

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

Accepted 11/6/25
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PRINTED: 10/20/2025
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 09/02/2025
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 This report is the result of an unannounced complaint investigation survey (CT #45238) that concluded on 9/2/2025. It was determined the Hospital was not in substantial compliance with the requirements of 42 CFR, Title 42, Part 482-Conditions of Participation for Hospitals. Based on observations during a tour of the hospital, a review of medical records, hospital documentation, and interviews with hospital staff, for one of 17 patients (Patient #1) reviewed for care in a safe setting, the hospital failed to provide adequate supervision to prevent self-harm. As a result, a patient attempted suicide by hanging using their clothing as a noose suspended from the bathroom door. The patient later expired at Hospital #2. As a result, Immediate Jeopardy was identified. The IJ template was provided to the hospital on 07/30/2025 at 3:35 PM. Immediate Jeopardy was removed on 07/31/2025 at 3:02 PM after the State Survey Agency verified during an onsite visit that the hospital implemented immediate corrective actions that included locking all patient bathroom doors and monitoring patients while using the bathroom until the doors could be removed.	A 000			
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by:	A 115	A115: 1. The plan for correction: Constant Observation by staff is the only intervention with a high likelihood of mitigating suicide risk. The patient had been placed on Q15 minute checks in this instance based on the evaluation of several psychiatrists. These decisions were based on clinical decision making which considered the patient's unmodifiable risk factors, e.g., recent, and remote history of suicide attempts, potentially modifiable risk factors, e.g., current suicidal ideation, intent, and plan, and protective factors. Given there is no valid or reliable method for predicting imminent suicidal behavior, the decision to place a patient on constant observation depends on clinical judgement. The process of making these complex clinical decisions can be improved by ensuring that relevant information related to suicide risk is gathered and considered. Going forward, we will require that there be a dedicated section of the electronic medical record where psychiatrists will document the relevant risk and protective factors and require a description of the specific clinical decision-making rationale leading to a level of observation decision and order. This will be required for all patients at the time of admission to the hospital and whenever constant observation is discontinued for a patient at risk for engaging in suicidal behavior. All psychiatrists will document the relevant risk and protective factors in a dedicated section of the electronic medical record as well as a description of the specific clinical decision-making rationale leading to a level of observation decision and order.		

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

[Signature]

TITLE

President and Medical Director

(X6) DATE

10/27/25

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 115	Continued From page 1 This CONDITION is not met as evidenced by: Based on observations during a tour of the hospital, a review medical records, hospital documentation, and interviews with hospital staff, for one of 17 patients (Patient #1) reviewed for care in a safe setting, the hospital failed to provide adequate supervision to prevent self-harm, in an environment with known risk factors. As a result, a patient attempted suicide by hanging using their clothing as a noose suspended from the bathroom door (documented risk). The patient later expired at Hospital #2. As a result, Immediate Jeopardy was identified. In addition, other risk factors were observed in numerous areas of the hospital (A-144) and failed to ensure that a physician's order was obtained for implementation of restraints (A-168). Cross Reference: §482.13(c)(2) Patient Rights: Care in a Safe Setting (A-144) 482.13(e)(5) Patient Rights: Restraint or Seclusion (A- 168)	A 115	A115 2 and 3. Medical Staff were required to participate in an educational training regarding the different factors that should be considered when determining observation levels for incoming patients. A new dedicated note template was created so that this rationale and decision making process will be available to all staff. A115 4. This plan of correction was completed on 10/27/2025. A115 5.30 Admission notes a month will be audited to ensure compliance until 100% compliance is reached over 3 consecutive months. At this point the item will be moved into our ongoing monthly clinical pertinence audits. All instances of a patient coming off of a CO status due to suicide risk will be audited until 100% compliance is reached and maintained for 3 consecutive months. At this point the item will be moved into our ongoing monthly clinical pertinence audits. A115 6. The Chief Medical Officer is responsible for this corrective action		
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 observations during a tour of the hospital, a review of medical records, hospital documentation, and interviews with hospital staff, for one of 17 patients (Patient #1) reviewed for	A 144	A144 1. Plan of Correction The doors to the ensuite bathrooms were removed on the inpatient units. Foam/collapsible doors are installed in their place. A144 2. Process Change Foam doors are replacing the solid wood doors. The foam doors are partial height, leaving space between the top of the door and the door frame. The doors are magnetically connected to the frame and release under 20 pounds of force. A144 3. Plan for implementing the plan The new doors will attach to the existing metal frame via a magnet. This will be done while the patinets have groups or meal times in order to reduce the disruption to their experience. A144 4. 10/28/2025 A144 5. The installation will be assessed annually		

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A 144	Continued From page 2 care in a safe setting, the hospital failed to provide adequate supervision despite knowing the patient had multiple high-risk factors for suicide-including recent attempts, current suicidal ideation, and high scores on risk assessments-and ordering 15-minute checks. Furthermore, the hospital failed to maintain a safe environment by not addressing known ligature risks, specifically the bathroom doors, which were incorrectly documented as safe and later used by the patient to attempt self-harm, a known risk that hospital safety management had failed to mitigate or correct properly. As a result, a patient attempted suicide by hanging using their clothing as a noose suspended from the bathroom door (documented risk). The patient later expired at Hospital #2. As a result, Immediate Jeopardy was identified. The findings include: a. Review of Patient 1's clinical record identified that the patient had diagnoses that included post-traumatic stress disorder, bipolar I disorder, and more than 10 previous suicide attempts. The "Admission RN Screening" dated 07/22/2025 at 7:41 PM revealed Patient #1 reported suicide attempts every four months for the last two years since his/her divorce. Patient #1 scored as high risk on the Columbia Suicide Severity Rating Scale (CSSRS) and Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (tools to conduct suicide risk assessments). The document indicated that the social worker and physician were notified and that the nurse stayed with the patient until he/she was transferred to a higher level of care (in-patient).	A 144	A144 5. continued. through the annual risk assessment. The condition of the doors will be assessed during weekly unit rounds. A144 6. The Manager of Safety/Security will be responsible for this corrective action.		

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A 144	Continued From page 3 The "MD Admission Assessment" dated 07/22/2025 at 9:54 PM revealed Patient #1 was voluntarily admitted for psychiatric care following a seven-day medical hospitalization at an outside hospital for an intentional overdose on lithium (mood stabilizer). According to the assessment, the patient made frequent references to wishing his/her suicide attempt had been successful and described his/her mood as hopeless. The note indicated Patient #1 had impaired judgment, limited insight, and passive suicidal ideation, but assured his/her safety at that time. A physician's order dated 07/22/2025 at 8:01 PM directed that the patient be observed every 15 minutes. The "Physician Initial Attending Evaluation" dated 07/23/2025 at 2:57 PM revealed Patient #1 had intended for the lithium overdose to be fatal and regretted surviving. The patient denied any intent to self-harm while on the unit, and "specifically requested not to be placed on 1:1" (a staff member constantly observing the patient). The plan was identified as monitoring the patient's mood and 15-minute checks "for now". A nursing note dated 07/23/2025 at 11:01 PM indicated Patient #1 was isolated in his/her room throughout the evening. He/she denied having suicidal ideation, but the note stated that the patient appeared guarded or resistant to discuss their thoughts or plans and had little or no social interaction. The "Clinician Psychosocial Assessment" dated	A 144			

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A 144	Continued From page 4 07/24/2025 at 9:06 AM revealed the patient endorsed a history of physical and sexual abuse, emotional and psychological trauma, and exploitation. Patient #1 reported that he/she had intended for the lithium overdose to be fatal and regretted surviving. The assessment identified that the patient endorsed passive suicidal ideation but denied a plan or intent. A physician's note dated 07/24/2025 at 1:54 PM revealed that Patient #1 was smiling while discussing the desire to be dead. The note indicated that the patient was upset the overdose did not end his/her life and reported he/she would like to be discharged to resume drinking and eventually end his/her life. The note revealed Patient #1 denied intent to act on these thoughts while inpatient, and that 15-minute checks were to continue "for now." A nursing note dated 07/25/2025 at 05:12 AM revealed that Patient #1 stated during the previous evening that their day was a "waste of time" and reported anxiety as a 7 out of 10 (10 being the highest level of anxiety) and depression as a 4 out of 10 (10 being the highest level of depression). The note indicated the patient had passive suicidal ideation, appeared guarded or resistant to discuss their thoughts or plans, and had little or no social interaction. The note further revealed that at approximately 8:40 PM, a psychiatric technician found the patient hanging from the bathroom door with a noose made from the patient's clothing. The noose was removed, and the patient was lowered to the floor, unresponsive. A medical alert was called, and life-saving measures were initiated. Emergency	A 144			

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A 144	Continued From page 5 Medical Services (EMS) arrived at the scene and transported the patient to a nearby hospital at approximately 9:30 PM. A review of the surveillance footage dated 07/24/2025, conducted with the Executive Director of Operations (EDO) on 07/29/2025 at 10:50 AM, identified that Patient #1 left the medication room window at 8:24:50 PM. The patient walked down the hall and entered their room at 8:25:12 PM. The inside of the room was not visible on the security footage. At 8:34:21 PM, a psychiatric technician entered Patient #1's room to conduct a 15-minute check, then exited. At 8:45:37 PM (11 minutes later), another psychiatric technician opened Patient #1's bedroom door and at 8:45:40 PM, the technician was seen outside the door, waving for help, and a nurse from a room across the hall immediately responded. Within 20 seconds, three other staff members arrived, followed by more staff, including security, the nursing supervisor, and the on-call physician. EMS arrived at the patient's door at 9:02:48 PM and exited the hospital with the patient on a stretcher at 9:21:17 PM. A review of the medical record from Hospital #2 dated 8/1/2025 identified that Patient #1 presented to the emergency department on 7/24/2025 following a suicide attempt by hanging. Patient was status post cardiopulmonary resuscitation (CPR) and field intubation. The note revealed that the patient was found to have anoxic brain injury leading to a comatose status as confirmed on Magnetic Resonance Imaging (MRI), Electrocardiogram (ECG), rising (Neuron - Specific Enolase - a biomarker for damage to	A 144			

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A 144	Continued From page 6 neurons) (NSE), patient was transitioned to comfort measures only (CMO) on 7/31/2025 and passed away at 11:41 PM. Review of the hospital's "Safety Risk Assessments" from 06/7/2021 through 06/05/2025 identified that suicide prevention bathroom doors were installed (alarmed or breakaway) to prevent hanging risk. The risk assessment documented "yes", identifying that the bathroom doors were either alarmed or breakaway doors. Tours of the unit on 07/25/2025 with Manager #3 and 07/30/2025 with Director #3 identified that there were 17 patient rooms, each with a private bathroom. Observation of the bathroom doors identified that none of the doors were alarmed or had breakaway potential. All 17 doors posed as a ligature risk with the top of the doors level, symmetrical, and abutting the upper door frames. Safety rounds were observed on 7/31/2025 at 11:52 AM on the ACU Unit with RN #14 (charge RN). RN #14 identified that RNs perform safety rounds of the unit every 2 hours throughout the day. The RN demonstrated that safety rounds consisted of a review of all patient rooms, bathrooms, and patient care areas. The RN revealed that while he observed all aspects of the bathroom during the safety rounds, the patient's bathroom doors had never been a focus during the safety rounds. During an observation of the 15-minute rounds	A 144	A 144 Finding 2 1. Plan of correction The Annual Risk Assessment document will be updated to present clear answers if a ligature risk has been identified. This will allow for information to be obtained by all staff in an upfront way if a ligature risk has been identified in the assessment. A144 Finding 2 2. Process change The Annual risk Assessment form was updated to provide clear prompts to the assessor as to how and where to document ligature risks. A144 Finding 2 3. Implementation The form was updated through Excel. The new version replaced the old template to ensure the most up to date version will be used. A144 Finding 2 4. 9/2025 A144 Finding 2 5. This will be monitored annually during the risk assessment process A144 Finding 2 6. Manager of Safety and Security		

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A 144	Continued From page 7 and interview with Psychiatric Technician #5 on 7/31/2025 at 12:25 PM, the tech. demonstrated that all rooms, bathrooms, and patient care areas as well as the location of each patient were checked and documented. The Psychiatric technician stated that during rounding she would check bathrooms but indicated that the bathroom doors were not identified as an issue. Review of the 'Safety Risk Assessment' dated 6/5/2025 and the Environmental Rounds Ligature Points Check" document (15-minute check list) with Manager #2 (Safety and Security) on 7/31/2025 at 1:30 PM identified that he completed the risk assessment on 6/5/2025. The manager revealed that during the assessment, he identified the patients' bathroom doors as a ligature risk because there were no gaps at the top, allowing anything placed on the door to remain in place and not slide off. Manager #2 stated that he documented on the assessment that every 15-minute checks was used as mitigation for the risk. The manager confirmed that the patients room doors, instead of bathroom doors, were inadvertently documented as ligature risk on the safety risk assessment document dated 6/5/2025. Additionally, a review of the ' Environmental Rounds Ligature Points Check" document (utilized by the staff during every 15- minute safety rounds) identified door hinges as ligature risk. Although the door hinges were documented on the Environmental Rounds Ligature point check document and were being monitored as a ligature risk, the manager stated that the bathroom door hinges were not identified as a ligature risk during the safety risk assessment.	A 144	A144 Finding 3 1. En suite bathroom doors have been removed, and partial foam doors have been installed. Environmental rounds sheets had the following added "Bedrooms doors free of hanging objects, inside and out" as well as "Check the top of each door for ligature risks". A144 Finding 3 2. Ensuite bathroom doors have been removed, with new foam doors in their place. Staff will check the remaining doors inside and out during each 15 minute environmental rounds check. A144 Finding 3 3. Staff have been educated regarding the ligature risks as well as how to complete the additions made to the check sheets. A144 Finding 3 4. 10/27/25 A144 Finding 3 5. Ligature check sheets will be audited for completeness by charge nurses during the shift and monthly by Nursing Quality. A144 Finding 3 6. Assistant Director for Nurse Quality		

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A 144	Continued From page 8 A review of the "Intervention: Environmental Rounds Ligature Points Check" document (revised 05/06/2025) identified a section for staff to sign, indicating that they have assessed the integrity of the unmitigated ligature risks listed. Although the list included door hinges, it did not include the bathroom doors. Interview with Director #3 on 7/31/2025 at 2:00 PM identified that he was informed by hospital staff that alarms that were placed on the patients' bathroom doors in 2019 but were never completely hooked up to a panel, never worked, and were removed in February of 2025 as this was providing a false sense of security for staff. The Director revealed that he was not aware of the number of doors that were alarmed, was unsure why the alarms were installed, and indicated he had no documentation of the installation or its purpose. Director #3 stated that his responsibilities included reviewing Risk Assessments completed by Manager #2 and addressing any issues noted in the assessment. The Director confirmed that at the time of the interview the risk assessment completed on 6/5/2025 had not yet been reviewed (56 days after completion of the assessment). An interview with the Executive Director of Operations on 07/29/2025 at 3:33 PM revealed that bathroom door alarms were installed in 2019. The alarms never worked correctly, and the hospital decided to remove them in February 2025 to prevent staff from having a false sense of security. On 07/30/2025 at 12:47 PM, she stated that no other mitigation measures had been implemented beyond the 15-minute ligature risk	A 144	A144 finding 4 1. Plan of correction A set date has been determined by which the assessments must be completed. This will allow for a tighter timeline of reviews. Another layer of review has been added. All risk assessments will be submitted for review by the Director of Quality on or before August 1st each year. A144 finding 4 2. Process change Another layer of review and a set date each year to complete the assessments are both process changes that will create reliable and consistent review timelines A144 Finding 5 3. Implementation of Plan Plan is in place. Director of Quality was oriented to the new form and trained on how to conduct reviews. A144 Finding 5 4. This plan was completed on 10/24/25 A144 Finding 5 5. This will be monitored annually in Environment of Care Committee to ensure the risk assessment is completed timely. A144 Finding 5 6. The Director of Facilities and Support Services is responsible for this corrective.		

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A 144	Continued From page 9 checks. An interview with MD #1 on 07/29/2025 at 10:03 AM revealed that Patient #1 reported symptoms of post-traumatic stress disorder during the admission process. MD #1 stated that Patient #1 requested not to have a staff member constantly observing him/her, as this would exacerbate their symptoms, and assured the MD #1 that there was no intent to self-harm while on the unit. MD #1 reported that on 07/22/2025, she was aware that the patient scored as high risk for suicide by the admissions nurse. She explained, however, that her own assessment determined the patient to be low risk for suicide, and she ordered 15-minute checks. An interview with MD #2 on 07/29/2025 at 12:33 PM revealed he first assessed the patient on 07/23/2025. He explained that Patient #1 stated a desire to die and appeared "somewhat" anxious and hopeless. He reported that he was concerned about the patient. This concern was reinforced by the patient's presentation, leading him to seek input from colleagues, (MD#4 and LSCW #1) a step he does not usually take unless a case is complicated. He collaborated with other team members, and together they decided that the unit's environment was safe for the patient. He and his supervising physician (MD #4) planned to meet with Patient #1 the next morning. An interview with Psychiatric Technician (PT) #1 on 07/29/2025 at 2:59 PM revealed that when she arrived at Patient #1's door, she had to force it open because a chair was pushed against it.	A 144			

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A 144	Continued From page 10 Once she entered the room, she saw the patient hanging from the bathroom door. PT #1 stated that she yelled for help and RN #2, who was in the next room, immediately responded. An interview with RN #2 (the first nurse who responded) on 07/29/2025 at 1:16 PM revealed that Patient #1 created a noose by making several knots in a shirt. The patient placed the shirt over the bathroom door and closed it to secure the noose. RN #2 stated that Patient #1 was unresponsive but had a pulse and shallow respirations. The RN stated that as the patient's condition declined, cardiopulmonary resuscitation was initiated. The hospital's "Patient Rights" policy (03/2024) stated that a patient's environment would be restricted as little as possible. The policy also indicated that patients are responsible for following the rules, regulations, instructions, and policies established to support a safe hospital environment. The hospital's "Safety Management Plan" (01/2025) identified the Environment of Care Committee as the party responsible for overseeing hospital safety. The policy stated that the committee's 2024 performance improvement activities included comprehensive environmental risk remediation, with a focus on ligature risks on inpatient units. The plan also indicated that a risk assessment of the care environment must be performed at least annually and whenever a modification is made to the environment. This assessment evaluates the impact on the	A 144			

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

PRINTED: 10/20/2025
FORM APPROVED
OMB NO. 0938-0391

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A 144	Continued From page 11 hospital's ability to perform clinical activities. The safety plan directed that action must be taken to eliminate or minimize identified risks that are not handled appropriately. The hospital's "Patient Observation Levels and Observation Checklist" (03/2025) directed, in part, that patients on standard 15-minute checks be observed every 15 minutes. Staff were also directed to offer additional support and oversight, as well as to document the patient's location and observed behavior on the "Patient Safety Rounds 24 Hour Flow Sheet." b. Observation of the bathroom in the main dining hall on 08/04/2025 at 9:00 AM with Director #3 (Facilities) identified that the bathroom was locked and could only be accessed with a key. On the outside of the door was a sign that the bathroom was not for adolescent use. Director #3 indicated that the bathroom may be used by other patients. The observation further identified that there was a window within the bathroom that was open with only a screen as barrier to the outside. The window was able to be opened to a maximum of 6" posing a ligature risk. The observation indicated that the soap dispenser attached to the wall was not in a safety enclosure, was not ligature free, and allowed access to the soap. The mirror was not securely attached to the wall with pick proof caulking and could easily be removed from the wall. Located on the floor was a heating unit that had several holes greater than 1/8" and not encased in a safety container. The observation further revealed that the paper towel dispenser was loose and not secured to the wall with appropriate caulking allowing the dispenser	A 144	A144 Finding 5 1. Plan of Correction The bathroom near the main dining hall underwent renovations to address the identified risk. A144 Finding 5 2. Process change The windows have been secured to not open higher than 6 inches. The soap dispenser has been converted to be anti ligature. The mirror has been secured to the wall and pick proof caulking has been used. The heating unit has been modified with an anti ligature cover. The paper towel dispenser has been converted to anti ligature and the lock on the bathroom door has been removed. A144 Finding 5 3. The changes were made by our Facilities staff under the direction of the Director of the department. A144 Finding 5 4. The plan was completed on 10/22/2025. A144 Finding 5 5. The condition of the bathroom will be assessed during Environment of Care Rounds. A144 Finding 5 6. The Director of Facilities and Support Services is responsible for this corrective.		

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A 144	Continued From page 12 to be easily pulled off the wall. In addition, the bathroom door was able to be locked from inside the bathroom. In an interview with Dietician #1 on 8/4/2025 at 9:00AM the Dietician identified that adult patients use this bathroom, but adolescents were not permitted to use this bathroom because it can be locked from the inside. Dietician #1 further identified that any patient who would utilize this bathroom is assessed to be at the lowest risk for self-harm. The dietician indicated that staff would give patients access to the bathroom and remain outside the room for privacy. In an interview with Manager #2 (Facilities) on 8/5/2025 at 9:16 AM, it was identified that safety risk assessments are completed yearly. The manager further identified that the dining area and bathroom in the main dining hall are not assessed as this is not considered a patient care area. Manager #2 indicated that common areas are assessed for risk through environment of care rounds, 3 times a year. The manager further indicated that he was unaware that patients were using the bathrooms in the gym, library, and dining hall. c. Observation of the gym with the Director of Quality on 08/04/2025 at 2:00 PM identified two bathrooms located in the main lobby area outside of the gym space that staff identified were for patient use. Observations of the two bathrooms identified that both bathrooms have glass-tiled walls, glass sinks and pedestals, multiple sconces over the sinks, toilets with exposed	A 144	A144 Finding 6 1. Patients are no longer allowed to use the two bathrooms in the main entryway. The bathroom located within the gym was renovated to be ligature resistant for patient use during gym hours. A144 Finding 6 2. Patients are escorted by staff past the two bathrooms in the main entryway to ensure that they are not accessible to patients. The bathroom inside the gym has been included on a environmental rounds check sheet.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 144	Continued From page 13 pipes, and hardware for toilet paper and hand towels that is not ligature safe. In one of the bathrooms, there was an infant 's changing table with a strap to secure a child to the table with multiple handrails that items can be tied to. An interview with the Director of Quality on 8/4/2025 at 2:00 PM identified patients who use the gym and the bathrooms, which are assessed as low risk for self-injury. However, the Director indicated that these bathrooms should be fully ligature safe if patients are going to use them. d. Observation of the library with the Director of Quality on 08/04/2025 at 2:30 PM identified that a window over the toilet was able to be fully opened and only had a removable window screen posing a safety and elopement risk. The observation further identified that the mirror was attached to the wall in a manner that renders it easily be removed. Soap was sitting on the sink, the toilet had a ceramic top that could be removed, and the toilet dispenser was not contained in a safe enclosure. In an interview with the Director of Quality on 08/04/2025 at 2:30 PM, it was identified that patients use this bathroom are assessed as low risk for self-injury, however, stated that any bathroom that is for inpatient use, must have ligature safe modifications to ensure patient safety. A review of the Safety Management Plan policy dated 1/2025, directed in part that the	A 144	A144 Finding 6 3. The renovations were completed by Facilities staff under the direction of the department Director. Nursing staff were trained on how to complete the environmental check sheet when patients are present in the gym. Any deficiencies or issues are to be brought to Nursing Leadership upon discovery. A144 Finding 6 4. The bathroom is checked daily by Nursing staff utilizing the environmental check sheet, as well as during Environment of Care Rounds. A144 Finding 6 5. The Director of Facilities and Support Services is the responsible party. A144 Finding 7 1. The Library was relocated to the Martin Center, where there is a ligature resistant bathroom available for patients to use. A144 Finding 7 2. The Library was moved to a different building. The identified bathroom in this finding is no longer accessible to patients A144 Finding 7 3. The Library was moved. A144 Finding 7 4. The Library was moved and set up by 10/20/25 A144 Finding 7 5. The Library is inspected during Enironment of Care rounds. A144 Finding 7 6. The Executive Director of Operations is the responsible party for this corrective		

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

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A 144	Continued From page 14 environment of care committee shall be responsible for overseeing the safety, security, hazardous materials, waste management, life safety, utilities equipment, medical equipment, and emergency preparedness for the facility. The policy further directs that a comprehensive environmental risk remediation, with a focus on ligature risks, be performed. e. Observation of the main dining hall with Director #3 on 08/04/2025 at 9:00 AM identified that there was a French door that closed the main dining hall off from the café area. This door was only accessed with a staff 's badge. However, the Surveyor was able to pull open the left door without the use of a badge. An interview with Director #3 on 08/04/2025 at 9:00 AM identified that both the French doors should be locked when the café area is not open for service. The café was not open for service during the observation. After the observation, a work order was placed to fix the locking mechanism of the door. f. Observation of the gym with the Director of Quality on 08/04/2025 at 2:00 PM identified two fire exit doors located at the back of the gym. Both doors led directly outside the building. The Surveyor was able to open both doors and neither door alarmed. Further observation identified that once the doors were opened, three steps led to a dense wooded area about 20 feet from the stairs. Additionally, although the entry door into the gym was badge entry access only, the door did not	A 144	A144 Finding 8 1. A work order was placed and the door was repaired so that it worked with the fob system. A144 Finding 8 2. The Dietary team will check to ensure the door is locked at the end of their night shift and will document it on their clean up check list. If faulty they will put in a work order immediately upon discovery. A144 Finding 8 3. The clean up check list was updated to include this task. The Director of Dietary was informed of the change and communicated this to their staff. A144 Finding 8 4. This was completed on 10/23/2025 A144 Finding 8 5. The sheets will be monitored and reviewed for completion by the Director of Dietary on a weekly basis A144 Finding 8 6. The Director of Dietary is responsible for this corrective. A144 Finding 9 1. The two doors that lead out of the back of gym are to be set to the locked position and released upon activation of the fire alarm. The door to the gym is now fob access to both enter and exit. A144 Finding 9 2. Doors in the gym used to open freely to the outside. The Director of Facilities worked in conjunction with the Fire Marshall for approval to have the doors stay locked except in case of a fire. A144 Finding 9 3. This plan of correction was implemented upon approval from the Fire Marshall. A144 Finding 9 4. This corrective was completed 9/18/25		

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

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A 144	Continued From page 15 lock on the inside, allowing patients to leave the gym, back into the lobby area independently. In an interview with the Director of Quality on 08/04/2025 at 2:00 PM, the Director identified that the doors in the gym are fire exit doors, should always be locked, and must alarm when opened. A review of the Safety Management Plan policy dated 1/2025, directed in part that the environment of care committee shall be responsible for overseeing the safety, security, hazardous materials, waste management, life safety, utilities equipment, medical equipment, and emergency preparedness for the facility. The policy further directs that a comprehensive environmental risk remediation, focus on ligature risks be performed.	A 144	A144 Finding 9 5. The doors in the gym both to the outside and the one to the lobby area will be monitored during Environment of Care rounds as well as by Nursing while patients are in the gym on the nursing environment ligature check sheet. A144 Finding 9 6. The Manager of Safety and Security is the responsible party for this corrective.		
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) §§482.13(e)(5) - The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on a review of medical records, facility documentation, and interviews with staff, for four of the four sampled patients (Patients #25, #26, #27, and #29) reviewed for restraints, the hospital failed to ensure a physician's order was obtained for the use of restraints. The findings include: a. Patient #25's diagnoses included bipolar disorder, general anxiety disorder, and body	A 168			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 168	Continued From page 16 dysphoria disorder. The history and physical (H&P) dated 1/28/25 at 11:00 PM identified that Patient #25 presented to the hospital with reports of insomnia and sleeping about four hours a night, hyper vigilance, reactivity, quick to anger, referential thinking, delusions of grandeur, and an inflated sense of self. Patient reports difficulty discerning delusional thoughts from appropriate paranoia. A physician's order dated 1/30/25 directed to administer Haldol (an antipsychotic medication) 5 milligrams (mg), Intramuscular (IM), 1 time. A review of the multidisciplinary restraint/seclusion record dated 1/30/25 identified that Patient #25 had a physical hold initiated at 3:12 AM on 1/30/25. Patient #25 was given Haldol 5mg IM, Ativan (medication used to treat anxiety and insomnia) 2mgs IM, and Benadryl (an antihistamine associated with causing drowsiness) 50 mg IM at the time of the restraint initiation. The record further identified that Patient #25 was removed from the physical hold at 3:55 AM, a total of 43 minutes. A nurse's note dated 1/30/25 at 3:12 AM identified that Patient #25 became agitated, screaming at staff, and making verbal threats, became increasingly angry and began hitting staff. The patient was moved to safe environment and held manually for safety. The clinical record lacked documentation of a physician's order for a physical hold on 1/30/25.	A 168	A 168 1. The requirements to place restraint orders within a timeframe consistent with hospital policy as well as writing separate orders for manual hold and chair restraint, when applicable, will be reinforced with all physicians. The charge nurse overseeing an episode of restraint will contact the responsible physician in the event there is a delay in entering the restraint order or the orders are not complete. If the physician's response is not timely or complete, the charge nurse will immediately notify the Chief Medical Officer or designee during daytime hours, and the Nursing Supervisor who will contact the Administrator on Call after hours, who will follow up with necessary action. Pattern failure to complete restraint orders in a timely and complete manner will be included among factors that will trigger a Focused Professional Practice Evaluation (FPPE). A168 2. The plan described above will include re-education of physicians, a "just-in-time" plan of escalation, and consequences for pattern delinquencies A168 3. Nursing and Medical Staff have been educated to this plan. A168 4. The corrective was completed on 10/23/25. A168 5. All restraint episodes will be audited until 100% compliance with timely restraint orders is achieved for three consecutive months. A168 6. The Chief Medical Officer is responsible for this corrective action.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 168	Continued From page 17 b. Patient #26's diagnosis included bipolar disorder. The H&P dated 2/11/25 at 7:28 PM identified that Patient #26 presented to the hospital secondary to medication changes leading to severe nausea and vomiting. Patient #26 further reported intensified paranoia focused on technology, believing his/her phone, laptop, and cameras could lead to police involvement causing him/her to become visibly tense and restless around electronic devices. A nurse's note dated 2/16/25 at 10:25 PM identified that Patient #26 attempting to enter another patient's room, was redirected to his/her room. While being redirected, patient swung at staff and attempted to assault staff. Manual hold initiated at 10:15 PM and assisted to chair restraint at 10:25 PM. A review of the multidisciplinary restraint/seclusion record dated 2/16/25 identified that Patient #26 was placed in a restraint chair on 2/16/25 at 10:25 PM. The patient was given Ativan 2 mg IM and Zyprexa 10 mg sublingual at the initiation of the physical hold on 2/16/25 at 10:15 PM. The restraint chair was discontinued on 2/17/25 at 12:55 AM (2 hours and 30 minutes after the chair restraint was initiated) Review of the clinical record failed to identify that an order was obtained for the chair restraint when the patient continued to require it beyond 2 hours, in accordance with the hospital's policy.	A 168			

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

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A 168	Continued From page 18 c. Patient #27's diagnoses included bipolar disorder, opioid use disorder, and sexual trauma. The H&P dated 6/25/25 at 12:03 PM identified Patient #27 presented to the hospital due to patient experiencing manic episodes approximately 1-2 weeks ago. Patient describes spending hundreds of dollars on video games, experiencing decreased need for sleep, racing thoughts, and euphoric mood during that period. A review of the multidisciplinary restraint/seclusion record dated 6/25/25 identified that Patient #27 was placed in a restraint chair at 3:20 PM. Patient #27 was administered Ativan 2 mg IM, Haldol 5 mg IM, and Benadryl 2 mg IM at the initiation of the restraint chair. The restraint chair was discontinued on 6/25/25 at 4:10 PM. A nurse's note dated 6/25/25 at 3:20 PM identified that Patient #27 became increasingly agitated after admission and orientation to unit. Patient demanded to be discharged, yelling, throwing the phone, and began verbally threatening staff with violence. A Psych emergency was initiated, and the patient was placed in a restraint chair, and medications were given. A review of the medical record on 8/5/25 at 12:30 PM identified that there was no multidisciplinary restraint/seclusion record for the event dated 6/25/25. Review of the medical record revealed that the Physician's orders for use of the restraint chair and a physical hold were placed 5 days after the incident on 6/30/25.	A 168			

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

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A 168	Continued From page 19 d. Patient #29's diagnoses included post-traumatic stress disorder, bipolar disorder, and suicidal attempts. The H&P dated 4/15/25 at 1:35 PM identified Patient #29, who presented to the hospital with reports of active suicidal ideation with multiple recent attempts. The patient reported strangling her/himself with tight clothing multiple times recently, including while in the hospital, once requiring medical response and transfer to medical unit. A nurse's note dated 4/19/25 at 3:43 PM identified that patient #29 switched to an alternate personality and tried to strangle self. A review of the multidisciplinary restraint/seclusion record dated 4/19/25 identified that Patient #29 was placed in a manual hold and then into a restraint chair at 3:43 PM. The restraints were discontinued on 4/19/25 at 5:04 PM. Review of the Physician's orders dated 4/19/25 failed to identify a physician's order for the initiation of a restraint chair. Interview with Manager #1 on 8/5/25 at 12:30 PM identified that each episode of restraints requires a separate order. Manager #1 further identified that if a patient is placed in a manual hold and then a restraint chair, each would require a separate order. The manager indicated that she is unsure of the timeframe for entering an order into the EHR for restraints; however, 5 days is not	A 168			

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

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A 168	Continued From page 20 a reasonable timeframe. The manager stated that a new order for a restraint chair is required every 2 hours. A review of the Restraint policy dated 3/2025 directed, in part that restraint orders are limited to a duration of two hours. If necessary, orders must be renewed every two-hours. To continue restraint beyond two hours, the MD must conduct a face-to-face evaluation and enter a documenting note along with a new order. The policy further identifies that a physician order is required to be placed on the restraint record under the MD order section and in the electronic health record. The policy indicates that each restraint type requires a separate time to order.	A 168			
A 309	QAPI EXECUTIVE RESPONSIBILITIES CFR(s): 482.21(e)(1), (e)(2), (e)(5) 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: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually.	A 309	A 309 1. The Environment of Care Committee will report out in Quality Council quarterly to ensure information reaches the Board of Directors. A309 2. The Hospital is improving the committee reporting process to ensure that decisions flow through the proper channels to ultimately reach the Board. A309 3. Committee chair for the Environment of Care Committee as well as Quality Council has developed a schedule that will ensure relevant and timely reporting of topics discussed. A309 4. The new calendar of meetings has been developed as of 10/27/2025. A309 5. This new process will be monitored during committee meeting minutes each quarter. A310 6. The Director of Quality is the responsible party for this corrective.		

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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 09/02/2025
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 309	Continued From page 21 This STANDARD is not met as evidenced by: Based on observations during tour of the hospital, review of hospital documentation, and interviews with staff, the hospital failed to ensure that the Quality Assurance Performance Improvement Committee evaluated and had oversight of the removal of alarms on all patient bathroom doors and failed to ensure this environmental modification was brought to the Environment of Care Committee in accordance with the hospital's policy. The finding includes: a. A review of the hospital's "Safety Risk Assessment" dated 06/07/2021 through 06/05/2025 identified that suicide prevention bathroom doors were installed (alarmed or breakaway) to prevent hanging risk. The risk assessment documented "yes", identifying the bathroom doors were either alarmed or breakaway doors. Tours of the acute care unit on 07/25/2025 and 07/30/2025 identified 17 patient rooms, each with a private bathroom. Observation of all 17-bathroom doors identified that the doors were neither alarmed nor had breakaway potential as identified in the Safety Risk assessment. All 17 doors posed as a ligature risk with the top of the doors level, symmetrical, and abutting the upper door frames. An interview with the Executive Director of Operations on 07/29/2025 at 3:30 PM revealed that the hospital installed pressure sensor door alarms in 2019. However, the alarms never	A 309			

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

PRINTED: 10/20/2025
FORM APPROVED
OMB NO. 0938-0391

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A 309	Continued From page 22 worked properly and were removed in February 2025 to prevent staff from having a false sense of security. A review of the hospital's Quality Assurance and Performance Improvement Committee meeting minutes dated January 2023 through May 2025 with the Director of Quality on 07/31/2025 at 10:45 AM failed to identify documentation that the removal of the pressure alarms from bathroom doors was brought to the committee. The Director of Quality indicated that because the patient bathroom doors were not identified as a ligature risk, the modification was not brought to the Quality Assurance and Performance Improvement Committee. During an interview with the Director of Quality on 07/30/2025 at 9:26 AM and 3:28 PM, she explained that the hospital's "Safety Management Plan" policy directed that all modifications to the hospital environment to be reviewed at the Environment of Care (EOC) Committee meeting, where the risk assessment is maintained. However, a review of the "Environment of Care (EOC) Committee" minutes dated 02/27/2025 at 1:30 PM and 04/29/2025 at 1:00 PM did not identify any documentation that the removal of the bathroom door alarms was discussed. Additionally, she explained that while any changes to the risk assessment should have been discussed at the EOC Committee meeting, this specific change was instead addressed with staff at the nursing committee. She could not explain why the removal of the door alarms was not discussed during the EOC Committee meetings.	A 309	Type text here		

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

PRINTED: 10/20/2025
FORM APPROVED
OMB NO. 0938-0391

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A 309	Continued From page 23 A review of the "Nursing Staff Meeting Minutes" dated 03/18/2025 at 6:00 PM confirmed that the removal of the door alarms was discussed at the meeting. The meeting minutes did not address any additional mitigation measures that were put in place. The hospital's "Safety Management Plan" policy (01/2025) identified the Environment of Care (EOC) Committee as a multidisciplinary team that meets every other month to find and examine safety management problems and create suggestions to solve them. The policy directed, in part, for the Safety Officer and the committee to work together to oversee and report on all parts of the Safety Program. The policy directed the Safety Officer to provide guidance to the EOC Committee and Quality Council about safety issues that may necessitate changes to existing policies, procedures, orientation, education, or the spending of funds. Additionally, the policy directed that the "Safety Risk Assessment" to be reviewed at the Environment of Care Committee at least once a year, and also whenever an environmental modification occurs. Furthermore, the committee was directed to work with the appropriate staff to implement the committee's recommendations and to monitor how effective the changes were.	A 309			
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or	A 385			

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

PRINTED: 10/20/2025
FORM APPROVED
OMB NO. 0938-0391

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A 385	Continued From page 24 supervised by a registered nurse. This CONDITION is not met as evidenced by: This condition was NOT met as evidenced by: Based on a review of medical records, hospital documentation, and interviews with hospital staff, the hospital failed to ensure an order was obtained prior to administering patient medications outside of the specified time frame, and failed to ensure medication bottles were labeled with the date of opening in accordance with hospital policy (A-0405). Cross Reference: §482.23(c)(1), (c)(1)(i), (c)(2) Medication Administration (A-0405)	A 385	A 385 1. Reeducation of staff regarding the policy that states the MD must write a Nursing Order for a medication to be given early. That writing "ok per MD" in the comment section of the MAR is not sufficient A385 2. The Medication Administration policy and EHR were amended to allow for additional administration times that better align with the a patients preferred medication times. Thus eliminating some of the requests to take medication early or late. A385 3. Staff has been informed the changes to the policy and the corrective has been communicated to both nursing staff as well as ordering physicians. A385 4. The corrective action was completed on 10/27/2025 A385 5. The Assistant Director of Quality will audit 5 inpatient charts per week to ensure that all medication was given within ordered times. Once 100% compliance has been reached for 3 consecutive months, this audit will move into the Hospitals ongoing Clinical Pertanence audit. A385 6. The Assistant Director of Nursing Quality is responsible for this corrective.		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing	A 405			

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

PRINTED: 10/20/2025
FORM APPROVED
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A 405	Continued From page 25 or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on review of medical records, review of hospital documentation, and interviews with hospital staff, for four of four patients (Patient #1, #13, #14, and #15) reviewed for medication administration, the hospital failed to ensure an order was obtained prior to administering patient medications outside of the specified time frame, and failed to ensure medication bottles were labeled with the date of opening in accordance with hospital policy. The findings include: 1a. A review of Patient 1's medical record identified that the patient had diagnoses that included post-traumatic stress disorder, bipolar disorder, and numerous previous suicide attempts. The MD Admission Assessment dated 07/22/2025 at 9:54 PM revealed Patient #1 was voluntarily admitted for psychiatric care following a seven-day medical hospitalization at an outside hospital for an intentional overdose on lithium (mood stabilizer). According to the assessment, the patient made frequent references to wishing his/her suicide attempt had been successful and described his/her mood as hopeless. The note indicated Patient #1 had impaired judgment, limited insight, and passive suicidal ideation, but assured his/her safety at that time. A physician's order dated 07/22/2025 at 11:07 PM	A 405	A405 1. All over the counter medication bottles in use on the inpatient units will be labeled with an "open" date, as per our policy. A405 2. Stickers for writing an open date, exp date, and initials will be distributed to pharmacy staff. They will sticker the bottles before bringing them to the inpatient unit. Nursing staff will write the open date on the sticker when they first use the bottle. A405 3. Medication bottle stickers have been acquired. This process has been explained to both the pharmacy staff and the nursing staff. A405 4. The corrective was completed by 10/27/2025 A405 5. All medication bottles will be checked for compliance with this corrective during monthly med room audits. A405 6. The Assistant Director of Nursing for each unit will be responsible for this corrective action.		

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

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A 405	Continued From page 26 directed to administer 15 milligrams (mg) of phenelzine (an antidepressant) twice daily. A physician's order dated 07/22/2025 at 8:04 PM directed to administer 30 mg of phenelzine at bedtime. A review of the medication administration record dated 07/24/2025 at 8:23 PM revealed Patient #1 received a total of 45 mg of phenelzine at that time. "OD [on-call doctor] approved early med admin" was documented in the record. The MAR identified the administration times as 10 AM and 10:00 PM. 1b. A review of Patient #13's medical record identified that the patient had diagnoses that included depression, chronic obstructive pulmonary disease, and migraines. The MD Admission Assessment dated 07/27/2025 revealed that Patient #13 was voluntarily admitted to the hospital for treatment of chronic and worsening depression and passive suicidal ideation. The H&P indicated Patient #13 reported worsening mental health and a desire to go to sleep and not wake up but denied any plan or intention of acting on these passive suicidal thoughts. A physician's order dated 07/27/2025 directed to administer 100 mg of doxycycline (an antibiotic) daily for ten days. A review of the medication administration record revealed Patient #13 received the evening dose			A 405			

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

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A 405	Continued From page 27 of the medication on 07/27/2025 at 8:34 PM, on 07/28/2025 at 8:33 PM, and 07/29/2025 at 8:01 PM. The MAR identified an administration time of 10:00 AM. 1c. A review of Patient #14's medical record identified that the patient had a diagnosis that included concussion. The MD Admission Assessment dated 06/05/2025 revealed that Patient #14 was voluntarily admitted to the hospital for treatment of acute psychotic symptoms. The H&P indicated Patient #14 was unkempt, appeared fearful, exhibited a disorganized thought process, and was internally preoccupied. A physician's order dated 07/17/2025 at 1:59 PM directed to administer 3.125 mg of carvedilol (a blood pressure medication) twice daily. A review of the medication administration record dated 07/17/2025 through 07/30/2025 revealed Patient #14 received the evening dose of the medication between 7:00 PM and 8:59 PM on 9 of the 14 days. Each of these administrations indicated that the physician approved the medication's administration at these times. 1d. A review of Patient #15's medical record identified that the patient had diagnoses that included bipolar I disorder and hypertension.	A 405			

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

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A 405	Continued From page 28 The MD Admission Assessment dated 07/20/2025 at 3:47 PM revealed Patient #15 was voluntarily admitted to the hospital for treatment of manic or hypomanic symptoms. The H&P indicated that Patient #15 reported a reduced need for sleep and exhibited rambling and rapid speech, along with a tangential thought process. A physician's order dated 07/20/2025 directed to administer 200 mg of lamotrigine (a mood stabilizer) twice daily. A review of the medication administration record dated 07/20/2025 through 07/30/2025 revealed Patient #15 received the evening dose of the medication between 7:00 PM and 8:59 PM on 6 of the 11 days. Each of these administrations indicated that the physician approved the medication's administration at these times. An interview with RN #9 (the 07/24/2025 evening medication nurse) on 07/29/2025 at 3:45 PM revealed that medications ordered as "at bedtime" default to an administration time of 10:00 PM. She indicated that her process is to text the on-call physician to ask if early medication administration is permitted if a patient requests the medication outside the administration time window. She stated that she then documents the physician's permission for early administration in the medication administration record. During an interview and review of the medical record with Assistant Director of Nursing (ADON)	A 405			

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

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A 405	Continued From page 29 #1 on 07/31/2025 at 12:44 PM, she explained that if a medication is ordered twice daily, the electronic medical record (EMR) defaults to administration times of 10:00 AM and 10:00 PM. Additionally, medications ordered to be given at bedtime default to an administration time of 10:00 PM. She stated that the nurse has a two-hour administration window, which is an hour before and an hour after the scheduled administration time. However, if a patient desires the medication outside of this two-hour time frame, the nurse must obtain a new physician's order for medication administration at that time. The medical records of Patient #1, Patient #13, Patient #14, and Patient #15 did not indicate that orders were obtained for each patient's respective medications when administered outside of the ordered timeframe. The hospital's "Medication Safety: Preparation, Administration, and Documentation" policy (10/2024) directed, in part, to obtain a physician's order anytime a medication is given outside of the scheduled administration timeframe. 2a. A tour of the medication room on the Main 2 Unit with the Assistant Director of Nursing (ADON) #2 on 07/31/2025 at 1:10 PM identified the following: i. A 4-ounce plastic container of bismuth subsalicylate (antidiarrheal, 525 milligrams [mg] per 30 milliliter [mL] dose) was three-quarters full and did not have a label indicating the date it was opened. ii. An 8-ounce plastic container of bismuth	A 405			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 405	Continued From page 30 subsalicylate (262 mg per 15 ML dose) was three-quarters full and did not have a label indicating the date it was opened. iii. A 60-capsule plastic container of magnesium citrate (laxative, 200 mg capsules) was half full and did not have a label indicating the date it was opened. v. A 60-capsule plastic container of magnesium glycinate (supplement, 100 mg capsules) was half full and did not have a label indicating the date it was opened. An interview with RN #8 (Main 2 Unit's medication nurse) on 07/31/2025 at 1:10 PM revealed that hospital policy required multi-dose medication containers to be labeled with the date they were opened. RN #8 was unable to explain why the medications lacked the required labeling. The hospital's "Medication Safety: Preparation, Administration, and Documentation" policy (10/2024) directed, in part, the policy prohibited using medication from a container without a full label, from an open container that lacked the date of opening, or from a container with mixed medications. 2b. A tour of the medication room on the Main 3 Unit with ADON #2 on 08/04/2025 at 10:00 AM identified the following: i. A 350-capsule plastic container of vitamin D3 (supplement, 1000 international units [IU] per capsule) was three-quarters full and did not have a label indicating the date it was opened.	A 405			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 405	Continued From page 31 ii. A 60-capsule plastic container of biotin (supplement, 1000 micrograms [mcg] per capsule) was half full and did not have a label indicating the date it was opened. iii. A 60-tablet plastic container of melatonin (sleep supplement, 5 mg per tablet) had 10 tablets remaining and did not have a label indicating the date it was opened. iv. A 50-tablet plastic container of melatonin (1 mg per tablet) was one-quarter full and did not have a label indicating the date it was opened. An interview with RN #13 (Main 3 Unit's medication nurse) on 08/04/2025 at 10:00 AM indicated that she was unaware of the requirement to label opened medication bottles with the date of opening. She stated that her practice was to ensure the bottle was labeled with its expiration date. The hospital's "Medication Safety: Preparation, Administration, and Documentation" policy (10/2024) directed, in part, the policy prohibited using medication from a container without a full label, from an open container that lacked the date of opening, or from a container with mixed medications. 2c. A tour of the medication room on the Acute Care Unit with ADON #1 on 08/05/2025 at 9:09 AM identified the following:	A 405			

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A 405	Continued From page 32 i. Three 60-tablet plastic containers of melatonin (5 mg) were found without a label indicating the date they were opened. One container was half full, another was three-quarters full, and the third had one tablet remaining. ii. Two 60-tablet plastic containers of melatonin (5 mg bilayer tablets) were found without a label indicating the date they were opened. One was one-quarter full and the other was three-quarters full. iii. Two 96-tablet plastic containers of calcium carbonate (for upset stomach, 750 mg dose) were found without a label indicating the date they were opened. One was three-quarters full and the other had 3 tablets remaining. iv. A 12-ounce plastic bottle of cool mint liquid antacid was mostly full and did not have a label indicating the date it was opened. An interview with ADON #1 on 08/05/2025 at 9:15 AM revealed that although staff are reminded of the policy, they do not consistently label opened medication containers with the date they were opened, and she could not explain the reason. The hospital's "Medication Safety: Preparation, Administration, and Documentation" policy (10/2024) directed, in part, the policy prohibited using medication from a container without a full label, from an open container that lacked the date of opening, or from a container with mixed medications.	A 405			

