

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 074014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2019
NAME OF PROVIDER OR SUPPLIER SILVER HILL HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 208 VALLEY ROAD NEW CANAAN, CT 06840		
(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) COMPLETION DATE
A 000	INITIAL COMMENTS A substantial allegation survey concluded on 2/27/19 in response to CT24935. The Conditions of Participation for Patient Rights and QAPI were reviewed. The Condition of Participation for Patient Rights and QAPI have not been met.	A 000			
A 115	Silver Hill Hospital 208 Valley Road New Canaan, CT 06840 PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: The Condition of Participation for Patient Rights has not been met. Based on clinical record reviews, facility policy reviews, and staff interviews for 4 of 10 sampled patients (#2, #7, #8, and #17) who were admitted to the Transitional Living Program (TLP), the hospital failed to ensure that the patients were cared for in a safe setting when staff failed to conduct patient suicide risk assessments, failed to monitor and/or reevaluate the patients, and failed to implement appropriate interventions after the patients verbalized suicidal ideations. Please see A144	A 115	See Attachment A		

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

[Signature]

TITLE

Chief Quality Officer

(X6) DATE

3/27/19

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 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on clinical record reviews, facility policy reviews and staff interviews for five (5) of ten (10) sampled patients (Patients #2, # 7, # 8, #11 and #17) who were admitted to the Transitional Living Program (TLP), the hospital failed to ensure that bed checks and/or monitoring checks were completed in accordance with MD order, and/or that patients were reevaluated by the physician subsequent to identified concerns, and/or that suicide risk assessments were completed when the patient expressed suicidal thoughts, and/or patients were transferred to the acute unit as needed in accordance with facility policy. The findings include: a. Patient #2 was admitted to the facility on 1/22/18 with anxiety and depression and a recent suicide attempt. The patient had a history of pain and neurological autonomic dysfunction. Review of the Multidisciplinary Treatment Plan (MTP) dated 1/22/18 indicated that the patient's active problems included in part, Depression and Psychosis. A Residential Counselor (RC) note dated 2/15/18 at 2:22 PM indicated that Patient #2 had used the hospital's shared computer tablet and then returned to his/her room. After the computer tablet was returned there were concerning websites that were observed. RC #1's note indicated that this was shared with the treatment team members and that Patient #2 met with the treatment team to discuss the concerns.	A 144	See Attachment B See Attachment C		

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A 144	Continued From page 2 Interview with RC #1 on 2/13/19 at 1:30 PM indicated that she checked the unit computer tablet after Patient #2 had used it on 2/15/18 and was concerned about the websites the patient had visited. RC #1 reported this concern to the physician. Review of the physician's note dated 2/15/18 at 6:00 PM reflected that a review of the computer tablet history was completed by staff and identified searches related to suicide methods, autopsies, and an obituary in Patient #2's name. The note identified that Patient #2 repeatedly denied suicidal and homicidal ideation during the team interview and it was agreed that Patient #2 could stay in the transitional program safely and the patient would be reevaluated the next day (2/16/18). The record failed to reflect that a reevaluation of Patient #2 was completed on 2/16/18. Review of bed check documentation completed by RC #3 dated 2/17/18 indicated that bed checks were completed at 1:00 AM, 3:00 AM, 5:00 AM and 7:00 AM. The note indicated in part that the patient was observed sleeping through the night during periodic safety checks and no other issues at that time. A physician progress note dated 2/17/18 identified that the physician responded to a code on 2/17/18 at approximately 8:30 AM and upon arrival, Patient #2 was unresponsive, pulseless, cyanotic, and extremities were cold. Cardio Pulmonary Resuscitation (CPR) was in progress and continued with Emergency Medical Services (EMS), however, was unsuccessful. Interview with the Program Director on 1/14/19 at	A 144			

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A 144	Continued From page 3 11:20 AM indicated that at the time of the incident it was determined that the 7:00 AM bed check was not completed and RC #3's employment was terminated at that time. The Program Director indicated that the expectation is for staff to lay eyes on the patient and ensure that the patient's chest is moving. Interview on 2/14/19 at 11:15 AM with the Director of the Transitional living program stated subsequent to this event, bed check policies were standardized throughout the transitional living programs, all staff were reeducated on the bed check policy, orientation was formalized, and physician reeducation was completed. The Director further stated that a committee was created and a cross section of staff meet monthly to address concerns and a "hotspot" reporting system was developed to allow staff to communicate any concerns on a daily basis which are reviewed by the Assistant Director of Transitional Living Program daily. The Bed Check policy directed that the RC is responsible to check each bed making sure that the patient is breathing and the bed check form is to be completed only after having viewed the patient. b. Patient #7 was admitted to the facility 1/23/19 with diagnoses that included anxious affect, emotional distress, flashbacks and intrusive thoughts. Review of the treatment plan dated 1/25/19 identified the patient with a mood disorder with interventions to identify triggers and coping skills. Review of the clinical progress note dated	A 144	See Attachment D See Attachment E See Attachment F See Attachment G		

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A 144	Continued From page 4 2/12/19 at 4:05 PM identified Patient #7 verbalized "I'm so depressed, I have constant thoughts about dying, like it would be good to just die, not that I'd stab myself in the heart or anything, it would just be a relief." "I've been pretending that everything's fine but I've been pulling out my hair at night, my thoughts are racing." The note identified that the MD joined the session and Patient #7 further identified that he/she had passive suicidal ideation but had also engaged in risky behavior. Patient #7 identified that on the way to the dining hall he/she crossed the street without looking either way, being hit by a car would be a relief, and stated that he/she had no plan or intent to killself. Review of the Transitional Living Program (TLP) MD progress note dated 2/12/19 at 3:15 PM identified that he met with the patient briefly with the Social Worker regarding reports that the patient is "freaking out", thoughts are racing, and the patient is finally feeling "how I usually am". The note identified that the patient feels that he/she was manipulating staff, that medications haven't been working, that he/she has been secretly pulling out hair at night, he/she has been secretly wishing not to wake up and was behaving in a risky way. The note further identified that Patient #7 did not have a specific plan to harm her/himself and reports that he/she will stay alive until the next day when he/she can meet with MD to discuss further options. Further review of the progress note identified that Patient #7 was to remain in the house on 30 minute checks until a meeting the following day and to withhold additional sharps. The MD progress note failed to identify what withholding additional sharps meant.	A 144			

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A 144	Continued From page 5 A physician's order dated 2/12/19 at 3:06 PM directed to continue routine medications, Seroquel 50 mg every 2 hours as needed, not to exceed 100 mg and patient to remain in house with 30 minute checks until meeting tomorrow. Review of the Residential Counselor Daily Shift Note dated 2/13/19 at 6:49 AM identified bed checks were completed to ensure patient safety every half hour from 11:00 PM to 6:30 AM. The note identified that the patient appeared to be asleep during checks. Review of the daily report sheet on 2/13/19 at 10:30 AM identified under Patient #7's name, boxes were drawn in and checked every half hour identifying that 30 minute checks were completed. Review of the report sheet noted that the time slots for 11:00 AM and 11:30 AM had already been checked even though it was only 10:30AM. Further review noted the documentation lacked the location of the patient, the behavior of the patient and who completed the checks. Interview with Residential Counselor (RC) #2 on 2/13/19 at 10:30AM stated the patient reported during a session with Social Service of not wanting to wake up the next morning and subsequently 30 minute checks and house restriction were implemented until the physician could reevaluate the following day. RC #2 stated although the MD documented "withhold additional sharps", nothing was put in place to prevent the patient from obtaining sharps and she did not check the patient's room for sharps during the 30 minute checks. Tour of the TLP area and interview with RC #2 identified that the kitchen	A 144			

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A 144	Continued From page 6 had knives and other utensils available/accessible to patients. RC #2 further identified that she made check boxes on the daily report sheet for the every half hour checks and was unsure if there was a policy in the transitional living units for every 30 minute checks. Review of the clinical record with the Director of the TLP on 2/13/19 at 10:00 AM failed to identify that a suicidal risk assessment was completed when Patient #7 verbalized thoughts of wanting to die. Additionally, the treatment plan failed to identify suicidal ideation and/or interventions to monitor and/or assess the patient for safety. The TLP Director stated that recently, a new policy was implemented to complete a suicidal assessment on any patient who verbalizes suicidal ideation (SI) and/or has 3 or more increased risk factors on the daily diary sheets the patients complete. Interview with the Director of the TLP on 2/13/19 at 11:00 AM stated that there is no policy for every 30 minute checks in the transitional living area. The Director stated that normally, patients check in every few hours as part of the program schedule. The Director further stated that there is no form to identify the location of the patient, the behaviors the patient may be exhibiting and who completed the checks. Review of the TLP Physician Progress Note dated 2/13/19 at 11:02 AM identified that Patient #7 was still feeling dysphoric and anxious, has ongoing suicidal ruminations, no plans to harm self and does not feel he/she is a safety risk. Patient was agreeable to taking the van to	A 144			

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A 144	Continued From page 7 different places and having frequent checks , but doesn't feel/want that he/she needs to go inpatient. The note further identified the patient was agreeable to continued 30 minute checks and to increasing Seroquel. Review of the Suicide Assessment policy for the Transitional Living Program identified an assessment will be completed if there is increased suicidal risk due to a patient's behavior and/or presentation, and if there is a 3 point increase in self-harm urges and/or suicidal ideation reflected on the patient's diary card. The policy further identified if the patient is scored as high risk the treatment team and/or nursing supervisor are notified and the patient will remain visible in the milieu until assessed by the on-duty doctor. Additionally, the policy directed that the doctor will order interventions indicated by conducting a mental status exam, clinical observation, a review of the Suicide Severity Rating Scale (C-SSRS) and collaboration with the treatment team, with possible interventions may include but not limited to transfer to a crisis bed or a higher level of care. c. Patient #8 was admitted on 2/4/19 with diagnoses of depression, emotional distress and self-harm. The Multidisciplinary treatment plan dated 2/5/19 identified personality disorder with interventions to educate the patient, medication management, and report the ability to manage self-harm impulses. Review of the Suicide Severity Rating Scale (C-SSRS) dated 2/12/19 at 5:27 PM identified the patient as high risk for SI.	A 144	See Attachment E		

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A 144	Continued From page 8 Review of the TLP, Residential Counselor (RC) daily shift note dated 2/12/19 at 10:21 PM identified that Patient #8 requested skills coaching for increased sadness. The note identified the patient was tearful and crying while stating "I hurt so much and can't take it." The note identified Patient #8 was fearing a discharge living plan and being alone most of the time. The note further identified when the patient was asked questions regarding his/her safety the patient did not respond. When asked if the patient had a plan of self-harm Patient #8 responded "which place". The note identified the patient reported on planning to self-administer "all of his/her pills" when at home and has thoughts of eloping from the TLP program. Additionally, the note identified a suicidal risk assessment was completed and noted Patient #8 to be at high risk of self-harm. The Director was made aware, the physician assessed the patient and the patient was placed on a 1 to 1. Review of the physician's progress noted dated 2/12/19 at 11:31 PM identified he/she was called to evaluate the patient after scoring high risk on the C-SSRS and thoughts of eloping. The note identified the patient was feeling frustrated because he/she was scared of having ECT therapy. The note identified that although the patient may commit suicide eventually at home or somewhere else, he/she does not have thoughts/plans of doing so at the facility. The note further directed staff to check the patient every 30 minutes. Review of the daily report sheet on 2/13/19 at 10:45 AM identified under Patient #8's name, boxes were checked every half hour with a check mark. Additionally, upon review, the time slot for	A 144			

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A 144	Continued From page 9 11:00 AM had already been checked even though it was 10:45AM. Further review noted the documentation lacked the location of the patient, the behavior of the patient and who completed the checks. Interview with RC #2 at that time stated that she made those boxes for the every half hour checks. Interview with the Director of the TLP Program on 2/13/19 at 11:00 AM stated that there is no policy for every 30 minute checks in the transitional living area, however, the RC's should not complete checks in advance. The Director further stated that the policy identified if a patient scores high on the suicide assessment a possible intervention is to transfer the patient to a crisis bed or a higher level of care. The Director stated that Patient #8 should have been transferred to the acute side of the hospital for an evaluation. d. Patient # 17 was admitted 2/11/19 with diagnoses included anxious affect, emotional distress, and intrusive thoughts. Review of the TLP Residential Counselor daily shift note dated 2/12/19 at 7:07 PM identified a call was received from Person # 3 around 9:30 PM stating that Patient #17 was calling and didn't sound stable. The note further identified that MSW #1 checked on the patient who did not appear agitated or not stable but admitted to having an argument with Person #3. The note further identified that Person #3 called back to the facility and reported she was really worried because Patient #17 was saying scary things and demanding to be discharged. MSW #1 documented that he	A 144	See Attachment E		

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A 144	Continued From page 10 checked on the patient again who denied making any threats and showed no signs of distress. Additionally, the note identified the nursing supervisor was notified and bed checks would be increased to 30 minutes throughout the night. The note further identified the C-SSRS assessment (suicide assessment) was completed and the patient was a low risk for SI and the treatment team was notified. Interview with MSW #1 on 2/15/19 at 4:40PM stated that Person #3 called to report that Patient #17 was saying scary things on the phone and felt the patient needed more observation. MSW #1 stated he went and spoke to the patient and felt there was no SI (Suicidal ideation) and was he/she stable. MSW #1 stated that Person #3 called again stating the patient was verbalizing suicidal ideation, not being rationale and needed to be in a crisis bed. MSW # 1 stated that he assured Person #3 that he had spoken to the patient and he/she denied making any suicidal ideations. MSW #1 identified he contacted the nursing supervisor, completed the suicidal assessment (low risk) and was directed to closely monitor the patient and place him/her on every 30 minute checks. MSW #1 stated that he reported to the 11-7 RC that the patient was to be monitored every 30 minutes per the nursing supervisor until seen by the MD. Review of the TLP Residential Counselor daily shift note dated 2/13/19 at 7:04 AM identified bed checks were completed every two hours throughout the night and not every 30 minutes as directed from the nursing supervisor. Interview with the Director of the TLP on 2/15/19 at 4:50PM stated that the night shift RC should	A 144			

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A 144	Continued From page 11 have done the every 30 minute checks as the nursing supervisor ordered until the patient was seen by the doctor in the morning. e. Patient # 11 was admitted on 1/28/19 with diagnoses of anorexia nervosa, borderline personality disorder, anxiety, depression and self-harm. The Multidisciplinary treatment plan dated 1/29/19 identified self-harm with interventions to educate patient on health consequences of high risk behaviors, feelings of self-harm and was on every 30 minute checks. Review of the TLP daily shift note dated 2/6/19 indicated that Patient #11 had no self-harm behaviors. Review of the TLP Residential Counselor (RC) daily shift note dated 2/8/19 at 5:12 pm identified that Patient #11 had burned him/herself intentionally on his/her hand with a coffee maker a few days ago but never told anyone. Review of the Suicide Severity Rating Scale (C-SSRS) dated 2/8/19 at 9:35 pm identified the patient as high risk for suicide ideation. Patient #11 was placed on every 15 minute checks. Review of the TLP RC daily shift note dated 2/8/19 at 10:41pm (time that the note was written) identified that after the RC's break earlier in the evening, Patient #11 was found crying hysterically, rolling around and lightly bumping her	A 144	See Attachment E		

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A 144	Continued From page 12 head against the ground. Patient #11 showed his/her hands to the RC that s/he had burned him/herself earlier on the coffee machine when the RC was on break. Patient #11 sustained three medium size white spots on his/her left hand and knuckle. Patient #11 was assessed by the nursing supervisor and the physician and was placed on every 15 minute checks for high risk for suicide. Patient #11 was not transferred out of the transitional living area to a higher level of care when identified as high risk for suicide ideation. Subsequently on 2/11/19 (3 days later), Patient #11 was sent to the Emergency Department and treated for second degree burns to the left/right hands which included antibiotics and sulfadiazine topical ointment every day. Review of the clinician progress notes dated 2/8/19 on the 7-3pm/3-11pm shift failed to identify that every fifteen minute checks were documented in the daily shift notes. Interview with the TLP Manager on 2/13/19 identified that after the patient had the second burn on 2/8/19, they removed the coffee pot, replaced it with a coffee pod machine and placed the patient on every 15 minute checks. Interview with the Director of the TLP Program on 2/13/19 at 11:00 AM stated that there is no policy for every 30 minute checks in the transitional living area and the patients check in every few hours that is part of the program schedule. The Director further stated that the policy identified if a patient scores high on the suicide assessment a possible intervention is to transfer the patient to a crisis bed or a higher level of care. Review of hospital policy identified that patients	A 144			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 074014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2019
NAME OF PROVIDER OR SUPPLIER SILVER HILL HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 208 VALLEY ROAD NEW CANAAN, CT 06840		
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A 144	Continued From page 13 who were assessed as a high risk for suicide would be assessed by the physician who would order interventions that may include a transfer to a crisis bed or a higher level of care.	A 144	See Attachment H		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. 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. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: The Condition of QAPI has not been met. Based on review of the hospital's QAPI program, associated documentation, and staff interview, the hospital failed to develop and implement performance measures to include patient safety in the Transitional Living Programs (total of seven).	A 263			
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)	A 283			

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A 283	Continued From page 14 (b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (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. (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. This STANDARD is not met as evidenced by: Based on review of the hospital's QAPI program, associated documentation, and staff interview, the hospital failed to develop and implement performance measures to include patient safety in the Transitional Living Programs (total of seven). The finding includes: Review of the hospital's QAPI program identified that the hospital's performance measures included patient falls, weight loss, and medication errors. The data collected through performance measures demonstrated that the data was being analyzed, tracked, and included ongoing reviews	A 283			

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A 283	Continued From page 15 of the performance measures. The hospital's QAPI program was reviewed with the Director, Performance Improvement and Risk Management on 2/27/19 at 9:20 AM. The QAPI program failed to include patient safety measures specific to the Transitional Living Program to include previously identified safety concerns with suicide risk assessments, safety monitoring and/or implementation of appropriate interventions to maintain patient safety. Although the hospital implemented suicide risk assessments in the TLP, the hospital failed to analyze the data gathered in the assessments or evaluate the effectiveness of patient safety interventions for patients identified as a moderate to high suicide risk.	A 283			

Corrective Action Plan – CMS
Attachment A

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A115	the hospital failed to ensure that the patients were cared for in a safe setting when staff failed to conduct patient suicide risk assessments, failed to monitor and/or reevaluate the patients, and failed to implement appropriate interventions after the patients verbalized suicidal ideations.	Upon identification of these deficiencies Hospital Leadership (Medical Director, CQO, CFO, Physician-in-Chief, D TLP/SW, DON, D Admissions) met to formulate immediate response to address concerns, and increase response to and monitoring of TLP patients identified at increased risk. Response is contained in attachments B-H herein.	Immediate CAP completed 2/22/19 Full CMS response contained herein completed 4/1/19	100 % of all patients identified as at increased risk requiring milieu safety interventions for compliance	Dir. TLP/SW

Corrective Action Plan – CMS
Attachment B

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A144 Pt a.	The record failed to reflect that a reevaluation of Patient #2 was completed on 2/16/18.	Physician who failed to reevaluate the patient was counselled in person by the Physician-in-Chief regarding the importance of reevaluating patients identified as increased acuity	2/19/18	100 % of all patients identified as at increased risk requiring milieu safety interventions for compliance	Physician-in-Chief

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A144 Pt a.	the 7:00 AM bed check was not completed	All staff responsible for safety checks was reeducated on the correct procedure and documentation of same. Reeducation took place in person. No staff member was allowed to work a next shift without completing reeducation. -Reeducation was also completed in the RC staff meeting. -Policy revised to have standardized safety checks in all adult programs. -Staff educated on policy change via email	-3/27/18	30 charts/month will be audited for compliance with safety checks. The audit will be completed by the senior staff person in each transitional living house.	Director of Transitional Living Programs
			-2/26/18		
			-4/6/18		
			-4/10/18		

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A144 Pt a.	the 7:00 AM bed check was not completed	All staff responsible for safety checks was reeducated on the correct procedure and documentation of same. Reeducation took place in person. No staff member was allowed to work a next shift without completing reeducation. -Reeducation was also completed in the RC staff meeting. -Policy revised to have standardized safety checks in all adult programs. -Staff educated on policy change via email	-3/27/18	30 charts/month will be audited for compliance with safety checks. The audit will be completed by the senior staff person in each transitional living house.	Director of Transitional Living Programs
			-2/26/18		
			-4/6/18		
			-4/10/18		

Corrective Action Plan – CMS
Attachment D

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A144 Pt b.	Further review of the progress note identified that Patient #7 was to remain in the house on 30 minute checks until a meeting the following day and to withhold additional sharps. The MD progress note failed to identify what withholding additional sharps meant.	All Medical Staff have been educated that any safety related milieu interventions must be documented in a physician order and discussed with milieu for purposes of clarification and planning.	3/27/19 in Medical Staff Meeting	100 % of all patients identified as at increased risk requiring milieu safety interventions for compliance	Physician-in-Chief
		All Residential Counselors have been educated to speak directly with MD regarding milieu safety intervention orders in the event the order is unclear or of concern	3/27/19	100 % of all patients identified as at increased risk requiring milieu safety interventions for compliance	Dir. TLP/SW

Corrective Action Plan –CMS
Attachment E

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Party
A144 Pt b. Pt c. Pt d. Pt e.	The hospital failed to ensure that the patients were cared for in a safe setting when staff failed to conduct patient suicide risk assessments, failed to monitor and/or reevaluate the patients, and failed to implement appropriate interventions after the patients verbalized suicidal ideations.	1)Team meeting will be held on all patients identified at increased acuity to determine appropriateness to remain in the transitional living setting. Team meeting to include attending physician, social worker, TLP manager, Physician-in-Chief, President and Medical Director, Director of Nursing. Each of the identified patients will be assessed in person by the attending psychiatrist.	2/15/19		Physician-in-Chief
		2)TLP policy to be revised to address process for all observation levels, which will be consistent with our inpatient process	2/15/19		Director of Transitional Living Program
		3)Tool will be created to document patients on increased observation at the time of the	2/15/19	100 % of all patients identified as at increased risk	Director of Transitional Living Program

Corrective Action Plan –CMS
Attachment E

		observation, to include where the patient was observed and how they are behaving, consistent with our inpatient process		requiring milieu safety interventions for compliance	
		4) Nursing Supervisors, Doctors and all residential counselors will be trained on the new policy prior to starting next shift.	2/15/19- 2/22/19		Director of Transitional Living Program
		5) TLP leadership will advise Nursing Supervisor daily of any patient on increased patient observation level. Nursing will monitor compliance with policy.	2/15/19	Nursing will monitor every patient on increased observation three times/week for the duration of the increased observation status.	Director of Nursing

Corrective Action Plan – CMS
Attachment F

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A144 Pt b.	Failed to identify that a suicidal risk assessment was completed when Patient #7 verbalized thoughts of wanting to die	All Residential Counselors were reeducated on the correct process for suicide risk assessment, including documentation and notification of clinical team	3/4/19	100 % of all patients identified as at increased risk requiring milieu safety interventions for compliance	Dir. TLP/SW

Corrective Action Plan – CMS
Attachment G

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A144 Pt b.	Additionally, the treatment plan failed to identify suicidal ideation and/or interventions to monitor and/or assess the patient for safety	All Residential Counselors have been educated to addend the Treatment plan in the event increased safety checks or other milieu safety interventions are initiated. Documentation to include the problem, objective and intervention related to increased acuity.	Educated electronically via email on 3/27/19 Educated in person at staff meeting on 4/1/19	100 % of all patients identified as at increased risk requiring milieu safety interventions for compliance	Dir. TLP/SW

Corrective Action Plan – CMS
Attachment H

Tag #	Deficiency	PoC	Date of Completion	Monitor	Responsible Person
A263 A283	Although the hospital implemented suicide risk assessments in the TLP, the hospital failed to analyze the data gathered in the assessments or evaluate the effectiveness of patient safety interventions for patients identified as a moderate to high suicide risk.	A monitor has been implemented to track every step of the process for identification, assessment, intervention, and documentation regarding TLP patients identified at increased acuity. The monitor will data will be reviewed every morning in Leadership rounds, and aggregated data will be analyzed and reported to monthly Quality Council meeting	3/13/19	100 % of all patients identified as at increased risk requiring milieu safety interventions for compliance	Dir. TLP/SW

