unity center for behavioral health
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Summary of Deficiencies
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- The physical environment contained numerous hazards that resulted in actual harm, patient attempts at self-harm and suicide attempts. These included ligature risks.
- Systems for visual observation and supervision of patients when in high risk or vulnerable areas, or when engaging in high risk or vulnerable activities were lacking.
- The majority of patient rooms observed had significant "blind spots" in camera views that created the opportunity for patient self-harm or suicide without immediate detection.
- Clear processes and supplies/equipment for responding to urgent and emergency patient conditions were lacking. Responses were inconsistent.
- All staff had not received training as required by the Code of Federal Regulations or by hospital policy.
- Physical environment and security measures to prevent patient elopement were not effective.
- Restraint and seclusion policies and procedures were not fully developed to ensure staff were trained and demonstrated knowledge.
- The hospital failed to ensure ongoing assessment and monitoring of patients who were in physical restraints and/or seclusion.
- The governing body failed to ensure the provision of safe and appropriate care to patients in the hospital.
- The hospital failed to fully develop and implement policies and procedures that ensured that patient's rights were recognized, protected and promoted.
- Investigations of and response to actual or alleged abuse or neglect were not timely or complete.
- Response to patient's complaints and grievances were not timely or complete.
- Patients were not informed of their rights as required.
- Medicare beneficiaries did not receive Important Message from Medicare as required.
- Patients did not receive advance directives information as required.

- Drugs, restraints and other interventions were not administered in accordance with physician orders.