, the surveyor was informed that the treatment team nurse would inform and update the Mental Health Workers regarding any changes in the treatment plan relevant to them on the day of the treatment team meeting. However, it was acknowledged that this was not an effective means of communicating change in treatment plan modalities to staff not present on the day of the treatment team meeting.</p> <p>42 C.F.R. §482.61(c)(2). Based on review of medical records and interviews with key staff, the facility failed to assure that services ordered were provided at the frequency, intensity, and duration prescribed in the individualized Plan of Care, and that progress notes documented the services provided and the patient's response to these services for 2 of 19 current patients (Patient's A, and B) receiving services from the psychology department.</p> <p>Findings include:</p> <p>1. The Treatment Plan Goal/Intervention Sheet</p>	P303		

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P303	<p>Continued From page 4</p> <p>for patient A dated November 5, 2015, stated under the heading titled "Interventions" that the psychologist "Will offer to meet with [pt. name] up to 60 minutes per week for individual psychotherapy to monitor affect regulation, developmental factors related to emotional stability." There was no date provided indicating the initiation of this goal. The plan indicated that the current Long Term Goal was dated September 10, 2015 and the goal end date identified as December 4, 2015.</p> <p>A review of the electronic patient record indicated that only three (3) progress notes were entered by a Licensed Psychologist for this patient. These notes were dated; September 7, 2015 (30 minutes), September 14, 2015 (60 minutes), and October 26, 2015 (60 minutes). Additionally; all three progress notes were marked as dictated on October 28, 2015. A listing of all notes by "provider type", "Psychology", does not indicate any additional documentation by a Licensed Psychologist. The listing does include multiple notes by psychology interns; however the plan of care has specific interventions to be provided by interns. There was no evidence to validate that the patient was provided/attempted up to 60 minutes weekly interventions by a Licensed Psychologist as indicated in the Treatment Plan.</p> <p>2. The Treatment Plan Goal/Intervention Sheet for patient B dated November 30, 2015, stated under the heading titled "Interventions" that the psychologist "Will attempt to meet with [pt. name] 1 time a week per initial referral to accompany on vending trips when clinically indicated." There was no date provided indicating the initiation of this goal. The plan indicated no start date for the current Long Term Goal, but stated; "within 60</p>	P303		

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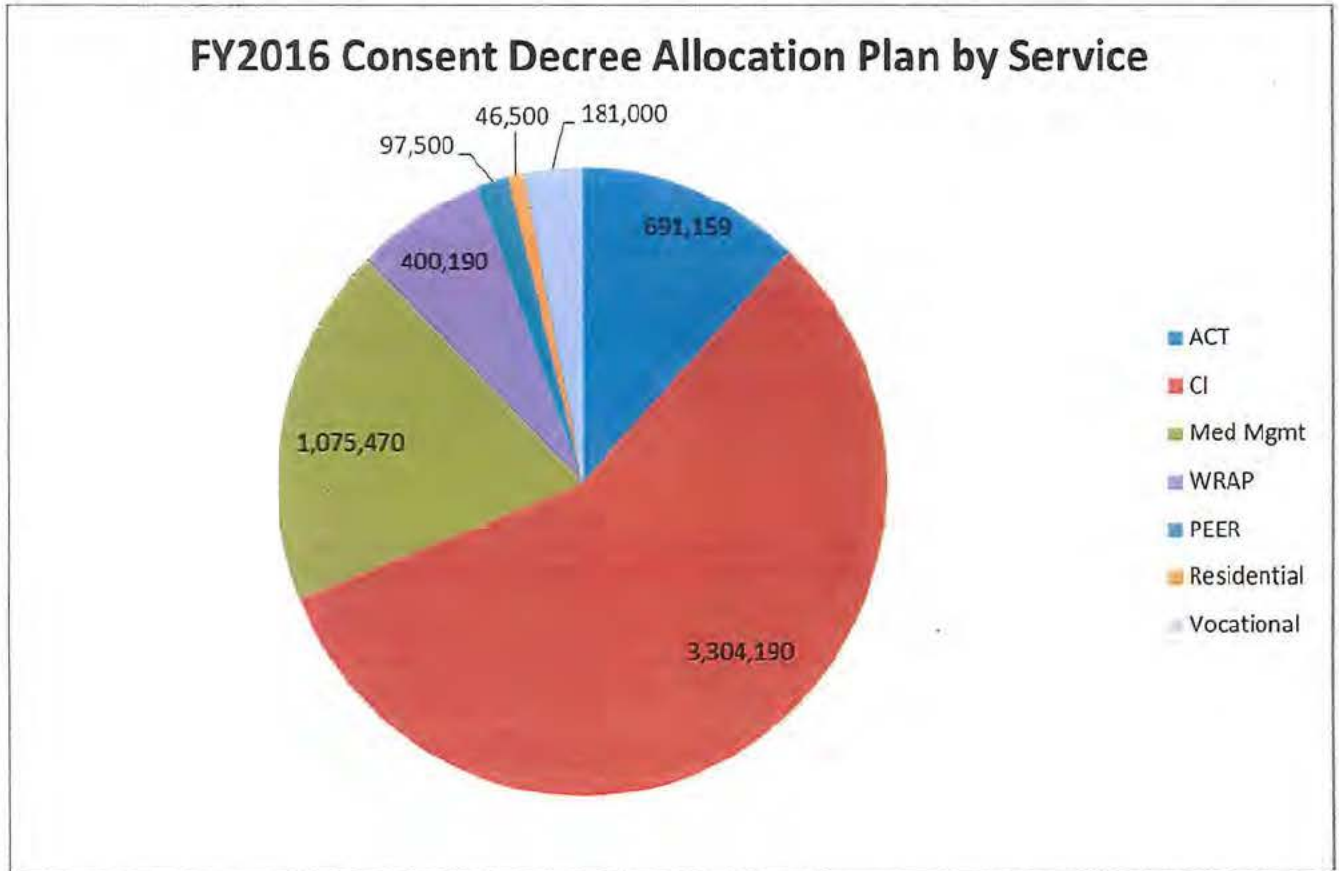
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P303	<p>Continued From page 5</p> <p>days". There was also no target date for the long term goal; however the short term goal end date was identified as December 14, 2015.</p> <p>Only one (1) psychology progress note was provided, and it was dated August 27, 2015. A listing of all notes by "provider type", "Psychology", indicated that the last note entered by any psychology practitioner was dated November 19, 2015. There was no evidence to validate that the patient was provided/attempted weekly interventions by a Licensed Psychologist as indicated in the Treatment Plan.</p> <p>The ongoing lack of documentation of observations and interventions, and the failure to document on the date of service, prevents pertinent patient information from being available to other team members.</p> <p>These findings were confirmed by the Director of Risk Management on January 13, 2015, at approximately 1:00 PM.</p> <p>3. The most current treatment plan in effect for Patient C was dated 12/30/15 and contained a psychologist intervention that stated "Psychologist will offer to meet with Patient C 2 times a week for up to 60 minutes per session." The treatment plan lacked the focus of these meetings or how this treatment modality would assist the patient in meeting short or long term goals. Additionally, the clinical record lacked sufficient recording of staff observations and patient response relative to the specific treatment modalities in order to evaluate their effectiveness. This finding was confirmed with the Charge Nurse on Upper Saco on 1-13-16 at 1:45 PM.</p>	P303		

Maine Department of Health and Human Services
Office of Substance Abuse and Mental Health Services

Consent Decree Overview

Budget: Consent Decree (010 14A Z16301) as originally allocated covered seven core services: Community Integration; Assertive Community Treatment; Medication Management; Peer Support; Residential Treatment; Supported Employment; and Wraparound. The Legislatively approved budget for Fiscal Year 2016 is \$5,797,300 and is planned to be encumbered as shown:



Fiscal Year 2016 Service Breakdown:

ACT	CI	Med Mgmt	WRAP	PEER	Residential	Vocational
\$691,159	\$3,304,190	\$1,075,470	\$ 400,190	\$ 97,500	\$ 46,500	\$ 181,000
11.92%	57.01%	18.56%	6.90%	6.90%	0.80%	3.12%

Fiscal Year 2015 Contracts Carried Forward:

ACT	CI	Med Mgmt	WRAP	DLSS
\$ 232,967	\$1,179,106	\$ 98,804	\$ 143,678	\$ 5,000