STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	314021	A. BUILDING _____ B. WING _____	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON BEHAVIORAL HEALTH SYSTEM	650 RANCOCAS ROAD WESTAMPTON, NJ 08060

(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 was a Centers for Medicare/Medicaid Services (CMS) authorized Federal Allegation Survey (C#NJ00148791) and Federal COVID-19 Focused Infection Control Survey conducted at Hampton Behavioral Health System on October 18, 19, and December 20, 2021 to determine compliance with the following Condition of Participation for Hospitals: 42 CFR Part 482.13 Patient Rights Standard level deficiencies were evident.	A 000		
A 119	PATIENT RIGHTS: REVIEW OF GRIEVANCES CFR(s): 482.13(a)(2) [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on one (1) out of two (2) medical records (Medical Record #1) reviewed for complaints and grievances, review of facility documents, and staff interview, it was determined that the facility failed to implement its grievance policy and document a grievance from a patient or a patient's representative. Findings include: Reference: Facility policy titled, Grievances: Patient, Family; Role of the Patient Advocate,	A 119		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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A 119	Continued From page 1 states, " ... PURPOSE: Definition: For the purpose of this policy, a "patient grievance" is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489. ... If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is considered resolved when the patient is satisfied with the actions taken on their behalf. ... PROCEDURES: ... 6. The grievance will be logged into the Grievance Log by the Patient Advocate or designee. ..." 1. On 10/18/21 beginning at 1:00 PM, Medical Record #1 was reviewed, and the following was revealed: a. The RN - Nursing Note dated and timed for 9/21/21 at 10:20 PM states, "... Nursing assessment 3-11 ... He/she stated he/she felt uncomfortable because his/her roommate put a pillow on his/her face last night. His/her roommate was placed on 1:1 at bedtime and his/her roommate will also be sleeping in the lounge. Pt [patient] stated, "I don't feel comfortable, I just want to leave." Pt's mother sent the police here this evening for a wellness check, and it was determined that the pt is in a safe environment. Pt told his/her mother on the	A 119		

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A 119	Continued From page 2 phone he wants to leave. Mother stated she wanted to sign the pt out tonight, she was offered a 48 [hour] notice several x's [times] but declined. She spoke [with] RN, RN supervisor, and APN (attending) on the phone. [Staff #1] and [Physician] were also notified. ..." b. The "Patient Request to Terminate Inpatient Treatment" document signed by the patient and dated 9/22/2021 indicated the reason for the request was, "Don't feel safe with other patient." The document also contained a hand-written checkmark that indicated, "I feel that I am no longer in a crisis situation and wish to leave treatment." c. The patient was discharged from the facility on 9/22/2021. The "Leaving Against Medical Advice" form, dated 9/22/21 and timed 1:45 PM included the Social Worker's signature and an indication that the "patient refused" to sign. 2. The complaint and grievance log for July 1, 2021 through October 18, 2021 was reviewed and Patient #1's grievance was not documented. During an interview at 2:45 PM, Staff #1 confirmed that there was no grievance documented and stated that it was decided to keep it at the treatment team level. Staff #1 stated that introducing a third party would have created more confusion. Staff #1 stated that he/she documented it as an incident report.	A 119		
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:	A 144		

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A 144	Continued From page 3 A. Based on medical record review, review of facility documents and staff interview, it was determined that the facility failed to ensure that policies and procedures for incident reporting were implemented by all staff. Findings include: Reference: Facility policy titled, Healthcare Peer Review (HPR) / Incident Reporting Process, states, "... B. Definitions: 1. Incident: An event, outcome, or situation that is not consistent with routine care of patients and/or the desired operations of the facility and results in or could have resulted in (near miss) unexpected medical intervention, unexpected intensity of care, or unexpected physical or mental impairment. ... PROCEDURES: ... B. Healthcare Facility Staff: 1. Any healthcare facility employee who discovers, is directly involved in or responds to an incident is to complete or direct completion of a HPR/Incident Report as soon after the event as possible, but not later than the end of the shift. ..." 1. During an interview on 12/20/21 at 10:20 AM, Staff #14 stated that during his/her evaluation of Patient #1 on 9/21/21, Patient #1 informed Staff #14 that his/her roommate (Patient #2) had told Patient #1 that he/she had tried to smother Patient #1 with a pillow during the night. 2. A review of Medical Record #1 revealed an "RN- Nursing note" dated 9/21/21 at 10:20 PM, which states, "... [He/she] stated [he/she] felt uncomfortable because [his/her] roommate put a pillow on [his/her] face last night. ..." 3. A review of a facility incident report for the alleged event occurring overnight on 9/20-9/21/21	A 144		

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A 144	Continued From page 4 revealed that the incident report was completed on 9/23/21 by Staff #1. Staff #1 was not the clinical staff who discovered the incident. a. The report was not completed at the time the incident was discovered by the staff members involved. This was not in accordance with facility policy. 4. The above finding was confirmed with Staff #1 on 12/20/21 at 12:59 PM. B. Based on review of facility policy, and staff interview, it was determined that the facility failed to ensure that policy and procedures for 1:1 patient monitoring were clarified and implemented in accordance with provider orders to ensure patient safety. Findings include: Reference: Facility policy titled, Special Precautions Patient Classification, states, "... B. One-to-One Observation Status - ... The patient will be maintained on constant visual observation by a staff member at a distance no greater than three (3) feet to ensure patient safety. ... 1. The patient on this level of observation must be with the assigned staff member at all times. ..." 1. A review of Medical Record #2 revealed a provider's order dated 9/21/21 at 9:30 AM, which states, "... 1:1 @ HS [bedtime] for safety". The medical record lacks evidence that staff clarified the intended start and end time of this order. a. A "RN- Nursing Note" dated 9/21/21 at 1315 states, "... Pt [patient] denies HI/SI [homicidal ideation/suicidal ideation] but attempted to	A 144		

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A 144	Continued From page 5 smother his roommate last night. Pt will be placed on a 1:1 from the hours of 11P-7A. ..." Documented evidence revealed that the 1:1 was initiated at 9:30 PM. The medical record lacked evidence that staff clarified the intended start time of the 1:1. 2. During interviews conducted with staff members on 12/20/21, the following was revealed: a. At 10:15 AM, Staff #12 and Staff #13 were interviewed about the unit schedule. Staff #12 stated that he/she does not work evening shifts and deferred to Staff #13. Staff #13 stated that doors to patient rooms are locked during the day for patient safety and are unlocked by staff between 8-8:30 PM. Staff #13 stated that patients can then go back and forth to their rooms until bedtime which is between 9:30PM-10:00 PM, dependant on the patient's assigned level of care. b. At 10:20 AM, Staff #14 stated that he/she evaluated Patient #1 and Patient #2 the morning after they were both admitted (9/21/21). Staff #14 stated that during his/her evaluation of Patient #1, the patient stated, "Just so you know, my roommate [Patient #2] told me he tried to smother me". Staff #14 stated that no one saw or heard any disturbance from the patient room. Staff #14 ordered a 1:1 sitter for Patient #2 at bedtime for safety. Staff #14 stated that at bedtime meant beginning at 9:30 PM. When asked for clarification, Staff #14 stated that the 1:1 monitoring should begin at the time the patient rooms are unlocked for the night. Staff #14 confirmed any time the patients are out of sight of staff there should be a 1:1 sitter in accordance	A 144		

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A 144	Continued From page 6 with his/her order for 1:1 at bedtime. (i) Staff #14 stated that when he/she arrived on the unit the next morning (9/22/21), he/she saw Patient #2 walking down the hallway with Patient #1 following. Staff #14 stated that it did not make sense that if Patient #1 feared Patient #2, that he/she would follow him/her alone. Staff #14 then made the decision to place Patient #2 on a continuous 1:1 as much for his/her own safety due to the patient's current mental state. c. At 10:50 AM a follow-up interview was conducted with Staff #13. Staff #13 stated that he/she does work evening (3PM-11PM) shifts on the Adolescent Unit "occasionally". Staff #13 confirmed his/her earlier statement that staff unlock the patient room doors between 8-8:30 PM. Staff #13 stated that 1:1's begin at whatever time the provider ordered the 1:1 to start. d. Staff #15 was also interviewed regarding the daily patient schedule. Staff #15 stated that the bedtime for Level 1 patients was at 9:30 PM and for Level 2 and 3 patients the bedtime was at 10 PM. Staff #15 stated the bedroom doors are unlocked at 9:30 PM. This was inconsistent with Staff #13's statement that doors are unlocked between 8-8:30 PM. (i) Staff #15 stated that the 1:1 typically ends after the night shift at 7 AM. When asked who is watching the patient after that time and before the doors are locked for the day, Staff #15 explained that the 1:1 observer will wake the patient prior to leaving and the patient will be moved to the lounge so that staff can see the patient. 3. During an interview on 10/19/21 at 12:10 PM,	A 144		

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A 144	Continued From page 7 Staff #1 confirmed that on the morning of 9/22/21, Patient #2 entered the patient room without a 1:1 observer while Patient #1 was alone in the room. Staff #1 stated that this occurred because Patient #2's order for 1:1 had expired at 7:00 AM on 9/22/21. Patient #2 was not being observed by staff to prevent interaction with other patients before the patient rooms were locked for the day. 4. During an interview on 12/20/21 at 11:16 AM, Staff #1 confirmed that the facility policy for 1:1 patient monitoring is not clear for a start time when ordered for "at bedtime". C. Based on one (1) of two (2) medical records (Medical Record #1) reviewed, review of facility documents, and staff interview, it was determined that the facility failed to ensure that staff notify the necessary agencies when allegations of assault are reported. Findings include: Reference #1: Facility policy titled, Assault Precautions, states, "PROCEDURES: ... In the event that a patient attacks another patient (provoked/unprovoked) and regardless of precaution, the following procedure is to be followed: ... 3. Notify the local police of patient to patient assault and provide police with patient demographics. 4. Notify the Risk Manager and the Department of Health of patient to patient assault. ..." Reference #2: Facility policy titled, Child Abuse, states, "... D. DCP&P Institutional Abuse must be notified immediately of the abuse allegation ... In cases involving allegations made by a patient against another patient, information on all parties	A 144		

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A 144	Continued From page 8 involved may be shared with DCP&P specific to the present allegation and investigation. ..." 1. A review of Medical Record #1 revealed an "RN- Nursing note" dated 9/21/21 at 10:20 PM, which states, "... [He/she] stated [he/she] felt uncomfortable because [his/her] roommate put a pillow on [his/her] face last night. ..." The medical record lacked evidence that this event was reported to the police, DCP&P, or institutional abuse per facility policy. 2. During an interview on 12/20/21 at 10:20 AM, Staff #14 was interviewed. Staff #14 stated that during his/her evaluation of Patient #1 on 9/21/21, the patient stated, "Just so you know, my roommate [Patient #2] told me he tried to smother me". Staff #14 stated that no one saw or heard any disturbance from the patient room. 3. During an interview on 10/19/21 at 3:07 PM, Staff #3 stated that he/she was made aware of Patient #1's allegations by the patient's mother on 9/21/21 at 3:50 PM and passed this information on to the Charge RN. Staff #3 stated that when a patient makes an accusation of a crime, potential crime, or abuse, that he/she needs to call Institutional Abuse and inform them of the allegations. Staff #3 stated that he/she did not report Patient #1's allegations because he/she did not believe the allegations occurred. This was not in accordance with facility policy referenced above. 4. During an interview on 12/20/21 at 11:30 AM, Staff #1 confirmed that the police were not notified of the potential criminal activity. This event was also not reported to the New Jersey Department of Health. This was not in	A 144		

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A 144	Continued From page 9 accordance with the above referenced facility policy.	A 144		

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A 000	INITIAL COMMENTS This was a Centers for Medicare/Medicaid Services (CMS) authorized Federal Allegation Survey (C#NJ00148791) and Federal COVID-19 Focused Infection Control Survey conducted at Hampton Behavioral Health System on October 18, 19, and December 20, 2021 to determine compliance with the following Condition of Participation for Hospitals: 42 CFR Part 482.13 Patient Rights Standard level deficiencies were evident.	A 000		
A 119	PATIENT RIGHTS: REVIEW OF GRIEVANCES CFR(s): 482.13(a)(2) [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on one (1) out of two (2) medical records (Medical Record #1) reviewed for complaints and grievances, review of facility documents, and staff interview, it was determined that the facility failed to implement its grievance policy and document a grievance from a patient or a patient's representative. Findings include: Reference: Facility policy titled, Grievances: Patient, Family; Role of the Patient Advocate,	A 119	Facility Patient Advocate participated in the Patient Advocate training recently provided to all facility Patient Advocates in January 2022. Facility Patient Advocate will update the annual complaint/grievance training for all staff by 3-15-22 and will introduce in the next orientation on 3-21-22. Risk Manager reviewed the complaint grievance procedure with the treatment team on the unit where the event occurred on 3-7-22. Re-education to be provided to all clinical staff regarding any complaints about abuse/neglect need to be treated as a grievance and forwarded to the Patient Advocate for intervention by 3-15-22. Complaint grievance procedure reviewed with the medical staff and and treatment team involved in the event on 3-7-22. The Staff Development Coordinator reviewed and revised education provided during orientation and on an annual basis concerning the complaint/grievance procedure process for the annual mandatory trainings by 3-15-22. Re-educated the complaint/grievance procedure with the medical staff on 3-8-22. Re-educated the Director of Social Services regarding the complaint grievance process on 3-8-22. Director of Social Services to review with all social workers by 3-15-22. Complaint/grievances are reviewed monthly in Complaint and Grievance Committee and quarterly in Performance Improvement Committee, Medical Executive Committee and Governing Board. Compliance with reports of timeliness of response, resolution of complaint and letter sent to patient/ patient representative is included in reports.	03/15/22 03/21/22 03/07/22 03/15/22 03/07/22 03/15/22 03/08/22 03/15/22 On-going monitor

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

Craig Hilton

TITLE

Craig Hilton, CEO/Managing Director

(X6) DATE

03/29/2022

OK 4/18/22 CD

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A 119	Continued From page 1 states, " ... PURPOSE: Definition: For the purpose of this policy, a "patient grievance" is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489. ... If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is considered resolved when the patient is satisfied with the actions taken on their behalf. ... PROCEDURES: ... 6. The grievance will be logged into the Grievance Log by the Patient Advocate or designee. ..." 1. On 10/18/21 beginning at 1:00 PM, Medical Record #1 was reviewed, and the following was revealed: a. The RN - Nursing Note dated and timed for 9/21/21 at 10:20 PM states, "... Nursing assessment 3-11 ... He/she stated he/she felt uncomfortable because his/her roommate put a pillow on his/her face last night. His/her roommate was placed on 1:1 at bedtime and his/her roommate will also be sleeping in the lounge. Pt [patient] stated, "I don't feel comfortable, I just want to leave." Pt's mother sent the police here this evening for a wellness check, and it was determined that the pt is in a safe environment. Pt told his/her mother on the	A 119	Re-education to be provided to the Nursing Supervisors on the complaint/grievance procedure with the Patient Advocate and Facility Risk Manager on 3-27-22. Re-Education includes definition of a complaint and a grievance. Actions to be taken by the treatment team if the complaint is about abuse or neglect the patient advocate must be notified In addition the requirement to notify appropriate agencies including DOH, police, and Institutional abuse if a minor. If a complaint cannot be resolved at the treatment team level it is treated as a grievance and forward to the Patient Advocate.. Administrators on-call will be re-educated by the facility Risk Manager regarding complaints/ grievances and to ensure compliance with appropriate notification of agencies by 3-15-22. Grievances submitted will be reviewed daily by the Patient Advocate and be available to review in daily operations meeting to ensure timely follow up and resolution by 3-16-22. OK 4/1/22 CP	03/27/22 03/15/22 03/16/22

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(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 119	Continued From page 2 phone he wants to leave. Mother stated she wanted to sign the pt out tonight, she was offered a 48 [hour] notice several x's [times] but declined. She spoke [with] RN, RN supervisor, and APN (attending) on the phone. [Staff #1] and [Physician] were also notified. ..." b. The "Patient Request to Terminate Inpatient Treatment" document signed by the patient and dated 9/22/2021 indicated the reason for the request was, "Don't feel safe with other patient." The document also contained a hand-written checkmark that indicated, "I feel that I am no longer in a crisis situation and wish to leave treatment." c. The patient was discharged from the facility on 9/22/2021. The "Leaving Against Medical Advice" form, dated 9/22/21 and timed 1:45 PM included the Social Worker's signature and an indication that the "patient refused" to sign. 2. The complaint and grievance log for July 1, 2021 through October 18, 2021 was reviewed and Patient #1's grievance was not documented. During an interview at 2:45 PM, Staff #1 confirmed that there was no grievance documented and stated that it was decided to keep it at the treatment team level. Staff #1 stated that introducing a third party would have created more confusion. Staff #1 stated that he/she documented it as an incident report.	A 119		
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:	A 144	Risk Manager to provide to all staff who provide care to patients on the requirement to complete an incident report for an event, outcome or situation that is not consistent with the routine care of patients and/or desired operations of the facility and results in or could result in (near miss) unexpected medical intervention, unexpected intensity of care, or unexpected mental or physical impairment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	314021	A. BUILDING _____ B. WING _____	12/20/2021

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A 144	Continued From page 3 A. Based on medical record review, review of facility documents and staff interview, it was determined that the facility failed to ensure that policies and procedures for incident reporting were implemented by all staff. Findings include: Reference: Facility policy titled, Healthcare Peer Review (HPR) / Incident Reporting Process, states, "... B. Definitions: 1. Incident: An event, outcome, or situation that is not consistent with routine care of patients and/or the desired operations of the facility and results in or could have resulted in (near miss) unexpected medical intervention, unexpected intensity of care, or unexpected physical or mental impairment. ... PROCEDURES: ... B. Healthcare Facility Staff: 1. Any healthcare facility employee who discovers, is directly involved in or responds to an incident is to complete or direct completion of a HPR/Incident Report as soon after the event as possible, but not later than the end of the shift. ..." 1. During an interview on 12/20/21 at 10:20 AM, Staff #14 stated that during his/her evaluation of Patient #1 on 9/21/21, Patient #1 informed Staff #14 that his/her roommate (Patient #2) had told Patient #1 that he/she had tried to smother Patient #1 with a pillow during the night. 2. A review of Medical Record #1 revealed an "RN- Nursing note" dated 9/21/21 at 10:20 PM, which states, "... [He/she] stated [he/she] felt uncomfortable because [his/her] roommate put a pillow on [his/her] face last night. ..." 3. A review of a facility incident report for the alleged event occurring overnight on 9/20-9/21/21	A 144	The incident report should be entered as soon as possible but no later than the end of shift. Education is provided at the time of hire and as part of the annual competencies. Risk Manager provided written communication to all clinical staff concerning the Incident Reporting policy for any unusual event that occurs during a patient staff by 3-15-22. Risk Manager reviews 100% off all incidents submitted either electronically or on paper. Risk Manager to review Nursing Shift Supervisor report to ensure incident reports are completed for all unusual patient/visitor events documented until 100% compliance is attained in reporting of events and documentation on Nursing Shift Supervisor Log. Risk Manager continues review of daily Nursing Shift Supervisor reports for any events to ensure incident report is completed 3-8-22. Risk Manager to report findings monthly in Patient Safety Council and quarterly in Performance Improvement Council, Medical Executive Committee and Governing Board. Risk Manager conducted re-education with the medical staff on 3-8-22 on the requirement to clarify order for off shift 1:1 observation status with requirement to document in the physician order the exact time frame for the high risk protocol to be implemented for the 1:1 observation. Written communication was provided to all Registered Nurses to ensure orders from physician/LIP includes specific time frames for 1:1 observation for shift only 1:1 observation status. Unit Managers to conduct daily audits for compliance with time requirements for shift only 1:1 until 100% compliance is maintained. Findings will be reported by the Director of Nursing monthly in Performance Improvement Council and quarterly in Medical Executive Committee and Governing Board by 3-28-22.	03/15/22 03/08/22 03/08/22 03/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	314021	A. BUILDING _____ B. WING _____	12/20/2021

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A 144	Continued From page 4 revealed that the incident report was completed on 9/23/21 by Staff #1. Staff #1 was not the clinical staff who discovered the incident. a. The report was not completed at the time the incident was discovered by the staff members involved. This was not in accordance with facility policy. 4. The above finding was confirmed with Staff #1 on 12/20/21 at 12:59 PM. B. Based on review of facility policy, and staff interview, it was determined that the facility failed to ensure that policy and procedures for 1:1 patient monitoring were clarified and implemented in accordance with provider orders to ensure patient safety. Findings include: Reference: Facility policy titled, Special Precautions Patient Classification, states, "... B. One-to-One Observation Status - ... The patient will be maintained on constant visual observation by a staff member at a distance no greater than three (3) feet to ensure patient safety. ... 1. The patient on this level of observation must be with the assigned staff member at all times. ..." 1. A review of Medical Record #2 revealed a provider's order dated 9/21/21 at 9:30 AM, which states, "... 1:1 @ HS [bedtime] for safety". The medical record lacks evidence that staff clarified the intended start and end time of this order. a. A "RN- Nursing Note" dated 9/21/21 at 1315 states, "... Pt [patient] denies HI/SI [homicidal ideation/suicidal ideation] but attempted to	A 144	Risk Manager formalized policy for Reportable Events to the Department of Health on 3-8-22. Education to Nursing Supervisors will occur on 3-27-22 regarding requirement to report when there is an allegation of assault by patient which includes notification of the local police for minors, the Division of Institutional Abuse in addition to the family. Risk Manager will provide re-education to the social workers and physicians as to the reporting requirements for an alleged assault by 3-27-22. Risk Manager to report compliance with Reportable Events Policy and notification of the Division of Institutional Abuse monthly in Patient Safety Council and quarterly in Performance Improvement Council, Medical Executive Committee and Governing Board until 100% compliance is maintained. 4/4/22 OK CR	03/08/22 03/27/22 03/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 144	Continued From page 5 smother his roommate last night. Pt will be placed on a 1:1 from the hours of 11P-7A. ..." Documented evidence revealed that the 1:1 was initiated at 9:30 PM. The medical record lacked evidence that staff clarified the intended start time of the 1:1. 2. During interviews conducted with staff members on 12/20/21, the following was revealed: a. At 10:15 AM, Staff #12 and Staff #13 were interviewed about the unit schedule. Staff #12 stated that he/she does not work evening shifts and deferred to Staff #13. Staff #13 stated that doors to patient rooms are locked during the day for patient safety and are unlocked by staff between 8-8:30 PM. Staff #13 stated that patients can then go back and forth to their rooms until bedtime which is between 9:30PM-10:00 PM, dependant on the patient's assigned level of care. b. At 10:20 AM, Staff #14 stated that he/she evaluated Patient #1 and Patient #2 the morning after they were both admitted (9/21/21). Staff #14 stated that during his/her evaluation of Patient #1, the patient stated, "Just so you know, my roommate [Patient #2] told me he tried to smother me". Staff #14 stated that no one saw or heard any disturbance from the patient room. Staff #14 ordered a 1:1 sitter for Patient #2 at bedtime for safety. Staff #14 stated that at bedtime meant beginning at 9:30 PM. When asked for clarification, Staff #14 stated that the 1:1 monitoring should begin at the time the patient rooms are unlocked for the night. Staff #14 confirmed any time the patients are out of sight of staff there should be a 1:1 sitter in accordance	A 144		

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A 144	Continued From page 6 with his/her order for 1:1 at bedtime. (i) Staff #14 stated that when he/she arrived on the unit the next morning (9/22/21), he/she saw Patient #2 walking down the hallway with Patient #1 following. Staff #14 stated that it did not make sense that if Patient #1 feared Patient #2, that he/she would follow him/her alone. Staff #14 then made the decision to place Patient #2 on a continuous 1:1 as much for his/her own safety due to the patient's current mental state. c. At 10:50 AM a follow-up interview was conducted with Staff #13. Staff #13 stated that he/she does work evening (3PM-11PM) shifts on the Adolescent Unit "occasionally". Staff #13 confirmed his/her earlier statement that staff unlock the patient room doors between 8-8:30 PM. Staff #13 stated that 1:1's begin at whatever time the provider ordered the 1:1 to start. d. Staff #15 was also interviewed regarding the daily patient schedule. Staff #15 stated that the bedtime for Level 1 patients was at 9:30 PM and for Level 2 and 3 patients the bedtime was at 10 PM. Staff #15 stated the bedroom doors are unlocked at 9:30 PM. This was inconsistent with Staff #13's statement that doors are unlocked between 8-8:30 PM. (i) Staff #15 stated that the 1:1 typically ends after the night shift at 7 AM. When asked who is watching the patient after that time and before the doors are locked for the day, Staff #15 explained that the 1:1 observer will wake the patient prior to leaving and the patient will be moved to the lounge so that staff can see the patient. 3. During an interview on 10/19/21 at 12:10 PM,	A 144		

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A 144	Continued From page 7 Staff #1 confirmed that on the morning of 9/22/21, Patient #2 entered the patient room without a 1:1 observer while Patient #1 was alone in the room. Staff #1 stated that this occurred because Patient #2's order for 1:1 had expired at 7:00 AM on 9/22/21. Patient #2 was not being observed by staff to prevent interaction with other patients before the patient rooms were locked for the day. 4. During an interview on 12/20/21 at 11:16 AM, Staff #1 confirmed that the facility policy for 1:1 patient monitoring is not clear for a start time when ordered for "at bedtime". C. Based on one (1) of two (2) medical records (Medical Record #1) reviewed, review of facility documents, and staff interview, it was determined that the facility failed to ensure that staff notify the necessary agencies when allegations of assault are reported. Findings include: Reference #1: Facility policy titled, Assault Precautions, states, "PROCEDURES: ... In the event that a patient attacks another patient (provoked/unprovoked) and regardless of precaution, the following procedure is to be followed: ... 3. Notify the local police of patient to patient assault and provide police with patient demographics. 4. Notify the Risk Manager and the Department of Health of patient to patient assault. ..." Reference #2: Facility policy titled, Child Abuse, states, "... D. DCP&P Institutional Abuse must be notified immediately of the abuse allegation ... In cases involving allegations made by a patient against another patient, information on all parties	A 144		

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A 144	Continued From page 8 involved may be shared with DCP&P specific to the present allegation and investigation. ..." 1. A review of Medical Record #1 revealed an "RN- Nursing note" dated 9/21/21 at 10:20 PM, which states, "... [He/she] stated [he/she] felt uncomfortable because [his/her] roommate put a pillow on [his/her] face last night. ..." The medical record lacked evidence that this event was reported to the police, DCP&P, or institutional abuse per facility policy. 2. During an interview on 12/20/21 at 10:20 AM, Staff #14 was interviewed. Staff #14 stated that during his/her evaluation of Patient #1 on 9/21/21, the patient stated, "Just so you know, my roommate [Patient #2] told me he tried to smother me". Staff #14 stated that no one saw or heard any disturbance from the patient room. 3. During an interview on 10/19/21 at 3:07 PM, Staff #3 stated that he/she was made aware of Patient #1's allegations by the patient's mother on 9/21/21 at 3:50 PM and passed this information on to the Charge RN. Staff #3 stated that when a patient makes an accusation of a crime, potential crime, or abuse, that he/she needs to call Institutional Abuse and inform them of the allegations. Staff #3 stated that he/she did not report Patient #1's allegations because he/she did not believe the allegations occurred. This was not in accordance with facility policy referenced above. 4. During an interview on 12/20/21 at 11:30 AM, Staff #1 confirmed that the police were not notified of the potential criminal activity. This event was also not reported to the New Jersey Department of Health. This was not in	A 144		

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A 144	Continued From page 9 accordance with the above referenced facility policy.	A 144		

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

POST-CERTIFICATION REVISIT REPORT

COPY

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
314021 Y1	A. Building B. Wing Y2	4/4/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON BEHAVIORAL HEALTH SYSTEM	650 RANCOCAS ROAD WESTAMPTON, NJ 08060

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0119 Reg. # 482.13(a)(2) LSC	Correction Completed 04/01/2022	ID Prefix A0144 Reg. # 482.13(c)(2) LSC	Correction Completed 04/01/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Christina Petruska	4/4/22
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
			[illegible]	4/4/22
FOLLOWUP TO SURVEY COMPLETED ON 12/20/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			