Summary of Deficiencies
May 2018

- The physical environment contained numerous hazards that resulted in actual harm, patient attempts at self-harm and suicide attempts. These included ligature risks.

- Systems for visual observation and supervision of patients when in high risk or vulnerable areas, or when engaging in high risk or vulnerable activities were lacking.

- The majority of patient rooms observed had significant "blind spots" in camera views that created the opportunity for patient self-harm or suicide without immediate detection.

- Clear processes and supplies/equipment for responding to urgent and emergency patient conditions were lacking. Responses were inconsistent.

- All staff had not received training as required by the Code of Federal Regulations or by hospital policy.

- Physical environment and security measures to prevent patient elopement were not effective.

- Restraint and seclusion policies and procedures were not fully developed to ensure staff were trained and demonstrated knowledge.

- The hospital failed to ensure ongoing assessment and monitoring of patients who were in physical restraints and/or seclusion.

- The governing body failed to ensure the provision of safe and appropriate care to patients in the hospital.

- The hospital failed to fully develop and implement policies and procedures that ensured that patient's rights were recognized, protected and promoted.

- Investigations of and response to actual or alleged abuse or neglect were not timely or complete.

- Response to patient's complaints and grievances were not timely or complete.

- Patients were not informed of their rights as required.

- Medicare beneficiaries did not receive Important Message from Medicare as required.

- Patients did not receive advance directives information as required.
Drugs, restraints and other interventions were not administered in accordance with physician orders.