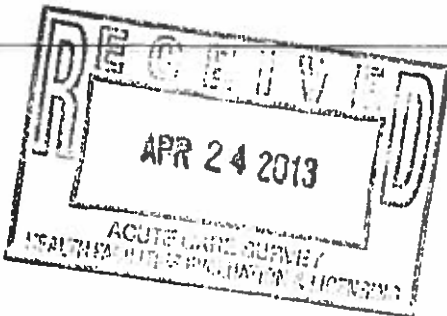


New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  52008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/14/2013
NAME OF PROVIDER OR SUPPLIER  SUMMIT OAKS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 19 PROSPECT ST SUMMIT, NJ 07901		
(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) COMPLETE DATE
D 000	8:43G INITIAL COMMENTS  C# NJ 62723  Sample size: 1  The facility is in substantial compliance with the requirements of N.J.A.C. Title 8 Chapter 43G for Hospital Licensing Standards, based on this complaint investigation only.	D 000		
D 465	8:43G-4.1(a)(27) PATIENT RIGHTS: PATIENT RIGHTS  The patient rights shall include at least the following:  To be given a summary of these patient rights, as approved by the New Jersey State Department of Health, and any additional policies and procedures established by the hospital involving patient rights and responsibilities. This summary shall also include the name and phone number of the hospital staff member to whom patients can complain about possible patient rights violations. This summary shall be provided in the patient's native language if 10 percent or more of the population in the hospital's service area speak that language. In addition, a summary of these patient rights, as approved by the New Jersey State Department of Health, shall be posted conspicuously in the patient's room and in public places throughout the hospital. Complete copies of this subchapter shall be available at nurse stations and other patient care registration areas in the hospital for review by patients and their families or guardians.	D 465	D 465 8 43G-4.1 (a) (27) Patient Rights: Patient Rights  The facility is now in compliance with the regulation regarding patient rights, by ensuring that the patient receives a summary of patient rights as approved by the New Jersey State Department of Health and any additional policy and procedures involving patient rights and responsibilities.  1. The signs located in the main lobby and patient care areas regarding patient rights now reflect the state's approved patient Bill of Rights as stipulated in N.J.A.C. 8 43G. 2. Signage will be located in visible areas in the lobby and patient care units 3. In the event that units have to be renovated, all posters will be moved to another visible area temporarily.  Responsible person (s) 1. Director of Plant Operations 2. Director of Performance Improvement  How audited:  1. Once implemented, the Director of Performance Improvement will conduct a random audit of the facility posters monthly to ensure that all posters are in place and located in visible areas on the patient care units and in the lobby	4/20/2013

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

STATE FORM

6899

TS0011

TITLE

(X4) DATE

4/23/13

If continuation sheet 1 of 3

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  52006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/14/2013
NAME OF PROVIDER OR SUPPLIER  SUMMIT OAKS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 19 PROSPECT ST SUMMIT, NJ 07901		
(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) COMPLETE DATE
D 465	Continued From page 1	D 465		
	<p>This REQUIREMENT is not met as evidenced by: Based on observations made during a tour of the facility and staff interview it was determined that the facility failed to ensure that a summary of the patients' rights was conspicuously displayed in the patients' rooms and in public places throughout the hospital.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. While touring the TU1 unit it was noted that there were no patient rights signs posted in the patient's rooms or in the dayrooms.</li> <li>2. While touring the TU5 unit it was noted that there were no patient rights signs posted in the patient's rooms or in the dayrooms.</li> <li>3. Staff # 2 stated that the patient rights signs were removed in order to paint the walls of the units.             <ol style="list-style-type: none"> <li>a. Staff # 2 stated that it takes approximately 6 weeks per unit to finish painting.</li> </ol> </li> </ol>	D 465		
D5907	<p>8:43G-26.2(a)(2) PSYCHIATRY: POLICIES &amp; PROCEDURES</p> <p>Policies and procedures of the psychiatry service shall include at least the following:</p> <p>Safety and security precautions for the prevention of suicide, assault, elopement, and patient injury.</p> <p>This REQUIREMENT is not met as evidenced</p>	D5907		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  52008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/14/2013	
NAME OF PROVIDER OR SUPPLIER  SUMMIT OAKS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 19 PROSPECT ST SUMMIT, NJ 07901		
(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) COMPLETE DATE
D5907	<p>Continued From page 2</p> <p>by:</p> <p>Based on observations made during a tour of the facility and staff interview it was determined that the facility failed to ensure that a summary of the patients' rights was conspicuously displayed in the patients' rooms and in public places throughout the hospital.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. While touring the TU1 unit it was noted that there were no patient rights signs posted in the patient's rooms or in the dayrooms.</li> <li>2. While touring the TU5 unit it was noted that there were no patient rights signs posted in the patient's rooms or in the dayrooms.</li> <li>3. Staff # 2 stated that the patient rights signs were removed in order to paint the walls of the units.             <ol style="list-style-type: none"> <li>a. Staff # 2 stated that it takes approximately 6 weeks per unit to finish painting.</li> </ol> </li> </ol>	D5907		


**State Form: Revisit Report**

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 52006	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 5/9/2013
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<b>Name of Facility</b> SUMMIT OAKS HOSPITAL	<b>Street Address, City, State, Zip Code</b> 19 PROSPECT ST SUMMIT, NJ 07901
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This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix D0465 Reg. # 8:43G-4.1(a)(27) LSC	Correction Completed 05/09/2013	ID Prefix D5907 Reg. # 8:43G-26.2(a)(2) LSC	Correction Completed 05/09/2013	ID Prefix _____ Reg. # _____ LSC	Correction Completed
ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed
ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed
ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed
ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed	ID Prefix _____ Reg. # _____ LSC	Correction Completed

Reviewed By	Reviewed By 	Date: 5/9/13	Signature of Surveyor: <i>William Fackelman</i>	Date: 5/9/13
State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By				
CMS RO				

Followup to Survey Completed on: 3/14/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		