Colorado Department of Public Health and Environment
Health Facilities and Emergency Medical Services Division

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
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| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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| L 000 | Colorado Psychiatric Hospitals Initial Comments<br><br>A survey prompted by complaints CO#21964, 21965, 21966 and 21971 was completed on 7/27/18. Deficiencies were cited. | L 000 | | |
| H 605 | IV.6.102(1) Governing Board: Scope of Care<br><br>[The governing board shall:] provide services and hospital departments necessary for the welfare and safety of patients. The scope of care and services shall be defined in writing.<br><br>This REGULATION is not met as evidenced by: Based on observations, interviews and document review the governing body failed to provide oversight of services provided within the hospital to ensure they were provided in a safe manner and in accordance with professional standards in the areas of patient safety, infection control, and nursing services. These failures affected all patients receiving services and all patient records reviewed (Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13).<br><br>Specifically, the governing body failed to investigate adverse events, including patient falls, injuries, and suicide attempts to determine the events' root causes and implement measures to avoid reoccurrence. The governing body failed to identify ligature risks and safety hazards and failed to put processes in place to mitigate the risks. When restraints or seclusion interventions were utilized on patients, there was no oversight to ensure physician orders were obtained prior to their initiation, face to | H 605 | 1. The procedure for implementing the Plan of Correction (PoC,<br><br>A. The Governing Board meeting was held to discuss the findings from the survey including the deficiencies identified in patient safety, infection control, and nursing services, root causes for the deficiencies and to propose plans of action to address correction of the problems and monitor for correction in the deficiencies as delineated below. The meeting concluded that the root causes which led to the deficiency included the planned change in Senior Leadership (LS) including the CEO, Director of Nursing (DON), Infection Control (IC) Nurse, Director of Compliance/Quality/Risk (DCQR) but the difficulty in obtaining qualified replacements. Subsequently, the leadership for the other sister hospital in Colorado assisted in the assumption of many of these duties but this was too wide | 09/21/2018 |

I attest that the plan of correction will be implemented and monitored for compliance

AUTHORIZED PROVIDER REPRESENTATIVE'S SIGNATURE TITLE DATE

H 605

Continued From page 1

face evaluations were conducted by qualified staff within one hour, and that the interventions were discontinued at the earliest possible time.

With regards to nursing services, the governing body failed to ensure staffing was adequate to meet the needs of patients including monitoring patients for safety, providing practitioner ordered nursing groups and in assisting patients in hygiene needs. In addition, the governing body failed to provide adequate housekeeping staff and provide oversight to the infection control program to ensure all patient rooms and patient care areas were sanitary.

These failures resulted in patients receiving care in an unsafe and unsanitary environment, which led to the declaration of two Immediate Jeopardies under the conditions of Infection Control and Patient Rights.

Findings Include:

A. The governing body failed to investigate patient falls and suicide attempts to determine whether patients were injured, experienced a change in medical condition, or required a higher level of care or higher observation status to prevent further falls and suicide attempts.

The Fall Reduction Policy read, the facility was committed to the safety of its patients. All falls were referred to a physician for further follow-up and evaluation. Any fall which occurred was reviewed for trending, prevention, and demographics (where, when, and why).

The Completion of Incident Reports policy read, the risk manager reviewed and categorized all incident reports. The risk manager conducted an investigation and followed-up as necessary.

1. The facility was made aware of patient injuries when Patient #9 was transferred to an

H 605

a span of responsibility to ensure that all requirements were being maintained per all standards.
Pursuant to this “lesson learned”, the Governing Board concluded that, on a go-forward basis, the two hospitals in Colorado will not, again, share Senior Leadership members at the same level of responsibility for each hospital (i.e. Director of Nursing responsible for both facilities concomitantly) but, instead, should a vacancy in the leaders occur, a qualified, Interim Leader with the specific title and responsibilities will be assigned to the Hospital until the position is filled. This change is not intended to replace the ability to have a Senior Leader at one hospital have an advisory role to the Senior Leader at the hospital with newer members of the Senior Leadership team.

In addition, the GB also discussed findings from the survey pertaining to the following identified deficiencies:
(1) failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital’s kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for dietary and hospital cleanliness, sanitation, and infection prevention; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were receiving care and nutrition in a sanitary environment.
The root causes were identified as

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| H 605 | Continued From page 2<br>acute care hospital. However, the facility failed to investigate and determine if the injuries resulted from a fall which occurred at the facility four days prior to the patient's emergent transfer.<br><br>a. Review of the Comprehensive Psychosocial Assessment Tool, dated 12/31/17 at 10:58 p.m., revealed Patient #9 was brought to the facility by ambulance from the Emergency Department (ED) at an acute care hospital. Patient #9 was admitted with a diagnosis of unspecified schizophrenia. Review of imaging results, provided to the facility by the sending acute care hospital, documented an x-ray of the left hip and pelvis showed no evidence of an acute fracture, dislocation, and showed normal alignment on 12/31/17 at 5:22 p.m.<br><br>Review of a Health Pre-Incident Review Report (incident report) written by Registered Nurse (RN) #13 revealed Patient #9 had an unwitnessed fall on 1/2/18 at 1:30 p.m. RN #13 documented Patient #9 was in bed and was later found lying on the floor. Review of the incident report revealed RN #13 documented Patient #9 had no apparent injuries. It was not evident how RN #13 determined the patient had no injuries as there was no documented nursing assessment.<br><br>A progress note, on 1/6/18 at 2:25 a.m. written by RN #22, revealed Patient #9 awoke at 1:30 a.m. shouting he was having chest pain and asking for his defibrillator. RN #22 documented she entered Patient #9's room with the mental health technician (MHT) and found the patient mildly responsive (only responding to loud commands), diaphoretic (sweating heavily), shaking, and visibly clutching his chest in pain. RN #22 documented Patient #9 stated his defibrillator was going off constantly. Patient #9 had an elevated heart rate of 115 beats-per-minute and a low oxygen saturation | H 605 | follows: The DON was overseeing two facilities due to the difficulty in filling the DON position at Clear View Behavioral Health. This DON had too wide a span of control between the two hospitals to meet all requirements and, though experienced in Infection Control (IC), was not doing so at her main facility so not aware of the requirements for not only patient but environmental surveillance including the cafeteria and housekeeping areas. Additionally, the Dietary Manager was inexperienced in his job and failed to seek assistance from corporate resources within his contract company. As another root cause, the Director of Environment of Care (EOC) was under-performing as relates to his job duties and not taking timely actions on infection-related issues in the environment, not escalating issues for intervention, not documenting EOC-related activities. This Director of EOC departed the hospital before the survey was over and an Interim EOC identified and appointed. An action plan was developed and M&E processes and tools proposed.<br><br>B. A meeting was conducted between the GB and Hospital/MS leaders to review the findings and identify expectations related to the conduct and oversight of the following:<br>-Through critical event analysis process, the need to consistently investigate adverse events, including patient falls, injuries, and suicide attempts to determine injuries, changes in medical conditions, The need for higher level of care or higher observation status;<br>-The need to investigate and determine if injuries resulted from a fall which occurred four days prior and investigate all patient | |

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| H 605 | Continued From page 3<br>level of 82 percent. Oxygen was placed on Patient #9, a code white (medical emergency) was called, Physician #21 was contacted and an order was obtained to call 911. An ambulance transported Patient #9 to an acute care hospital at approximately 2:00 a.m.<br><br>Review of the Medical Transfer Monitoring Tool, documented by RN #22 on 1/6/18 at 2:45 a.m., revealed Patient #9 had arrived at the receiving facility and was admitted with fractures to his left ribs, numbers 2 through 5, and a left pelvic fracture. This was a new finding as compared to the imaging results, provided to the facility by the sending acute care hospital, which documented an x-ray of the left hip and pelvis showed no evidence of an acute fracture, dislocation, and showed normal alignment on 12/31/17 at 5:22 p.m.<br><br>b. On 7/26/18 at 1:55 p.m., an interview was conducted with Director Of Nursing (DON) #2 who stated the investigation for Patient #9 should have been handled differently. DON #2 stated she remembered talking about the patient, but she could not locate any record of an investigation. DON #2 stated it was possible Patient #9's fall may have been the reason he was spending a lot of time crawling and scooting on the floor. DON #2 stated an investigation would have been helpful to determine if the patient's injury occurred at the facility and what could have been done to prevent the injury.<br><br>c. On 7/19/18 at 2:46 p.m., an interview was conducted with Director of Quality (Director) #25 who stated she was not aware of the results of the investigation into Patient #9's transfer. Director #25 stated the incidents were reviewed by Risk Manager #18 who was no longer working at the facility. Any further investigation of the incidents, for Patient #9's fall and transfer, were requested. On 7/19/18 at 4:08 p.m., Director #25 returned and stated she did not | H 605 | falls<br>-The need to have a process in place to ensure suicide attempts are investigated and appropriate measures put in place to prevent further attempts<br>-The need to ensure unit staffing is sufficient to ensure all patients are monitored to ensure safe patient care<br>-The need to identify safety hazards of patients in the environment and put processes in place to mitigate risks<br>-The need to ensure that S/R interventions are implemented per policy, only until after the situation has ceased even if the S/R order has not expired, only used when the patient is a danger to self/others, a face to face assessment is done by a qualified individual within one hour of the episode<br>-The need to ensure that patients area assessed and monitored in order to ensure their safety and comfort.<br>-The need to ensure patients receive group therapy sessions and hygiene care per policies and procedures<br>-The need to ensure staffing is adequate to consistently permit patient observation checks at every 15 minutes<br>-The need to ensure patients are provided consistent group therapy<br>-The need to ensure that patients receive showers or baths and assistance with hygiene care, when required<br>-The need to provide adequate housekeeping staff<br>-The need to have oversight of the Infection Control program to ensure a sanitary environment<br>The root causes that were presented were concurred by this group.<br><br>C A meeting was held between the GB members and Hospital Leaders including the IC Nurse and Dietary Manager to | |

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| H 605 | Continued From page 4<br>know what was done to investigate Patient #9's fall or the injury discovered after his transfer out of the facility. Director #25 stated she could not locate any notes from Risk Manager #18. Director #25 stated Risk Manager #18 reported to her, but Director #25 would not have been made aware unless there were any outstanding concerns.<br><br>d. During a meeting with Quality Coordinator (QC) #1, Director #25, Chief Operating Officer (COO) #15, Chief Executive Officer (CEO) #6, and DON #2, on 7/19/18 at 4:45 p.m., the facility was asked to provide documentation on how they followed up and investigated Patient #9's injuries which were identified upon his transfer and subsequent admission to an acute care hospital. On 7/19/18 at 5:14 p.m., QC #1 reported there was no documentation of any further investigation into the cause of Patient #9's fractured ribs and pelvis.<br><br>e. Record review revealed similar findings for Patient #5 in which the facility failed to investigate the patient's falls. Cross Reference A-0144<br><br>2. The governing body failed to have a process in place to ensure all suicide attempts within the facility were investigated and appropriate measures were put in place to prevent further suicide attempts.<br><br>The Suicide Precautions Policy read, the facility was to provide for the safety and well-being of each individual patient found to be at risk for harm to themselves.<br><br>According to the Practice Guidelines for Levels of Observations Policy, guidelines for 1:1 would include seclusion, restraint or emergency use of medication, actively attempting to or imminent harm to self or others, acting on suicidal ideation, hallucinations, demonstrated | H 605 | examine findings, analyze root causes of the findings and delineate expectations and plan of action related to the following deficiencies cited: (1)Failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital's kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for cleanliness, sanitation and infection prevention in the kitchen and patient care areas; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were receiving care and nutrition in a sanitary environment. The Leaders concurred with the assessment of the GB as relates to the root causes that were identified, the action plan and the M&E process to be used.<br><br>-The vacant Environment of Care Director position was replaced and the employee was trained on requirements related to IC prevention and intervention as well as documentation.<br>-Housekeeping vacancies were replaced through a contract service that will continue to be used daily until there is Housekeeping coverage on both shifts on a daily basis and whenever there are future housekeeping vacancy issues.<br>-A competency training for contract and staff housekeepers on cleaning requirements was completed.<br>-Consideration was made to add an IC policy on environment of care. Question | |

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| H 605 | Continued From page 5<br>unpredictable or impulsive behavior placing themselves or others at risk, patient failed line of sight observations, unsafe at a lower level, status post suicide attempt for 24 hours.<br><br>According to the Critical Event Review and Reporting Policy, a critical event was an event which resulted in or had the potential to cause serious harm or death, even if the outcome was not serious harm or death, includes attempted suicide and falls with significant injury.<br><br>A critical event analysis attempted to determine the underlying causes of critical events and whether there was reasonable potential for performance improvement to reduce the likelihood of such events in the future. Adverse patient occurrences may be identified through occurrence reporting. The Performance Improvement (PI) coordinator determines if an event meets the definition of a critical event and initiates the critical event analysis within 30 days of knowledge of the event.<br><br>a. Patient #5 had multiple suicide attempts while admitted to the facility. The facility failed to investigate two suicide attempts by Patient #5 to ensure patient safety. In addition, the facility failed to increase Patient #5's level of observation to prevent future suicide attempts.<br><br>According to the H&P, documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic. On 3/18/18 at 6:14 a.m., Physician #21 performed an Evaluation of Risk and added Patient #5 had previous suicide attempts by hanging and numerous suicide gestures such as swallowing rubber gloves.<br><br>According to an incident report, dated 3/27/18 at 8:00 p.m., Patient #5 had a blanket wrapped around her neck in a threat to harm herself. | H 605 | was raised if the Dietary Services had adequate policies and it was concluded by the GB and LS teams that the IC plan needed to be the document to lead the IC nurse and it contained the requirements but, again, though credentialed as an IC Nurse, the acting DON/IC Nurse was not actively working as the IC Nurse at her own facility so not as versed in all the requirements of the IC plan that she could be. In meeting with the Corporate Dietary Company it was concluded that the policies were sufficient but were not being followed by the Hospital's Dietary Manager.<br>-The IC Nurse was apprised of these associated requirements and her authority, responsibility ,and expectations related to identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.<br>-The IC Nurse was trained by the VP of Nursing /PI/ Regulatory Affairs, who is a DNP, FNP-BC, NP-C versed in Infection Control requirements as well as through evidence- based infection control training resources on conducting environmental checks by directly surveying the kitchen at least twice weekly to ensure cleanliness<br>-The policy on "Use of the ADA Showerhead" was implemented . While not a new policy, an Environmental Checklist was developed for use by the Infection Control Nurse. The policy on Seclusion and Restraint (S/R) that is utilized by the Hospital's Corporation was also implemented for use at the Hospital in place of its current existing one as the former was more comprehensive. [Note: policies were implemented concurrently with training due to the acuity of the deficiencies identified<br>-All pertinent Hospital and Medical staff | |

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| H 605 | Continued From page 6<br>Patient #5 was restrained and required emergency intramuscular (IM) medication administrations of Zyprexa (antipsychotic medication), Ativan (relieves anxiety) and Benadryl (causes drowsiness).<br><br>According to the incident report, Director of Nursing (DON) #2 reviewed the incident on 3/28/18 at 10:10 a.m. with no further actions documented. On 4/3/18 at 12:07 p.m., Quality Coordinator (QC) #1 reviewed the incident report and documented it as a minor incident. QC #1 further documented the incident was reviewed in the daily safety meeting and wrote she would "continue to monitor."<br><br>There was no documentation the facility investigated the incident according to its Critical Event Review and Reporting policy to classify the suicide attempt as a critical event and determine whether there was a potential for performance improvement to reduce the likelihood of such event in the future.<br><br>b. Record review revealed Patient #5 had a second suicide attempt on 4/7/18 at 6:20 p.m. According to the RN Mental Assessment, Patient #5 gagged and vomited up a plastic bag. RN #3 gave Patient #5 Thorazine (antipsychotic medication that can reduce anxiety) and told her to stay in the milieu (common area) so she could be observed. However, Patient #5 was not observed and went to her room where staff found her with a sheet tied tightly around her neck and had difficulty removing it. There was no change in observation status after the patient attempted self harm, by swallowing a plastic bag, to potentially reduce the likelihood of additional suicide attempts.<br><br>According to an incident report dated 4/8/18 at 8:10 a.m., DON #2 completed a review of the incident. DON #2 documented Patient #5 was attempting to harm herself and attacked staff | H 605 | were inserviced through face to face training on the requirements to meet the above associated requirements that relate to their job-specific areas.<br>-A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as described below. Using the indicators, data from the ongoing assessment for compliance with established standards is being conducted on a daily basis (S-S). The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday<br><br>2. The procedure for implementing the Plan of Correction (PoC,<br><br>A. The Governing Board meeting was held to discuss the findings from the survey including the deficiencies identified in patient safety, infection control, and nursing services, root causes for the deficiencies and to propose plans of action to address correction of the problems and monitor for correction in the deficiencies as delineated below. The meeting concluded that the root causes which led to the deficiency included the planned change in Senior Leadership (LS) including the CEO, Director of Nursing (DON), Infection Control (IC) Nurse, Director of Compliance/Quality/Risk (DCQR) but the difficulty in obtaining qualified replacements. Subsequently, the leadership for the other sister hospital | |

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| H 605 | Continued From page 7<br>when they intervened. On 4/9/18 at 2:08 p.m., QC #1 signed the incident report and checked it as a major incident. QC #1 wrote Patient #5 was placed on a 1:1 observation status after the incident and staff followed policy and procedure. QC #1 documented she would "continue to monitor." There was no documentation the facility investigated the incident according to its policy to determine the underlying causes of the suicide attempts as a critical event and whether there was a potential for performance improvement to reduce the likelihood of such event in the future.<br><br>On 7/26/18 at 8:01 a.m., an interview with QC #1 was conducted. QC #1 stated a patient tying a sheet around their neck would be considered a suicide attempt and confirmed there had been no further investigation conducted on Patient #5's suicide attempts.<br><br>On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 stated she was unable to perform all of her duties because she was just trying to address issues as they arose. DON #2 was currently acting as the director of nursing for two hospitals approximately 125 miles apart. DON #2 stated her role in incident report review was to ensure the report was complete, and determine if staff required education.<br><br>On 7/26/18 at 1:59 p.m., a follow up interview with DON #2 was conducted. DON #2 stated an investigation should have been completed on all suicide attempts. DON #2 stated the compliance manager made the decision on when to perform an investigation. DON #2 confirmed there had not been an investigation on either of Patient #5's two suicide attempts. DON #2 stated Patient #5's observation status should have increased after she was gagging on the plastic bag to prevent the subsequent suicide attempt. Cross Reference A-0144 | H 605 | in Colorado assisted in the assumption of many of these duties but this was too wide a span of responsibility to ensure that all requirements were being maintained per all standards.<br>Pursuant to this “lesson learned”, the Governing Board concluded that, on a go-forward basis, the two hospitals in Colorado will not, again, share Senior Leadership members at the same level of responsibility for each hospital (i.e. Director of Nursing responsible for both facilities concomitantly) but, instead, should a vacancy in the leaders occur, a qualified, Interim Leader with the specific title and responsibilities will be assigned to the Hospital until the position is filled. This change is not intended to replace the ability to have a Senior Leader at one hospital have an advisory role to the Senior Leader at the hospital with newer members of the Senior Leadership team.<br><br>In addition, the GB also discussed findings from the survey pertaining to the following identified deficiencies:<br>(1) failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital’s kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for dietary and hospital cleanliness, sanitation, and infection prevention; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were receiving care and | |

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| H 605 | Continued From page 8<br><br>3. The governing body failed to ensure unit staffing was sufficient to ensure all patients were monitored in a manner to effect safe patient care. This resulted in an unwitnessed suicide attempt by Patient #13 while she was on line of sight (constant observation status).<br><br>a. On review of Patient #13's medical record, the patient was transferred to the facility on 7/15/18, after she stated she was going to kill herself. On 7/15/18 at 9:24 a.m., a comprehensive psychosocial assessment was completed. Patient #13 was documented as depressed and anxious and endorsing suicide with a plan to hang herself, cut herself or overdose on medication. At 9:47 a.m., an evaluation risk was completed and Patient #13 was identified as at an imminent risk for suicide.<br><br>Review of the psychiatric progress notes for 7/21/18 and 7/23/18, revealed Patient #13 continued to endorse suicide with a plan but she would not disclose the plan.<br><br>On 7/23/18 at 8:30 a.m., the physician ordered Patient #13 on line of site observation.<br><br>According to the policy, Levels of Observation, line of sight patients must be in sight of a staff member at all times. When the patient uses the bathroom the staff member will remain outside the bathroom door and visually check on the patient. Staff assigned to LOS must hand-off responsibility for maintaining observation of the assigned patient.<br><br>b. On 7/24/18 at 12:20 p.m., an incident report documented Patient #13 was found in her bathroom with a blanket tied around her neck which was attached to the toilet seat. The patient attempted to strangle herself after ripping off her scabs causing her to bleed. | H 605 | nutrition in a sanitary environment.<br>The root causes were identified as follows: The DON was overseeing two facilities due to the difficulty in filling the DON position at Clear View Behavioral Health. This DON had too wide a span of control between the two hospitals to meet all requirements and, though experienced in Infection Control (IC), was not doing so at her main facility so not aware of the requirements for not only patient but environmental surveillance including the cafeteria and housekeeping areas. Additionally, the Dietary Manager was inexperienced in his job and failed to seek assistance from corporate resources within his contract company. As another root cause, the Director of Environment of Care (EOC) was under-performing as relates to his job duties and not taking timely actions on infection-related issues in the environment, not escalating issues for intervention, not documenting EOC-related activities. This Director of EOC departed the hospital before the survey was over and an Interim EOC identified and appointed. An action plan was developed and M&E processes and tools proposed.<br><br>B. A meeting was conducted between the GB and Hospital/MS leaders to review the findings and identify expectations related to the conduct and oversight of the following:<br>-Through critical event analysis process, the need to consistently investigate adverse events, including patient falls, injuries, and suicide attempts to determine injuries, changes in medical conditions, The need for higher level of care or higher observation status;<br>-The need to investigate and determine if | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 605 | Continued From page 9<br><br>c. During an interview, on 7/25/18 at 3:44 p.m., Mental Health Technician (MHT) #20 stated she was providing line of site (LOS) observation for Patient #13 when she attempted suicide on 7/24/18 at 12:20 p.m. In addition, her duties included conducting 15 minute checks for all other patients on the unit and in group therapy. MHT #20 stated it was busy.<br><br>MHT #20 stated Patient #13 was in her room when a therapist came in to speak with the patient, at which point the MHT left the room and carried on with other unit duties. When MHT #20 noticed the therapist had left Patient #13's room she went to check on the patient, who was already in the restroom. MHT #20 stated Patient #13 took the "opportunity" to go to the restroom with a blanket. MHT #20 stated there was no hand off or report done between her and the therapist at anytime. MHT #20 stated she was not aware if the therapist knew Patient #13 was on LOS observation.<br><br>MHT #20 stated she did not follow the patient into the restroom or visually check on Patient #13, but instead stood at the hallway door of the patient's room and did a verbal check by calling the patient's name and waiting for a response. MHT #20 then continued her duties of monitoring the hall for other patients at the same time and stated "it was hard." This was in contrast to the observation policy, which stated the staff member would visually check on patients when they were in the bathroom to ensure patient safety.<br><br>MHT #20 stated when the patient failed to respond to a verbal check, she went into the restroom and found the patient with a blanket tied around her neck. MHT #20 then used her radio to call for assistance.<br><br>d. On 7/26/18 at 1:59 p.m., an interview was conducted with DON #2. DON #2 stated facility | H 605 | injuries resulted from a fall which occurred four days prior and investigate all patient falls<br>-The need to have a process in place to ensure suicide attempts are investigated and appropriate measures put in place to prevent further attempts<br>-The need to ensure unit staffing is sufficient to ensure all patients are monitored to ensure safe patient care<br>-The need to identify safety hazards of patients in the environment and put processes in place to mitigate risks<br>-The need to ensure that S/R interventions are implemented per policy, only until after the situation has ceased even if the S/R order has not expired, only used when the patient is a danger to self/others, a face to face assessment is done by a qualified individual within one hour of the episode<br>-The need to ensure that patients area assessed and monitored in order to ensure their safety and comfort.<br>-The need to ensure patients receive group therapy sessions and hygiene care per policies and procedures<br>-The need to ensure staffing is adequate to consistently permit patient observation checks at every 15 minutes<br>-The need to ensure patients are provided consistent group therapy<br>-The need to ensure that patients receive showers or baths and assistance with hygiene care, when required<br>-The need to provide adequate housekeeping staff<br>-The need to have oversight of the Infection Control program to ensure a sanitary environment<br>The root causes that were presented were concurred by this group.<br><br>C. A meeting was held between the GB | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| H 605 | Continued From page 10<br>policy did not indicate how many patients on LOS precautions one staff member could observe at one time, but felt three LOS patients for one staff member was appropriate. DON #2 was unable to explain how one staff member would be able to accomplish the LOS duties for all three patients as patients were able to be in different rooms and different areas on the units. Cross Reference A-0144<br><br>B. The governing body failed to identify safety hazards for patients at risk for intentional harm and failed to put processes in place to mitigate the risks. These hazards included flexible shower hose extenders, plastic bags, corded bed alarms, oxygen tubing, and sharpened pencils.<br><br>1. According to the policy, Securing Of Patient Rooms When Patients Are Not Present, when a patient room is vacated and there are no patients currently occupying the room the door shall be kept locked. Multiple observations conducted throughout the facility showed there was no standard process to ensure doors to rooms were closed and locked when patients were not in their room and items which posed a ligature risk were secured and unavailable for patient harm.<br><br>a. During a tour beginning on 7/23/18 at 11:32 a.m., Lead Mental Health Technician (MHT) #33 stated anytime patients were not in their room the door was supposed to be closed in order to prevent access by unauthorized patients and to prevent patients from isolating in rooms.<br><br>b. On 7/17/18 at 12:05 p.m., a tour was conducted of the 200 unit with the quality coordinator (QC #1). The 200 unit was designated for patients who were 55 years or older. Review of the daily census indicated 10 patients were on suicide precautions. Patients were observed on the unit during the tour. | H 605 | members and Hospital Leaders including the IC Nurse and Dietary Manager to examine findings, analyze root causes of the findings and delineate expectations and plan of action related to the following deficiencies cited: (1)Failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital's kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for cleanliness, sanitation and infection prevention in the kitchen and patient care areas; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were receiving care and nutrition in a sanitary environment. The Leaders concurred with the assessment of the GB as relates to the root causes that were identified, the action plan and the M&E process to be used.<br><br>-The vacant Environment of Care Director position was replaced and the employee was trained on requirements related to IC prevention and intervention as well as documentation.<br>-Housekeeping vacancies were replaced through a contract service that will continue to be used daily until there is Housekeeping coverage on both shifts on a daily basis and whenever there are future housekeeping vacancy issues.<br>-A competency training for contract and staff housekeepers on cleaning requirements was completed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 605 | Continued From page 11<br>Observation of room 202 revealed the door to the room was open and the room was not occupied, allowing access to all patients on the unit. Noted inside the bathroom shower of room 202 was a six foot flexible metal shower hose extender wand hanging from the shower arm (a piece of pipe which connected a standard overhead shower head to the bathroom wall). The hose extender wand was long enough for patients to utilize for self-harm or harm to others.<br><br>On 7/18/18 at 12:25 p.m., a tour was conducted of the 400 unit with QC #1. The unit was designated for the high acuity adult patient population. According to the mental health technician on the unit, all patients on the unit were suicidal.<br><br>Observation of room 406 revealed no patients were currently in the room and the door to the room was open, allowing access to all patients on the unit. Noted inside the bathroom shower, was a six foot flexible metal shower hose extender hanging from the shower arm.<br><br>On 7/24/18 at 1:38 p.m. Chief Operating Officer (COO) #15 and DON #2 stated there was no formal check-out or check-in process for the shower heads. Before the survey the shower heads were kept in the supply closet and upon a patient's request they were given to the patient. There was no way to ensure how long the hand held shower hoses had been left in an open room, unattended on units with patients who were suicidal.<br><br>c. On 7/18/18 at 1:28 p.m., a tour was conducted on unit 500, an adult unit. Observation of room 504 revealed a thermal hot pack in a plastic bag and a plastic chip bag in the patient's trash can. According to QC #1 the plastic bags were not supposed to be left in patient trash cans, as it could be used for | H 605 | -Consideration was made to add an IC policy on environment of care. Question was raised if the Dietary Services had adequate policies and it was concluded by the GB and LS teams that the IC plan needed to be the document to lead the IC nurse and it contained the requirements but, again, though credentialed as an IC Nurse, the acting DON/IC Nurse was not actively working as the IC Nurse at her own facility so not as versed in all the requirements of the IC plan that she could be. In meeting with the Corporate Dietary Company it was concluded that the policies were sufficient but were not being followed by the Hospital's Dietary Manager.<br>-The IC Nurse was apprised of these associated requirements and her authority, responsibility ,and expectations related to identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.<br>-The IC Nurse was trained by the VP of Nursing /PI/ Regulatory Affairs, who is a DNP, FNP-BC, NP-C versed in Infection Control requirements as well as through evidence- based infection control training resources on conducting environmental checks by directly surveying the kitchen at least twice weekly to ensure cleanliness<br>-The policy on "Use of the ADA Showerhead" was implemented . While not a new policy, an Environmental Checklist was developed for use by the Infection Control Nurse. The policy on Seclusion and Restraint (S/R) that is utilized by the Hospital's Corporation was also implemented for use at the Hospital in place of its current existing one as the former was more comprehensive. [Note: policies were implemented concurrently with training due to the acuity of the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 605 | Continued From page 12<br>self-harm. QC #1 was unsure why and how plastic bags were located in a patient's room. On review of the daily census the unit had 14 patients who were on suicide precautions.<br><br>d. On 7/19/18 at 10:22 a.m., a tour of unit 400 was conducted. Patients were noted to be on the unit. Observations of room 408 were conducted. The room was occupied by two patients. The patient in 408A had a medical condition which required the use of oxygen at night. The medical equipment included oxygen tubing and a machine, with an electrical cord, which provided the oxygen.<br><br>The patient in 408B had been admitted to the facility due to placing a noose around her neck in an attempt to kill herself. On review of the suicide risk assessment tool for the patient in 408B, dated 7/19/18, the patient was documented as a high suicide risk.<br><br>According to the policy, Unit Bed Assignment, roommates on medium or high suicide risk will not be placed with patients requiring medical equipment or other accommodations which pose a potential risk of harm, such as oxygen equipment.<br><br>An interview was conducted with the registered nurse (RN #4) who was in charge of nursing care for the unit. RN #4 stated she was unaware the two patients were sharing a room. RN #4 stated the two patients should not be roommates due to the patient's suicide attempt by strangulation.<br><br>e. A tour was conducted on unit 200 at 3:37 p.m. on 7/19/18. RN #3 stated there were patients who were on suicide precautions on the unit. Observation of room 203 was conducted and revealed the door was open. Located on the bed was a corded bed alarm (a pad which will alarm and is commonly used to notify staff when a | H 605 | deficiencies identified<br>-All pertinent Hospital and Medical staff were inserviced through face to face training on the requirements to meet the above associated requirements that relate to their job-specific areas.<br>-A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as described below. Using the indicators, data from the ongoing assessment for compliance with established standards is being conducted on a daily basis (S-S). The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday<br><br>3.The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br>Performance indicators to assess for compliance with these requirements have been implemented as follows: 1) Root cause analysis meetings are held for serious patient events per policy including falls and suicide attempts; 2)Staffing meets requirements of acuity and patient need; 3)Compliance with completion of environmental safety checks to identify ligature risks/lack of ligature risks found during rounds; 4)Seclusion/Restraint (S/R) episodes have a MD order, are discontinued at earliest possible time, patients are seen by a QRN in an hour; | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| H 605 | Continued From page 13<br>patient is trying to get out of bed) on the bed. Also a patient, not assigned to room 203, was observed entering and leaving the room unaccompanied. RN #3 stated the cord which was approximately five feet long presented a risk for patient harm and was not found during prior room checks.<br><br>On review of the facility risk assessment, Environment Of Care, dated 12/28/17, bed alarms were not identified as a risk; therefore, there were no "strategies put into place." Additionally, no risk rating and recommendations for risk reduction had been identified.<br><br>f. On 7/21/18 at 11:06 a.m., a tour was conducted of the 600 unit with Chief Executive Officer (CEO) #6. The 600 unit was designated for adolescent patients, ages 12-18, who presented with psychiatric diagnosis and complaints. Observation of room 601 revealed a sharpened pencil located on the patient's bed. According to the daily census the patient in room 601 was on suicide precautions.<br><br>During the tour, an interview was conducted with RN #11, who was in charge of nursing care for the unit. RN #11 stated the patient should not have a pencil, due to being on suicide precautions as it could be used as a way to self harm. Cross Reference A-0144<br><br>C. The governing body failed to ensure restraint and seclusion interventions were implemented pursuant to regulations and policy.<br><br>According to the Seclusion and Physical Restraint Hold Policy, once a restraint or seclusion is initiated, the registered nurse (RN) has to obtain a telephone or written order from the psychiatrist as soon as possible, but within one hour of implementation. Restraints or seclusion must be used only until the safety | H 605 | 5)Compliance with patient assessments and monitoring for safety; 6) Documentation of provision of patient groups; 7))Compliance with/documentation of patient showers/baths for patients who need assistance; 8) Staffing requirements are met to accomplish patient observation per requirements; 9) Housekeeping staff meet staffing requirements for each shift; 10) Environmental rounds by IC Nurse reflects compliance with requirements for cleanliness.; Housekeeping schedule; and the Infection Control Environment of Care Checklist.<br><br>The following data collection tools were devised and/or utilized to collect data pertaining to the indicators above: Supervisor Rounds (to assess for reports of serious incidents per incident reports), Staffing schedule; Environmental Checks by MHTs; Removable Showerhead Check out Sheet; Seclusion and Restraint (S/R) packets, Daily Groups Log; Patient Medical Records (to assess for compliance with Assessments).<br><br>To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to indicators under review to assess for compliance with the corrective actions taken pursuant to the deficiencies are assessed for evidence of effectiveness in the corrective actions taken. The findings are being aggregated by the Quality Coordinator and being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 605 | Continued From page 14<br>situation has ceased and the patient's safety and safety of others can be insured, even if the restraint or seclusion order has not expired. Restraint or seclusion are only utilized in an emergency when a patient's behavior presents imminent danger to the patient, staff or others. When the patient has regained control, he/she will be removed from seclusion or restraints by the RN. Problematic behavior which does not present an immediate risk to the patient, staff or others shall be addressed by less restrictive strategies. Once a restraint or seclusion has been initiated, the RN must obtain an order. A new order must be obtained to renew for an additional one hour in the event the restraint or seclusion is extended from the original one hour order.<br><br>According to the Seclusion and Physical Restraint Hold Policy, the Registered Nurse (RN) shall conduct a face to face evaluation within one hour of initiation. The RN providing the one hour face-to-face evaluations will be trained to evaluate the patient's medical and behavioral condition to determine the need to continue or terminate the seclusion or restraint. This training will be provided during orientation and annually thereafter. The face-to-face assessment must be documented in the medical record. The QRN will assess the patient in restraints or seclusion at least every hour or more frequently as warranted by the patient's condition.<br><br>According to the Qualified Registered Nurse (QRN) Training Policy, QRNs provide timely and quality review of patients in seclusion or restraints and effective guidance to staff. There is special training to the staff designated as a QRN. QRNs can provide one hour face-to-face medical and behavioral evaluations only after they have completed the training and demonstrated competency. QRN training includes: use of behavioral criteria for | H 605 | Performance indicators to assess for compliance with the environmental standards for cleanliness in the kitchen and hospital areas were devised and incorporated into a checklist for the IC Nurse that is entitled the Infection Control Environment of Care Checklist. The indicators for inspections to be utilized by Dietary staff were implemented and mirror the indicators of the IC Nurse specific to dietary department cleanliness and food safety standards. Additionally, a list of IC environmental indicators was devised and compiled for the Hospital Leadership specific to compliance with standards for hospital cleanliness. Last, the Hospital's weekly EOC rounds that was to be led by the EOC Director was re-instituted. Using the indicators from these data collection tools, there is ongoing assessment for compliance with the associated standards being conducted by the IC Nurse during her environmental surveillance at least twice weekly, by the Dietary Manager as well as Hospital Leaders on a daily basis (S-S), and by the entire Hospital Leader/EOC team on a weekly basis.<br><br>The findings, conclusions, recommendations, and actions of the IC Nurse, the Dietary Manager, and Hospital Leadership rounds are being reported at the Hospital's Morning Leadership. This level of reporting will continue indefinitely due to the gravity of the issue that ensured from failure to be attentive to EOC surveillance.<br><br>To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to the Infection Control EOC indicators as described above are under | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 605 | Continued From page 15<br>discontinuation of seclusion or restraints and how to help patients in meeting these criteria, evaluation of patients' immediate situation, reaction to the intervention and need to continue or terminate the seclusion or restraint, mental status examination, physical assessment of patients and proper documentation on the Face to Face form. All QRN training is documented, including dates of completion and competency. In addition, ongoing feedback regarding any documentation and/or incident is reviewed with the QRN by the medical director or designee on a timely basis.<br><br>1. The facility failed to obtain physician's orders for each instance of restraint or seclusion, and an additional order for each incident that extended longer than a one hour time period, failed to ensure seclusion was discontinued at the earliest possible time, and failed to ensure face to face evaluations were performed by Qualified Registered Nurses (QRNs) within one hour of the restraint or seclusion initiation.<br><br>a. According to the History and Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic. According to the Physician Order on 4/2/18 at 9:36 a.m., Nursing Supervisor (NS) #16 received a verbal order from Physician #14 for restraints or seclusion for up to one hour for aggressive behaviors of tipping herself backwards in her wheelchair and trying to run over staff with the same wheelchair.<br><br>Review of the Restrictive Intervention Observation Assessment Flow Sheet (RI flowsheet) revealed Patient #5 was restrained on 4/2/18 from 9:45 a.m. to 11:50 a.m. (a total of two hours and five minutes). Patient #5 was seen by Physician #14 at 11:45 a.m., then released from restraints at 11:50 a.m. to use the | H 605 | review to assess for compliance with the standards, to determine any need for corrective actions and to assess the effectiveness of any corrective actions taken. The findings are being aggregated by the Director of Compliance/ Quality/Risk and being forwarded to the Infection Control Committee, the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings.<br><br>4. Title of the person(s) responsible for implementing the acceptable PoC: Chief Executive Officer/Chief Operating Officer<br><br>5.<br>GB and Hosp/MS Leaders meeting held on<br>7/17/18<br>718/18<br>7/19/18<br>8/1/18<br>8/6/18<br>9/7/18<br>9/11/18<br><br>Showerhead policy implemented 7/20/18<br><br>Improved S/R policy implemented 8/6/18<br><br>Hospital and MS training on shower heads, cords, tubing<br>environmental safety, observation of patient<br>7/20/18<br>7/24/18<br>8/1/18<br><br>Training on S/R<br>8/6/18<br><br>Training on rounds | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 16<br>bathroom, but refused.<br><br>Further review of the RI flowsheet revealed Patient #5 was restrained a second time, 50 minutes later, from 12:40 p.m. to 1:20 p.m. There was no additional order obtained for the extended time when the patient was first placed in restraints or the second incidence of restraints. This was in contrast to the policy which stated to obtain a new order for each additional hour of restraints and each incident of restraints or seclusion.<br><br>According to the H&P documented on 7/12/18 at 3:40 p.m., Patient #2 was admitted to the facility on 7/12/18 due to manic, hostile, and psychotic behaviors in addition to expressing suicidal and homicidal ideations. Review of the RI Flowsheet, dated 7/16/18, revealed Patient #2 was restrained and escorted to seclusion for attacking staff. She remained in seclusion from 10:10 a.m. to 1:21 p.m. (a total of three hours and eleven minutes).The Physician Order for restraints and seclusion was obtained on 7/16/18 at 10:13 a.m. for one hour of intervention, but no additional order was obtained for the extended seclusion time that occurred.<br><br>On 7/25/18 at 11:03 a.m., an interview with Physician #14 was conducted. Physician #14 reviewed Patient #5's RI Flowsheet, dated 4/2/18 and stated there should have been an additional order for restraints after the first hour. Upon further review, Physician #14 stated an additional order for restraints should have been obtained once the patient was released from restraints for 50 minutes and then restrained again. Additionally, Physician #14 stated there were no behaviors documented on the 4/2/18 RI Flowsheet to warrant the second incident of restraints.<br><br>On 7/25/18 at 2:48 p.m., an interview was | H 605 | 8/1/18 and 8/6/18<br><br>Training on groups 8/14/18<br><br>Training on showers and bathing 8/14/18<br><br>Training on assessments<br>After injury and fall<br>7/25/18<br>Suicide risk assessments<br>8/1/18<br><br>Housekeeping contract in place 7/23/18<br><br>M&E tool to assess all areas in place<br>8/1/18<br><br>Interim dedicated DON/IC Nurse in place;<br>8/6/18 (oriented<br>7/25-27/18)<br><br>Weekly PI meeting with GB representative started<br>9/14/18<br><br>Interim EOC Director replaced and trained<br>7/24/18<br><br>IC Plan and<br>Policy Review<br>7/19/18<br><br>IC Nurse training<br>7/19/18<br>Hosp. LS training<br>7/19//18<br>IC Committee training<br>9/14/18<br><br>Dietary staff training:<br>7/17/18<br>7/19/18<br>8/3/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | **064027** | | **07/27/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 17<br>conducted with NS #16, who stated her role was to ensure the hospital was functioning effectively and ran smoothly. NS #16 stated an order was required for each emergency intervention of a restraint or seclusion. NS #16 further stated a restraint order was valid as long as staff needed it, which was in contrast to the policy of requiring a physician order after one hour or for each additional incidence of restraint or seclusion.<br><br>On 7/26/18 at 10:59 a.m., an interview with Director of Nursing (DON) #2 was conducted. DON #2 stated seclusion should be used for dangerous behaviors such as self-harming, not as a punishment. DON #2 stated an order for seclusion or restraint was valid for up to four hours, which was in contrast to the facility policy.<br><br>b. Review of Patient #8's medical record revealed she was admitted on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. Patient #8 was placed in restraints or seclusion 20 times during her hospitalization. Patient #8 was not released from seclusion when behaviors no longer warranted the seclusion.<br><br>According to the Restrictive Intervention Observation Assessment Flow Sheet (RI Flowsheet) on 6/28/18, Patient #8 was placed in seclusion for hitting staff and peers. Patient #8 was in seclusion from 6:10 p.m. to 7:10 p.m. Patient #8's behavior was documented as sitting or lying quietly for the entirety of her seclusion by Mental Health Technician (MHT) #31. According to the policy, the patient should have been released when she regained control of her behavior.<br><br>On 7/25/18 at 4:27 p.m., an interview with MHT #31 was conducted. MHT #31 stated the decision to release a patient from seclusion was | H 605 | Dietary checklist reviewed and approved 7/17/18<br><br>M&E in place through EOC checklist in place and IC Nurse and Hospital LS EOC Rounds::7/19/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 18 | H 605 | | |

made by the nurse or physician, but the MHT had input based on the patient's behavior. MHT #31 explained the patient needed to be calm, non threatening and able to be around other patients and staff as behaviors required for seclusion release. Additionally, MHT #31 stated lying quietly would be an identified behavior that would warrant seclusion release.

MHT #31 stated she remembered Patient #8 as she was on a behavior plan. MHT #31 further explained that due to the behavior plan, when Patient #8 was placed in seclusion she was required to spend one full hour in seclusion regardless of her exhibited behavior. This was in contrast to the policy which required patients to be released when they regained control of their behavior. MHT #31 stated the practice of keeping patients in seclusion for one full hour had become common practice in the facility.

MHT #31 was unable to provide the behavior plan that mandated Patient #8 remain in seclusion for one full hour regardless of her behavior.

The RI Flowsheet revealed on 6/26/18, Patient #8 was placed in seclusion for attempting to tie bed linens and a shower curtain around her neck. Patient #8 was in seclusion from 11:28 a.m. to 12:35 p.m. Patient #8's behavior was documented as lying quietly on the floor at 11:45 a.m., and lying on the floor for the remainder of the seclusion by MHT #38. No aggressive or harmful behaviors were documented. Patient #8 was not released from seclusion when her behavior no longer warranted intervention.

On 7/23/18 at 3:03 p.m., an interview with MHT #38 was conducted. MHT #38 stated the documentation sheets were created for one hour increments, so patients could spend an hour in seclusion based on time rather than behavior if that was what the team decided on.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 19 | H 605 | | |

MHT #38 stated a patient could be required to stay in seclusion for one hour based on their behavior plan. Additionally, MHT #38 stated the behavior plan would be verbally given in the oncoming shift report and also by the therapist.

According to the RI Flowsheet on 6/20/18, Patient #8 was placed in seclusion for hitting staff. Patient #8 was in seclusion from 5:55 p.m. to 7:02 p.m. Patient #8 had no documented aggressive or harmful behaviors; therefore, it was not evident why the seclusion continued. The patient was able to use the bathroom at 6:30 p.m., with no documented adverse behaviors and was subsequently returned to seclusion for another 32 minutes. Patient #8 was not released from seclusion per policy.

On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 explained patients were released from seclusion when they were calm and talking and their behavior was not a threat to themselves or others. DON #2 explained further, release from seclusion was based on behavior, not time. DON #2 reviewed Patient #8's RI Flowsheets and stated when Patient #8 was lying quietly, she should have been released from seclusion. DON #2 stated seclusion should be used for dangerous behaviors, not as a punishment. However, DON #2 stated Patient #8 was on a behavior plan to include seclusion as a behavior modifier that was discussed in rounds and should have been a part of the medical record.

DON #2 was unable to provide the aforementioned behavior plan that required Patient #8 to continue to remain in seclusion for a set time rather than based on behaviors.

c. Further review of Patient #8' record showed face to face evaluations were not performed by Qualified Registered Nurses (QRNs).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 20<br><br>According to an Incident Report on 6/28/18, Patient #8 was placed in seclusion at 5:40 p.m. for attempting to hit staff and other patients on the unit as well as attempting to elope. Patient #8 was released from seclusion at 7:10 p.m. The face to face evaluation was performed at 7:00 p.m., by Mental Health Technician (MHT) #31. This was in contrast to the policy which required the face to face evaluation to be performed by a QRN who had additional training.<br><br>On 7/25/18 at 4:27 p.m., an interview with MHT #31 was conducted. MHT #31 stated registered nurses (RNs) completed the paperwork on the unit associated with seclusion and restraints. MHT #31 stated physicians or nurses made the decision when to release a patient from a restraint or seclusion with the MHTs input. MHT #31 verified she had signed the face to face evaluation for Patient #8. MHT #31 stated she did not know what a face to face evaluation was, but since she signed the evaluation she must have performed it.<br><br>Review of MHT #31's personnel file confirmed she was a mental health technician and did not have additional training to perform face to face evaluations.<br><br>Review of a Face to Face Evaluation, dated 6/17/18, showed Patient #8 was placed in restraints and seclusion from 12:50 p.m. to 1:45 p.m. The face to face evaluation was performed at 1:50 p.m. There was no signature of who performed the evaluation; therefore, there was no way to know which staff performed the evaluation or to confirm staff qualifications.<br><br>Additionally, Patient #8 was placed in a physical restraint due to punching and kicking staff on 6/3/18. According to the Face to Face evaluation record, Patient #8 was restrained from 1:30 p.m. to 1:45 p.m. The face to face | H 605 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 21 | H 605 | | |

evaluation was documented by Registered Nurse (RN) #32 at 2:55 p.m.

On 7/23/18 at 5:07 p.m., an interview with RN #32 was conducted. RN #32 stated a nurse was required to perform a face to face evaluation every time a patient was restrained or secluded to evaluate the patient's condition and determine when they could be released. RN #32 stated MHTs were unable to perform face to face evaluations because it was part of the nurse's role. RN #32 stated there was no special training for nurses to perform face to face evaluations and verified that she had not had any special training.

Review of the QRN Restraint and Seclusion Proctoring Records provided by Quality Coordinator (QC) #1 revealed RN #32 had not been trained on how to perform face to face evaluations; therefore, was not qualified to do so per the facility policy.

On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 explained nurses were specifically trained to perform face to face evaluations after they had been employed by the facility for one year. DON #2 stated nurses received additional training to become Qualified Registered Nurses (QRNs) in order to perform face to face evaluations. DON #2 verified MHTs were not permitted to perform face to face evaluations as they were not trained to do so. DON #2 further stated the patient would not be appropriately assessed if a MHT performed the face to face evaluation. DON #2 stated she reviewed the face to face evaluations to ensure they were filled out completely, but she did not audit the signatures to ensure the face to face evaluations were performed by a QRN. DON #2 stated RN #32 was qualified to perform face to face evaluations.

However, on 7/26/18 at 4:47 p.m., DON #2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 22<br>confirmed the QRN Restraint and Seclusion Proctoring Records provided by QC #1 were the only verified staff trained to perform the one hour face to face evaluations. Review of the QRN qualified staff list did not include RN #32.<br><br>d. Review of Patient #5's record revealed several instances in which the face to face evaluation was not completed within the one hour time frame.<br><br>According to the History & Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic. Patient #5 was discharged on 4/10/18 and was placed in a restraint or seclusion eight times throughout her hospitalization. The face to face evaluation was performed only four of eight times within one hour of initiation of the restraint or seclusion according to policy. For example,<br><br>According to an Incident Report on 4/2/18, Patient #5 was restrained and given emergency medications for trying to tip her wheelchair over and run over staff with her wheelchair. Patient #5 was restrained from 9:33 a.m. to 1:10 p.m. NS #16 documented the face to face evaluation at 1:10 p.m., which was 3 hours and 37 minutes after initiation of the restraint. Patient #5 had an additional incident of being restrained on 4/1/18 at 9:56 p.m. According to the Incident Report, she was restrained from 9:56 p.m. to 10:40 p.m. The face to face evaluation was performed at 11:15 p.m., which was 1 hour and 21 minutes after initiation of the restraint. Both face to face evaluations should have occurred within one hour of initiation of the restraint in order to evaluate the need to continue or terminate the restraint according to the policy.<br><br>Record review showed Patient #5 was restrained for wrapping a blanket around her | H 605 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 23 | H 605 | | |

neck and then becoming aggressive with staff for intervening on 3/27/18 at 8:05 p.m. until 8:40 p.m. There was no time documented to indicate when the face to face occurred; therefore, there was no way to verify the evaluation was completed within the one hour timeframe.

On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 stated face to face evaluations were performed to assess the patient's mental and physical condition in order to ensure patient safety. Furthermore, the QRN was required to perform the face to face evaluation within one hour of initiating restraints or seclusion.

Similar findings of restraint and seclusion interventions not implemented in accordance to regulations or policy were identified during medical record reviews of Patients #3, #4, #9, #12, and #13. Cross Reference A-0144

D. The governing body failed to ensure patients were assessed and monitored in order to ensure their safety and comfort. Additionally, the governing body failed to ensure patients received group therapy sessions and hygiene care in accordance with policy and practitioner orders.

The Staffing Plan for Provision of Care policy read, nursing staffing will be sufficient to promptly recognize untoward changes in a patient's condition and to intervene appropriately utilizing nursing, medical or hospital staff and shall be based upon identified minimum staffing requirements by unit, actual patient needs asses through use of the acuity tool. This acuity staffing system shall be based upon objective assessment tools which qualify the number of nursing staffing members needed to fulfill patient needs on each unit. The procedure for staffing is as follows, the staffing plans for the unit are on file in the charge nurse binder in the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 24 | H 605 | | |

nurses station. Staffing is based upon patient census and acuity. Staffing schedules for the nursing department to include registered nurses and mental health technicians. Variances between projected needs and actual staffing are described, acknowledged and justified according to census and acuity. The provision of nursing care is evaluated on an annual basis as a preliminary activity to the budgeting process.

The Hospital Plan for Provision of Nursing Care policy read, staffing, both in numbers and competency, will be sufficient at all times to ensure emergency and safety requirements for patient care are met.

The Observation policy read, a minimum of fifteen-minute observations is required for all patients. The patient is observed at minimum, every fifteen minutes by a designated staff member to monitor for safety, behavioral changes and to indicate clients location.

1. The governing body failed to ensure staffing was adequate to consistently conduct 15 minute patient safety checks as ordered.

a. Review of Patient #8's medical record revealed the patient was admitted on 6/3/18, after she stated she was going to break her neck in an attempt to kill herself. On 6/3/18 at 12:16 p.m., a comprehensive psychosocial assessment was completed. Patient #8 was documented as manic and euphoric. Patient #8 was placed on every 15 minute safety checks.

Review of the safety check reports for Patient #8 showed a total of 110 safety checks were documented as being missed from 6/3/18 until the patient was discharged on 7/3/18 at 10:09 a.m. Examples of missed checks included:

On 6/4/18 at 3:18 a.m., the patient was checked on. The next check was documented 24

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
| --- | --- | --- | --- | --- |
| H 605 | Continued From page 25 | H 605 | | |

minutes later at 3:42 a.m. by Registered Nurse (RN) #22. RN #22 continued to document every 15 minute checks until 7:47 a.m. during which time three more safety checks were missed. The reason for the missed every 15 minute safety checks was documented as "unit disruption". Review of the daily shift assignment for 6/4/18 showed RN #22 was assigned to medications, admissions, discharges, code blue response and hall monitor from 5:00 a.m. until 7:30 a.m. There was no MHT or additional staff scheduled from 5:00 a.m. until 7:30 a.m. for the unit.

On 6/24/18 at 6:31 a.m. a safety check was documented. The next check was documented 24 minutes later at 6:55 a.m. with the reason for the missed check as "RN only one on the floor taking vitals". Review of the daily shift assignments, for 6/24/18, revealed no staff were assigned to complete the safety checks and hall monitoring from 7:00 p.m. until 9:00 p.m. and then again from 1:00 a.m. until 7:30 a.m.

This was in contrast to the staffing matrix provided by the DON, which stated the unit should have one MHT and one RN at all times.

On 7/26/18 at 1:59 p.m., an interview was conducted with Director of Nursing (DON) #2. DON #2 stated there should be at least one RN and one MHT on the unit at all times. DON #2 reviewed the daily shift assignment from 6/24/18 and stated she was unaware RN #10 was the only staff member on the unit for all patient care and stated "it was not best practice."

b. On 07/24/18 at 4:34 p.m. an interview with MHT #34 was conducted. MHT #34 stated she worked on all units within the facility and was responsible for conducting patient safety checks. MHT #34 stated patients within the facility were seeking treatment for suicide, depression and anxiety and the purpose of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 26 | H 605 | | |

safety checks was to ensure these unstable patients were prevented from self harm.

MHT #34 stated a unit disruption would be noted on the safety checks if one MHT was with a patient in seclusion. The other MHT would be required to continue with all other unit activities to include safety checks and groups. MHT #34 stated if a unit disruption occurred and the 15 minute safety checks were missed, this was mainly due to having only one MHT on the floor and no additional staff. MHT #34 stated the facility MHTs were overtasked and understaffed.

c. On 7/25/18 at 2:49 p.m., an interview was conducted with Nursing Supervisor (NS) #16. NS #16 stated safety checks were expected to be completed and she "hoped the techs were holding themselves accountable." NS #16 further stated she assumed staff on the unit would complete the safety checks in a timely manner and if staff was busy they could grab the nurse to do safety checks.

NS #16 then stated she had not performed any audits of the 15 minute safety checks to ensure timely completion was done. NS #16 stated "there was only one of me and many different units."

d. On 7/26/18 at 1:59 p.m., an interview with DON #2 was conducted. DON #2 stated RN and MHT staffing was determined by the policy. On review of the policy, Staffing Plan for Provision of Care, which stated the acuity staffing system shall be based upon objective assessment tools which qualify the number of nursing staffing members needed to fulfill patient needs on each unit, DON #2 stated she had never implemented a staffing tool and was unsure what the staffing tool was. DON #2 stated she did not do reviews or audits to determine if staffing was appropriate for the patient and unit acuity.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 27<br>DON #2 further stated she did not review or audit 15 minute safety checks to determine the rationale or cause of the missed checks. She stated she felt they were missed due to MHTs being younger, who lacked critical thinking and experience on how to handle situations which arose on the unit.<br><br>e. Similar findings were identified in review of the medical records for Patients #1, #2, #3, #4, #5 #6, #7, #9, #10, #11, #12, and #13, which all included missed 15 minute safety checks. Cross Reference A-0392<br><br>2. The governing body failed to ensure patients were provided consistent group therapy<br><br>The Program Therapies Overview policy read, therapies would have been available to all patients in the program. The program offered a variety of therapeutic services for individuals aged 12 and older who suffer from acute or chronic psychiatric disorders. Each patient received care from an interdisciplinary team of mental health professionals. Under the direction of a psychiatrist, members of the team include psychologists, psychiatric nurses, therapists, mental health technicians, dieticians, and recreation therapists who assess the patient's needs, develop an individualized treatment plan to address those needs and implement the therapy program.<br><br>The inpatient group therapy daily schedule established the theme for all groups offered on a given day of the week for each of the hospital's 4 units. While the schedule was different for each unit, every unit was scheduled for a daily nursing group to teach and reinforce health-related topics and led by the nurse.<br><br>In addition, the mental health technicians (MHTs) were scheduled to lead six groups each day on each unit: goal group (to set individual | H 605 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 28 | H 605 | | |

goals for the day), topic group (to explore the theme of the day through guided discussion and activity), structured exercise (to reinforce healthy outlets for emotions), journal time (to provide a time of quiet reflection through journaling), community meeting (to discuss milieu-related topics), and wrap up group (to reflect back on daily goals and progress made during the day).

a. Review of Patient #8's medical record revealed she was admitted to the adolescent unit on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. Patient #8 remained at the facility until she was discharged on 7/3/18. Review of the Final Ancillary Orders revealed an order was placed by Physician #21 on 6/3/18 for Patient #8 to attend group therapy. The Final Ancillary Orders also revealed, on 6/4/18, Therapist #39 created action steps for Patient #8 which included daily groups to explore self-soothing strategies and coping skills for depression and suicidal thoughts. Review of the Initial Psychiatric Evaluation, conducted on 6/3/18 at 4:25 p.m., revealed Physician #40 determined engagement in groups and therapy was a criteria for Patient #8's discharge from inpatient treatment.

Review of the Nursing Group Notes revealed the daily nursing group was not held on the adolescent unit on the following dates during Patient #8's admission: 6/6/18, 6/12/18, 6/14/18, 6/17/18, 6/22/18, 6/25/18, and 6/28/18. In addition, there was no documentation to determine whether the nursing groups were held or whether Patient #8 participated on 6/16/18, 6/19/18, and 6/27/18. Patient #8 did not have access to the nursing group on 10 days of her 30 day admission.

b. According to the History and Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 29<br>#5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt. Patient #5 was discharged on 4/10/18. Review of the Final Ancillary Orders for Patient #5, revealed an order from Physician #21 placed on 3/18/18 at 5:00 a.m. to initiate therapeutic activities per assessment and program schedule. Physician #21 placed a second order, also on 3/18/18 at 5:00 a.m., for process groups and education groups per the program schedule.<br><br>Review of the Medication Administration Record for Patient #5 revealed the Nursing Group was not held on 3/19/18, 3/30/18, or 4/9/18. There was no explanation documented why the group was canceled.<br><br>c. On 7/22/18 at 3:51 p.m., a tour was conducted of the geriatric (200) unit. According to the posted program schedule, the nursing group was scheduled at 5:00 p.m. RN #45 stated she was not planning to lead the group because she did not have time.<br><br>d. An interview was conducted with Mental Health Technician (MHT) #44 on 7/24/18 at 9:35 a.m. She stated it was important for MHTs to encourage patients to attend groups because groups were an important part of preparing patients to be ready for discharge. MHT #44 added sticking to a routine schedule was necessary because consistency was important for these patients. MHT #44 then stated groups were sometimes canceled or shortened when staff was busy with discharging patients.<br><br>e. On 7/16/18 at 10:36 a.m., an interview was conducted with DON #2. She stated she did not track whether groups were held. DON #2 stated she was aware there were occasionally times when the nursing groups were not held.<br><br>A follow-up interview with DON #2 was held on | H 605 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 30 | H 605 | | |

7/26/18 at 1:59 p.m. DON #2 stated the purpose of the nursing groups was to follow the theme of the day, talk about medications and plans after discharge, and provide patient education related to various topics. DON #2 stated the groups were important because they helped patients be successful after discharge.

Review of the medical records revealed similar findings of missing nursing groups for Patients #1, #2, #3, #4, #5, #6, #7, and #11. Cross Reference A-0392

3. The governing body failed to ensure regular showers or baths were provided for patients on the geriatric (200) unit, many of whom required assistance with hygiene care.

The Bathing of Patients policy read, staff were to assist patients who were unable to be independent with their bathing needs and to assist and encourage independent patients to maintain appropriate personal hygiene practices. Patients who needed assistance had staff assist with hygiene needs as required, including offering a shower/bath every other day or as needed if indicated. Document the completion of a bath in the patient medical record.

a. Review of Patient #4's medical record revealed she was admitted to the geriatric (200) unit on 12/29/17 with a diagnosis of schizophrenia. Patient #4 was discharged to an acute care hospital for medical clearance on 1/31/18 and was readmitted from 2/3/18 until 5/9/18, when Patient #4 was discharged to an assisted living facility.

Review of Nurse Practitioner (NP) #27's medical Progress Notes from 1/19/18, 1/20/18, 1/21/18, and 1/22/18 revealed Patient #4 had bowel incontinence and initially refused to let the RN or MHTs change her. NP #27 documented

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 31 | H 605 | | |

eventually Patient #4 allowed staff to help her change clothes. No showers were documented in Patient #4's medical record for these days.

Review of the RN note from the night shift of 1/24/18 revealed Patient #4 was incontinent of a large loose bowel movement, which was dried and caked on her buttocks and legs. No shower was documented in Patient #4's medical record on that day.

During her second admission, beginning on 2/3/18, Patient #4 was documented as incontinent of loose stool or diarrhea on 2/6/18, 2/7/18, 2/9/18, 2/14/18, 2/22/18, 3/5/18, and 3/6/18. There was no documentation the patient was showered or offered a shower on these dates. In addition, no showers were documented in Patient #4's medical record from 3/4/18 until 3/24/18.

b. Review of Patient #1's medical record revealed she was admitted to the 200 unit on 7/12/18 and discharged 7/20/18 with a diagnosis of bipolar disorder II and major depressive disorder. Review of the Comprehensive Psychosocial Assessment Tool revealed Patient #1 was too anxious to shower in a communal shower at the residential facility she had been living at prior to this hospitalization.

Further review of Patient #1's medical record did not reveal any evidence Patient #1 was offered a shower or bath during her entire admission. Review of the July, 2018 Daily Shower Log revealed no documentation Patient #1 was offered a bath or shower during her 9 day admission except on 7/15/18 when it was documented on the Shower Log Patient #1 did not shower.

c. On 7/25/18 at 12:50 p.m., an interview was conducted with MHT #20 who stated assistance with showers was primarily needed by patients

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 32 | H 605 | | |

on the 200 unit. MHT #20 stated staff prompted patients to shower, and if there were enough staff available, patients were able to have a bath in the tub, if needed. When a patient needed assistance with showering, MHT #20 stated she would ask the RN to assist the patient.

On 7/24/18 at 9:35 a.m., MHT #44 was interviewed. MHT #44 stated she primarily worked on the 200 unit. MHT #44 stated, in general, staff attempted to bathe patients every other day on the the 200 unit. Some patients required assistance with bathing, including patients with dementia. MHT #44 stated good hygiene was a good way to care for yourself so it was an important aspect of patient care. She stated the unit had a binder where staff was expected to document when patients showered on a Shower Log. MHT #44 was unsure whether showers were documented in patient medical records.

Daily Shower Logs were provided for the months of February, March, April and July, 2018. On 7/26/18 at 7:52 a.m., DON #2 stated the facility was unable to locate the Daily Shower Logs for the months of January, May, and June, 2018.

Review of patient medical records and the Daily Shower Logs revealed similar findings of missed showers for Patients #3, #5, #6, and #9.

E. The governing body failed to provide adequate housekeeping staff and oversight of the infection control program in order to ensure a sanitary environment throughout all patient care areas.

a. During tours of the facility conducted on 7/16/18 and 7/18/18, multiple sanitary concerns were identified. For example:

On 7/16/18 at 11:26 a.m., a tour of the geriatric

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 33 | H 605 | | |

unit was conducted. Dust balls, food stains, and insects, both dead and alive, were observed on the floor of the patient milieu (common area) and dining area. The therapy group room showed similar findings of dust on the floor and also a cigarette butt was found under a chair.

Observations in patient room 207 revealed piles of dust and debris in the doorway of the room and underneath the beds. A used gauze dressing was also noted on the floor of the room. Similar findings of dust and debris on the floor were found in patient room 207 and room 203.

At 12:00 p.m., the high acuity adult unit was toured, where a strong and pungent odor of urine and body odor was immediately present in the hallway. The carpeting in the hallway was visibly dirty. Patient room 404 was particularly odorous of urine and was dirty.

The tour then continued to the seclusion area on the adolescent unit. The garbage can in the bathroom located next to the seclusion room was overflowing with used paper towels and garbage on the floor next to the can. The toilet seat and bowl were stained and additional garbage was found on the floor next to the toilet.

Upon entering patient room 201, puddles of liquid were observed on the floor as well as an odor of urine. The toilet was also stained.

On 7/18/18 at 3:28 p.m., an interview with the infection control nurse (DON #2) was conducted. DON #2 stated she was familiar with the patient in patient room 201 and stated the patient frequently urinated on the floor. DON #2 further stated it was difficult to clean the patient's room because he would become agitated and would not allow staff to clean the floor. When asked what interventions were put in place to ensure the patient's urine was not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 34 | H 605 | | |

tracking throughout the rest of the unit, DON #2 stated typically no one went into the patient's room because he did not allow people in his room. DON #2 then verified that the patient used a wheelchair, which would be wheeled in and out of his room and throughout the unit. There was no way to ensure urine from the patient's was not being tracked and spread throughout the common areas.

On 7/18/18 at 12:36 p.m., a tour of the adolescent and adult units was conducted. Observations in patient room 403 revealed insects flying around one of the beds. Also during this tour, several bathrooms in patient rooms were noticeably soiled. For example, toilet seats and toilet bowls stained with fecal matter, urine, and/or blood were observed in patient rooms 401, 402, 403, 406, 408, 506, and 605. A used Band-Aid was observed in the shower drain in patient room 408. Observations of the shower curtains revealed a pink and dark gray colored residue at the bottom of the curtains in patient rooms 402, 408, and 506.

On 7/18/18 at 3:28 p.m., an interview with the infection control nurse (DON #2) was conducted. DON #2 stated she was told by Director #61 that the pink discoloration at the bottom of the shower curtains was not mold. DON #2 stated she did not know how Director #61 had concluded the discoloration was not mold or if there was any documentation of how the conclusion was determined. DON #2 further stated she was unaware if any testing had been done on the shower curtains to determine what the cause of the discoloration was.

b. Review of an Environment of Care Risk Assessment, conducted on 12/28/17, identified the carpeting in the facility as an infection control risk. The assessment documented routine carpet shampooing was in place to reduce this risk. On 7/18/18 at 2:42 p.m., a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | **064027** | | **07/27/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 35<br>request was made for documentation showing how often the carpeting had been shampooed.<br><br>During an interview with the infection control nurse (DON #2) on 7/18/18 at 3:28 p.m., she stated the environment of care staff were responsible for shampooing the carpeting and that she was responsible for ensuring the carpets were clean. DON #2 stated she was unsure of when the last time the carpeting was shampooed. No evidence was provided prior to the conclusion of the survey to show how often the carpeting was expected to be shampooed and when it had been done in order to decrease the facility's identified infection control risk.<br><br>c. A review of the Housekeeping Schedule from 4/1/18 to 7/31/18 was conducted. All housekeeping shifts were scheduled between the hours of 6:00 a.m. to 2:30 p.m. In April, there were no housekeepers scheduled from 4/27/18 through 4/30/18 and only one housekeeper scheduled on 4/1/18-4/8/18, 4/13/18-4/15/18, 4/20/18-4/22/18, and 4/25/18-4/26/18. In May, there were no housekeepers scheduled on Sundays. On all other days in May, except on 5/30/18, there was only one housekeeper scheduled, which was the same staff member (Housekeeper #53). In June, there were no housekeepers scheduled on 6/3/18 and 6/17/18. In addition, there was only one housekeeper scheduled on 6/218, 6/5/18, 6/7/18, 6/9/18, 6/16/18, 6/19/18, 6/21/18, 6/24/18, 6/26/18, 6/28/18, and 6/30/18. In July, there were no housekeepers scheduled on Sundays. In addition, there was only one housekeeper scheduled on 7/7/18 and 7/14/18.<br><br>According to the current staff roster, there were only two housekeepers listed as being employed by the facility (Housekeeper #53 and #54). On 7/26/18 at 3:32 p.m., the COO #15 stated one of the two housekeepers was on maternity leave while the other housekeeper had resigned the | H 605 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 36 | H 605 | | |

prior week, resulting in the facility not having any current housekeepers on staff.

d. A review of the monthly Infection Control Safety Meeting minutes, from 1/18/18 to 6/21/18, was conducted. The meeting held on 3/15/18 included discussion of Director #61 reaching out to a separately certified hospital to see if one of their staff members would come to the facility to help train housekeepers. However, there was no follow up documentation noted to show if a staff member had come to the facility to assist in training.

During the Infection Control Safety Meeting held on 6/21/18, a RN from a separately certified hospital was going to begin supporting the infection control program at the facility; however, her scheduled start date was not until 7/27/18.

Also discussed during the 6/21/18 meeting was the low retention rate of housekeepers and how staff would be assisting in the emptying of trash and cleaning of units. A subsequent meeting with the MHTs and nurses was planned for 7/10/18 and 7/12/18 to discuss assisting with housekeeping duties while the facility was struggling to maintain housekeepers.

Review of the MHT and Nurse's Meeting Agenda, held on 7/10/18 and 7/12/18, revealed no documentation on what types of housekeeping duties MHTs and RNs were expected to perform or how staff would be trained on cleaning the facility.

e. On 7/18/18 at 6:04 a.m., an interview was conducted with Mental Health Technician (MHT) #51, who was assigned to work the night shift on the adolescent unit. MHT #51 explained cleaning responsibilities for night shift MHTs included cleaning the nurses station and the countertops in the group therapy rooms. MHT #51 stated it was his understanding that patient

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 37 | H 605 | | |

rooms were cleaned during the day shift; however, he was not sure how that was getting done because there currently was no janitorial staff employed at the facility.

MHT #51 then stated he was also responsible for cleaning up after patients when they had accidents. MHT #51 explained he had noticed an increase in having to clean patient care areas and patient rooms of fecal matter, urine and menstrual blood; however, he had not received training on how to ensure he was properly cleaning patient rooms and patient care areas. MHT #51 further stated it would have been important to receive training on cleaning in order to help stop the spread of disease potentially found in bodily fluids.

f. On 7/18/18 at 3:27 p.m., an interview with the DON #2 was conducted. DON #2 stated in addition to her duties as the DON, she also was the designated infection control nurse at the facility as well as working as a chief nursing officer at a separately certified hospital, approximately 125 miles from the facility.

DON #2 stated her role as the infection control nurse mostly involved conducting hand hygiene audits. She explained she would watch staff performing hand hygiene on the camera monitors from her office or at her home. If she identified a hand hygiene breach, she would notify the staff member for coaching by text message, phone call, or in person if she was at the facility. DON #2 stated she did not maintain documentation of the coachings nor did she conduct any trending from the hand hygiene audit data collected on potential patterns identified during the audits.

Upon reviewing the infection control concerns identified during tours conducted throughout the survey, DON #2 stated she was responsible for providing oversight of interventions taken for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 605 | Continued From page 38<br>pest control at the facility. DON #2 said it was important to keep the facility free of insects because they could spread bacteria. DON #2 then stated a pest control company was contracted to provide services at the facility; however, she did not know how often they came to the facility.<br><br>DON #2 explained MHTs and RNs had been asked to he | H 605 | | |
| H 606 | IV.6.102(2) Governing Board: Responsibility<br><br>[The governing board shall:]<br>be responsible for all the functions performed within the hospital.<br><br>This REGULATION is not met as evidenced by:<br><br>Based on observations, interviews and document reviews, the governing body facility failed to ensure contracted services were provided in a manner which maintained a sanitary environment within the food services department. This failure resulted in an unsafe and unsanitary environment for the preparation of patient meals. This affected all patients receiving care in the facility.<br><br>Findings Include:<br><br>Policy:<br><br>The Leftover Foods policy read, the date an item is removed from the freezer will be marked on the item. Vegetables that turn color or lose texture should not be re-used. Leftover foods should be wrapped/covered and labeled with product name, condition (cooked or raw), amount and date prepared. Foods to be placed | H 606 | 1. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited;<br><br>A. A meeting of the GB was conducted to discuss findings from the survey pertaining to the following deficiencies: (1) failure of the GB to ensure that contracted services were provided in a manner which maintained a sanitary environment within the food services department resulting in an unsafe and unsanitary environment for the preparation of patient meals (2)Failure of the GB to ensure the contracted food service director maintained a safe and sanitary environment for food storage and preparation. The GB meeting concluded the root cause for this issue was that, while the contractual dietary company is well-established, the Hospital's Director of | 09/21/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 39 | H 606 | | |

in freezer must be covered with aluminum foil or freezer wrap.

The Nutrition Services Safety Plan policy read, safety procedures will be utilized in Nutrition Services to prevent injury and infection. Remove any grease, food or wet spots from the floor at once.

Reference:

According to the facility's job description for the position of Cook, essential job function and responsibilities include ensuring safe food storage and preparation, i.e. stock rotation and labeling/dating food items and discarding out-of-date food.

According to a contracted agreement between a food management services company and the facility, the food management company shall clean the kitchen, including kitchen walls, floors, windows and equipment.

According to the contracted food management services company's inservice, titled Food Product Labeling and Dating, all leftover foods or foods removed from their original containers require proper labeling when stored. Proper food labeling requires the following: name, identification, date of preparation and date foods are to be used or discarded.

At the time food is being removed from its original container and placed in another container, date it. Once refrigerated items are properly stored with name and dates, they need to be used or disposed of within seven days. At the time food is moved from freezer to refrigerator for thawing, date it.

1. The governing body failed to ensure the contracted food service director (Director #41) maintained a safe and sanitary environment for

Food Services was new to his role and did not want to appear incompetent by asking for help. Further, the current Infection Control (IC) Nurse for the hospital was overseeing two facilities and was not conducting ongoing environment of care checks in the dietary area, as required.

B. A meeting was held between the GB, CEO of Contractual Dietary Services, Infection Control Nurse and Hospital Leaders to examine findings and delineate expectations, plan of action related to each deficiency cited, and plan to monitor for evidence of correction of problems identified.

C. A Dietary Services representative from the contractual dietary company was obtained to provide the GB representative the content to be used to re-train Dietary Director and Staff and the method to be used to monitor for compliance with maintaining a safe and sanitary environment for food storage and preparation. This content was approved by the GB representative.

D. The contractual Dietary Services conducted training for the Hospital Dietary Director on expectations related to maintaining a safe and sanitary environment for food storage and preparation and monitoring for same. A competency was completed by the Hospital Dietary Director on key components for maintaining a safe and sanitary environment for food storage and preparation and monitoring expectations.

E The contractual Dietary Services representative re-trained all dietary staff on food preparation, handling, storage, and cleanliness requirements for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 40<br>food storage and preparation.<br><br>a. According to the contracted food management services company's job description for Food Services Director, duties and responsibilities include maintaining a sanitary and safe operation in accordance with federal, state, and local regulations. The Director will be able to schedule employees to meet food production, service and cleaning requirements. The Director will be able to administer in-service training and evaluate performance and training methods.<br><br>b. On 7/17/18 at 10:35 a.m., a tour of the kitchen and cafeteria was conducted with Food Service Director (Director #41), which revealed multiple instances of a dirty environment, food stored without discard dates noted on the packaging, and other infection control concerns. For example:<br><br>At 10:35 a.m., the cafeteria was toured. At this time, there were no patients eating. The floors were sticky with visible brownish stains and crumbs. At 11:45 a.m., patients were observed eating in the cafeteria and the same stains and crumbs were noted.<br><br>The floors in the kitchen area were also sticky with visible stains and food particles on the floors throughout the entire kitchen area. According to the Nutrition Services Safety Plan policy, any grease, food or wet spots were to be removed from the floor at once.<br><br>Two large metal sheet pans were observed on the floor propped up against a refrigerator. Director #41 stated the pans were used to cover cold food items; however, they should not have been stored on the floor due to the possibility of contamination.<br><br>Upon entering the dish cleaning area of the | H 606 | maintaining a safe and sanitary environment for food storage and preparation. Content included: the proper washing of dishes, proper handling of leftovers, food dating and labeling, maintaining and cleaning equipment, maintenance of the dishwasher temperature log, maintenance of refrigerator and warmer temperature logs, food borne illness and its prevention, and the checklist of indicators that would be utilized to monitor their compliance with requirements.<br><br>F. The dishwasher was serviced so that it was properly functioning and maintaining all temperature requirements.<br><br>G. Hospital Leaders and the Infection Control Nurse were trained by the VP Nursing/PI/Regulatory Affairs on their oversight responsibilities to ensure that a sanitary and safe environment is maintained in the hospital's kitchen.<br><br>H. Monitoring and evaluation tools were established for use by the Dietary Director, the IC Nurse as well as Hospital Leadership to complete and report out on compliance results on an ongoing basis to the Governing Board through the mechanism, as described below<br><br>2. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited;<br><br>A. A meeting of the GB was conducted to discuss findings from the survey pertaining to the following deficiencies: (1) failure of the GB to ensure that contracted services were provided in a manner which maintained a sanitary | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 41 | H 606 | | |

kitchen, a sign stating "Out of Order" was taped to the dishwasher. Cook #43 stated the dishwasher had been broken for the last 4 to 5 days and that staff were washing trays, pots, pans, and utensils by hand utilizing three separate sinks. Cook #43 explained the first sink was filled with water and soap, the second sink was filled with water to rinse the dishes, and the third sink had sanitizing chemicals in the water. Cook #43 further explained he would check the concentration of the chemicals in the third sink by conducting a test of the water with test strips located on top of the sink. According to Cook #43, it was important to conduct this test in order to ensure the correct amount of sanitizer was added when washing items used by patients.

Review of the vial of test strips revealed a printed expiration date of June of 2017. Further review of the vial noted the test strips were intended for antimicrobial fruit and vegetable treatment and not for measuring the concentration of the sanitizer. Director #41 confirmed the test strips were expired. Director #41 stated he was unaware the strips were expired and stated he could not guarantee the proper amount of solution was added to the water to sanitize the dishes.

Observation of a steel countertop revealed a plastic bin filled with bananas. At the bottom of the bin were several blackened colored bananas with loosened skins, exposing the fruit to the open air. Approximately five small insects were observed flying around the bin of bananas. Director #41 identified the insects as gnats and stated he did not have time to throw out the blackened bananas. Underneath the countertop was a container of bread crumbs with the lid of the container not completely sealed, allowing the gnats access to the bread crumbs.

A second countertop located next to the bin of

environment within the food services department resulting in an unsafe and unsanitary environment for the preparation of patient meals (2)Failure of the GB to ensure the contracted food service director maintained a safe and sanitary environment for food storage and preparation. The GB meeting concluded the root cause for this issue was that, while the contractual dietary company is well-established, the Hospital's Director of Food Services was new to his role and did not want to appear incompetent by asking for help. Further, the current Infection Control (IC) Nurse for the hospital was overseeing two facilities and was not conducting ongoing environment of care checks in the dietary area, as required.

B. A meeting was held between the GB, CEO of Contractual Dietary Services, Infection Control Nurse and Hospital Leaders to examine findings and delineate expectations, plan of action related to each deficiency cited, and plan to monitor for evidence of correction of problems identified.

C. A Dietary Services representative from the contractual dietary company was obtained to provide the GB representative the content to be used to re-train Dietary Director and Staff and the method to be used to monitor for compliance with maintaining a safe and sanitary environment for food storage and preparation. This content was approved by the GB representative.

D. The contractual Dietary Services conducted training for the Hospital Dietary Director on expectations related to maintaining a safe and sanitary environment for food storage and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 42 | H 606 | | |

bananas had opened and unsealed bags of cereal, shaved almonds, and sunflower seeds. None of the bags were labeled with a date of when the items had been opened or when they expired. Director #41 stated all opened packages of food were expected to be labeled with the date they came into the facility in order to know when the food items expired and needed to be discarded.

Observation of the facility's spices revealed one large container of ground white pepper and one large container of ground pepper with the date of 1/30/15 written on the containers. Director #41 stated he assumed pepper would expire but he did not know when. Director #41 then presented a copy of the guidance he was expected to use for food storage. According to the food management company's Storage Periods for Retaining Food Quality, ground spices were to be stored for 6 months.

Underneath the spice storage area was a shelf holding a one gallon bottle of "browning and seasoning sauce" with a handwritten date of "11/3" (no year was indicated). The outside of the bottle was stained with streaks of brown liquid.

Observation of a metal bin storing serving tongs, ladles, and ice cream scoopers revealed the utensils had old bits of food on them and the bottom of the metal bin was covered in food stains and crumbs.

The walk in refrigerator revealed unwrapped and uncovered food items exposed to the environment, including a package of smoked ham, a package of roast beef, a pan of seasoned nuts, a package of sliced cheese, and a package of flour tortillas. Further inspection of the package of flour tortillas revealed a printed expiration date of February, 2018. Director #41 stated all food items should have been covered

preparation and monitoring for same. A competency was completed by the Hospital Dietary Director on key components for maintaining a safe and sanitary environment for food storage and preparation and monitoring expectations.

E The contractual Dietary Services representative re-trained all dietary staff on food preparation, handling, storage, and cleanliness requirements for maintaining a safe and sanitary environment for food storage and preparation. Content included: the proper washing of dishes, proper handling of leftovers, food dating and labeling, maintaining and cleaning equipment, maintenance of the dishwasher temperature log, maintenance of refrigerator and warmer temperature logs, food borne illness and its prevention, and the checklist of indicators that would be utilized to monitor their compliance with requirements.

F. The dishwasher was serviced so that it was properly functioning and maintaining all temperature requirements.

G. Hospital Leaders and the Infection Control Nurse were trained by the VP Nursing/PI/Regulatory Affairs on their oversight responsibilities to ensure that a sanitary and safe environment is maintained in the hospital's kitchen.

H. Monitoring and evaluation tools were established for use by the Dietary Director, the IC Nurse as well as Hospital Leadership to complete and report out on compliance results on an ongoing basis to the Governing Board through the mechanism, as described below

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 43<br>in order to maintain a sanitary environment. Director #41 further stated the tortillas should have been "long gone."<br><br>Several food items with expired dates or no dates written on the packaging were also observed in the walk in refrigerator. For example, a package of smoked ham revealed a date of "6/29" and a package of roast beef with a date of "5/21" noted on the packaging . In addition, a package of ham and a package roast beef were observed with no expiration date identified. According to the Storage Periods guidelines, cured pork and lunch meat was to be stored for one week. In addition, guidance documentation titled Food Product Labeling and Dating, provided from the contracted food management services company, stated once refrigerated items were removed from their original container, they were to be placed in another container and dated. Once refrigerated items were properly stored with name and dates, they needed to be used or disposed of within seven days.<br><br>Also noted in the walk in refrigerator was a pan of packaged ground beef. One of the packages included a printed "use or freeze by" date of 7/13/18 (four days prior to the date of the observation). The meat appeared discolored, and upon opening the packaging, Director #41 reported the meat smelled spoiled. Director #41 stated there was no way to tell if the meat had been frozen prior to the use by date and stated it should have been discarded. According to the Leftover Foods policy, if the meat had been previously frozen,the date an item was removed from the freezer should have been marked on the item.<br><br>Observations in the walk in freezer revealed the floor was stained and sticky with large crumbs noted. Unwrapped and uncovered food items including fish patties, chicken nuggets, and | H 606 | 3. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br>Performance indicators to assess for compliance with these requirements were implemented and established for daily completion by the Dietary Director; 2X/week by the Infection Control Nurse; daily by Hospital Leaders; and weekly during EOC rounds. The indicators are as follows: 1)Compliance with food storage requirements including covering, date of storage/expiration; absence of any appearance of spoilage; 2)Compliance with Kitchen Cleaning Schedule; 3)Compliance with temperature checks of Warmer, all Refrigerators, and Freezer; 4).Dishwasher is fully operational; 5) Dishwasher temperatures are in range; 6) There are no expired supplies present in kitchen; 7)Kitchen checklist is completed on a daily basis and meets all requirements for compliance or actions taken. The IC Nurse is tracking compliance with all elements on the Infection Control Environmental Checklist. Using the indicators, data from the ongoing assessment for compliance with established dietary food preparation, storage, and cleanliness standards is being conducted on a daily basis (S-S). The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday.<br><br>To ensure ongoing GB oversight, a weekly | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 44<br>green beans were observed being stored in the freezer. Also noted were food items with no date indicating their expiration, including approximately 6 loaves of bread, bags of cut zucchini and cauliflower, and bags of corn dogs, hushpuppies, chicken cordon bleu, and catfish. Director #41 stated all food in the freezer should have been wrapped or covered and labeled with an expiration date. Director #41 further stated he was unsure why this was not done. According to the Leftover Foods policy, all foods placed in the freezer must be covered with aluminum foil or freezer wrap.<br><br>Observations in the dry food storage room revealed the floor was stained and sticky. An opened, uncovered, and undated box of lasagna noodles was stored in a plastic bin. One opened and uncovered box of cornbread mix revealed a printed best by date of 1/27/18 and a written date of "5/5" on the top of the box. One opened and uncovered box of Devil's Food cake mix revealed a printed best by date of 2/21/18 and a written date of "10/22" on the top of the box. Director #41 reiterated that all food items were expected to be covered and labeled with the date they were received at the facility. Director #41 stated he was unsure of if or when the Devil's Food cake mix and cornbread mix were expired.<br><br>c. On 7/17/18 at 4:42 p.m., an interview with Cook #42 was conducted. Cook #42 stated he began noticing the kitchen was becoming increasingly dirty at the beginning of summer. Cook #42 stated this was partially due to the lack of staff in the kitchen. Cook #42 stated at times he would be the only staff member in the kitchen, usually from around 4:00 p.m. until his shift ended at 7:30 p.m. During these times alone, Cook #42 stated he would be in charge of cooking the meals, serving the food, cleaning up the kitchen and washing the dishes. Cook #42 then said kitchen staff did the best job they | H 606 | Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to these and other indicators under review to assess for compliance with the corrective actions taken pursuant to the deficiencies are reviewed for evidence of effectiveness in the corrective actions taken. The findings are being aggregated by the Quality Coordinator and being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings.<br><br>4. Title of the person(s) responsible for implementing the acceptable PoC: Chief Operating Officer<br><br>5.<br>GB meeting:<br>7/17/18<br><br>GB/Contract Service meeting<br>7/17/18<br>7/25/18<br>8/1/18<br>9/4/18<br>9/19/18<br><br>Inservices by Contract Dietary rep<br>7/17/18<br>7/19/18<br>8/3/18<br><br>Additional training by Contract Dietary rep for Hospital Dietary Director<br>7/17/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 45<br>could do; however, there was too much work to do and if there were more time and staff he stated the kitchen would be cleaner.<br><br>d. On 7/17/18 at 5:15 p.m., an interview with contracted Director #41 was conducted who stated he was responsible for providing oversight to the kitchen staff. When asked how Director #41 provided oversight to ensure kitchen staff were completing necessary tasks to keep the kitchen sanitary, Director #41 presented laminated checklists titled Cleaning Schedules. The checklists were covered in food stains. Director #41 stated staff was expected to complete the tasks on the checklists daily. Items on the checklists included labeling food properly, sweeping and mopping the floors, and cleaning spills. The checklists also included areas for staff to date and initial that the tasks were completed and an area for the supervisor to sign. Director #41 then reported he had not been ensuring the checklists were completed and stated they probably hadn't been filled out for the last few months.<br><br>Director #41 said he did not know where the "ball was dropped" in maintaining a clean kitchen. Director #41 further stated the kitchen staff had been asked to complete the tasks on the checklists but they were not getting done. Director #41 then stated the department had been understaffed since he began working at the facility 2 years prior.<br><br>e. On 7/17/18 at 1:09 p.m., an interview with the Quality Coordinator (QC #1) was conducted. QC #1 explained environment of care rounding throughout the facility was conducted on a weekly basis with leadership staff, including the Chief Executive Officer (CEO #6), Chief Operating Officer (COO) #15, Director of Plant Operations #61 (Director), and the Director of Nursing and infection control nurse (DON #2). According to QC #1, the rounding consisted of | H 606 | 7/18/18<br><br>Dishwasher functioning<br>7/18/18<br><br>Training of Hosp. LS and IC Nurse<br><br>Implement<br>M&E tools<br>8/1/18<br>Weekly PI meeting with GB rep. 9/14/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 46<br>walking through the facility to identify safety risks and the findings were documented in a weekly checklist created by the Director #61.<br><br>A request was made to review the checklists from 1/1/18 to 7/17/18. QC #1 then replied Director #61 resigned one day ago and staff were noticing that he had not been keeping up with his responsibilities prior to his resignation.<br><br>Approximately two hours later, at 2:52 p.m., QC #1 presented all of the checklists she could find in Director #61's office. Review of the checklists revealed only six were available from 1/1/18 to present. Findings on the checklist dated 6/28/18 and signed by COO #15 documented the kitchen and cafeteria were dirty. The checklist dated 7/16/18 and signed by COO #15 and QC #1 documented the cafeteria floor was dirty. The infection control nurse (DON #2) was not documented in attendance on either checklist. In addition, there was no further documentation noted regarding what measures were put in place to ensure the kitchen and cafeteria were cleaned.<br><br>f. On 7/18/18 at 3:27 p.m., an interview with the DON #2 was conducted. DON #2 stated in addition to her duties as the DON, she also was the designated infection control nurse at the facility as well as working as a chief nursing officer at a separately certified hospital, approximately 125 miles from the facility. DON #2 stated her role in providing infection control guidance with food services involved conducting a weekly walk through the kitchen. During these walkthroughs, DON #2 explained she would identify areas of concern, such as finding dented cans of food or expired food.<br><br>DON #2 stated she had concerns that the kitchen was not as clean as it should have been. However, DON #2 stated she was unable to provide documentation of the walkthroughs or of | H 606 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 606 | Continued From page 47<br>interventions put into place for improving the cleanliness of the kitchen because Director #61 was responsible for maintaining that information. DON #2 further stated at the other separately certified hospital she worked for, they conducted a more detailed environment of care walk through and she was unsure of why that wasn't happening at the facility.<br><br>g. On 7/26/18 at 3:32 p.m., an interview with the Chief Operating Officer (COO) #15 was conducted. COO #15 stated he conducted daily rounding in the kitchen and cafeteria in order to make sure the areas were clean. During these rounds, COO #15 stated he mentioned to staff on several occasions to do a better job wiping stainless steel counters in the kitchen and to keep the cafeteria tables and floors clean between meals. COO #15 then stated he did not keep documentation of the daily rounds and could not provide evidence of interventions put into place to improve the cleanliness of the kitchen and cafeteria.<br><br>COO #15 further explained during the rounds he would not go into the refrigerator or freezers because he trusted the contracted food services director was properly maintaining food storage in the refrigerator and freezers. COO #15 then stated it was disturbing to learn about the infection control concerns in the kitchen because there were no issues identified with patient satisfaction regarding food. | H 606 | | |
| H 901 | IV.9.101(1) Infection Control: Providing Service<br><br>The facility shall have an infection control program responsible for reducing the risk of acquiring and transmitting nosocomial infections and infectious diseases in the facility. | H 901 | | 09/21/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: CLEAR VIEW BEHAVIORAL HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE: 4770 LARIMER PARKWAY JOHNSTOWN 80534 | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 48<br>This REGULATION is not met as evidenced by: Based on observations, interviews and document reviews, the facility failed to maintain a sanitary environment throughout all patient care areas and in the kitchen used to prepare patient meals. In addition, the facility's leadership staff failed to provide oversight around infection control practices to ensure patients were receiving care in a sanitary environment. These failures resulted in all patients receiving care in an unsanitary environment which increased the risk of patients obtaining infections.<br><br>Findings Include:<br><br>Policy:<br><br>The Leftover Foods policy read, the date an item is removed from the freezer will be marked on the item. Vegetables that turn color or lose texture should not be re-used. Leftover foods should be wrapped/covered and labeled with product name, condition (cooked or raw), amount and date prepared. Foods to be placed in freezer must be covered with aluminum foil or freezer wrap.<br><br>The Nutrition Services Safety Plan policy read, safety procedures will be utilized in Nutrition Services to prevent injury and infection. Remove any grease, food or wet spots from the floor at once.<br><br>The Environmental Services (EVS)/Housekeeping Introduction policy read, the housekeeping management program functions to provide a clean and pleasant environment free from the harmful effects of infections through compliance with procedures and standards set forth by the Occupational Safety and Health Agency (OSHA) and other regulatory agencies. The Infection Control Committee is responsible for monitoring | H 901 | 1. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited;<br><br>A. A meeting of the GB was conducted to discuss findings from the survey pertaining to the following identified deficiencies:<br>(1) failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital's kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for dietary and hospital cleanliness, sanitation, and infection prevention; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were receiving care and nutrition in a sanitary environment.<br>The root causes were identified as follows: The DON was overseeing two facilities due to the difficulty in filling the DON position at Clear View Behavioral Health. This DON had too wide a span of control between the two hospitals to meet all requirements and, though experienced in Infection Control (IC), was not doing so at her main facility so not aware of the requirements for not only patient but environmental surveillance including the cafeteria and housekeeping areas. Additionally, the Dietary Manager was inexperienced in his job and failed to seek assistance from corporate resources within his contract company. As another | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 49<br>housekeeping systems and processes as it relates to overall quality of patient care environment and control infections. The Infection Control Committee is also responsible for the identification of problems, and evaluating and assessing actions taken for effectiveness.<br><br>The Safety Plan for Environment of Care policy read, all trash will be disposed of in a manner which will not produce any unsafe conditions. All restrooms will be kept clean, as an unclean area may produce unsafe conditions.<br><br>The Departmental Cleaning policy read, the facility will maintain a clean environment for our patients and our co-workers by ensuring an environment is as low risk as possible in regard to coming into contact with infectious pathogens. Department equipment shall be cleaned by each department personnel. Housekeeping personnel perform all other duties: dusting, mopping, spot cleaning, disinfecting and sanitizing furnishings, woodwork, walls, floors, doors, vents, ledges, sinks and bathrooms according to established housekeeping procedures. Waste and trash is removed by housekeeping personnel. Environmental of Care Rounds are done weekly to assure all areas are sanitary.<br><br>The Housekeeping Chemicals policy read, a carpet stain remover should be used to remove stains that carpet shampoo will not remove or stains which occur between shampooings.<br><br>The Safety Plan for Materials Management policy read, floors are kept clean and dry and cleared of obstructive objects of any type.<br><br>The EVS/Housekeeping Orientation and Training Policy read, all housekeeping employees will participate in an orientation and continuing education program. Training topics include: cleaning procedures, new techniques, | H 901 | root cause, the Director of Environment of Care (EOC) was under-performing as relates to his job duties and not taking timely actions on infection-related issues in the environment, not escalating issues for intervention, not documenting EOC-related activities. This Director of EOC departed the hospital before the survey was over and an Interim EOC identified and appointed. An action plan was developed and M&E processes and tools proposed.<br><br>B. A meeting was held between the GB members and Hospital Leaders including the IC Nurse and Dietary Manager to examine findings, analyze root causes of the findings and delineate expectations and plan of action related to the following deficiencies cited: (1)Failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital's kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for cleanliness, sanitation and infection prevention in the kitchen and patient care areas; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were receiving care and nutrition in a sanitary environment. The Leaders concurred with the assessment of the GB as relates to the root causes that were identified, the action plan and the M&E process to be used. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
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| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 901 | Continued From page 50<br>routine cleaning schedules, terminal cleaning of rooms, use of new products, special isolation cleaning procedures, the spread of infections, and principles and methods for control of infection.<br><br>The Safety Plan for Housekeeping General Safety policy read, floors are kept clean, dry and unobstructed. Spills and broken objects are promptly and safely removed. Debris of all varieties (paper clips, rubber bands, paper, etc.) are removed immediately when reported or observed. Floors are mopped immediately when leaks, spilled water, coffee, tracking, etc. are reported or observed<br><br>Reference:<br><br>According to the facility's job description for the position of Cook, essential job function and responsibilities include ensuring safe food storage and preparation, i.e. stock rotation and labeling/dating food items and discarding out-of-date food.<br><br>According to a contracted agreement between a food management services company and the facility, the food management company shall clean the kitchen, including kitchen walls, floors, windows and equipment.<br><br>According to the contracted food management services company's job description for Food Services Director, duties and responsibilities include maintaining a sanitary and safe operation in accordance with federal, state, and local regulations. The Director will be able to schedule employees to meet food production, service and cleaning requirements. The Director will be able to administer in-service training and evaluate performance and training methods.<br><br>According to the contracted food management services company's inservice, titled Food | H 901 | C. The vacant Environment of Care Director position was replaced and the employee was trained on requirements related to IC prevention and intervention as well as documentation.<br><br>D. Housekeeping vacancies were replaced through a contract service that will continue to be used daily until there is Housekeeping coverage on both shifts on a daily basis and whenever there are future housekeeping vacancy issues.<br>A competency training for contract and staff housekeepers on cleaning requirements was completed.<br><br>E. Consideration was made to add an IC policy on environment of care. Question was raised if the Dietary Services had adequate policies and it was concluded by the GB and LS teams that the IC plan needed to be the document to lead the IC nurse and it contained the requirements but, again, though credentialed as an IC Nurse, the acting DON/IC Nurse was not actively working as the IC Nurse at her own facility so not as versed in all the requirements of the IC plan that she could be. In meeting with the Corporate Dietary Company it was concluded that the policies were sufficient but were not being followed by the Hospital's Dietary Manager.<br><br>F. The IC Nurse was apprised of these associated requirements and her authority, responsibility ,and expectations related to identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.<br><br>G. The IC Nurse was trained by the VP of Nursing /PI/ Regulatory Affairs, who is a | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| H 901 | Continued From page 51<br>Product Labeling and Dating, all leftover foods or foods removed from their original containers require proper labeling when stored. Proper food labeling requires the following: name, identification, date of preparation and date foods are to be used or discarded.<br><br>At the time food is being removed from its original container and placed in another container, date it. Once refrigerated items are properly stored with name and dates, they need to be used or disposed of within seven days. At the time food is moved from freezer to refrigerator for thawing, date it.<br><br>1. The facility failed to ensure the kitchen, food preparation areas and cafeteria were clean. In addition, the facility failed to ensure food was safe for patient consumption.<br><br>a. On 7/17/18 at 10:35 a.m., a tour of the kitchen and cafeteria was conducted with Food Service Director (Director #41), which revealed multiple instances of a dirty environment, food stored without discard dates noted on the packaging, and other infection control concerns. For example:<br><br>At 10:35 a.m., the cafeteria was toured. At this time, there were no patients eating. The floors were sticky with visible brownish stains and crumbs. At 11:45 a.m., patients were observed eating in the cafeteria and the same stains and crumbs were noted.<br><br>The floors in the kitchen area were also sticky with visible stains and food particles on the floors throughout the entire kitchen area. According to the Nutrition Services Safety Plan policy, any grease, food or wet spots were to be removed from the floor at once.<br><br>Two large metal sheet pans were observed on the floor propped up against a refrigerator. | H 901 | DNP, FNP-BC, NP-C versed in Infection Control requirements as well as through evidence- based infection control training resources on conducting environmental checks by directly surveying the kitchen at least twice weekly to ensure cleanliness and food safety to survey the hospital units for the cleanliness of patient care areas. A competency to assess for the DON/IC Nurse's demonstrated compliance with these requirements was completed.<br><br>H. IC Committee members, Hospital Leaders, and the IC Nurse were trained by the VP Nsg, PI, Regulatory Affairs on their oversight responsibilities to ensure that IC requirements related to prevention, intervention, and control of infections specific to the dietary and patient care environments are being upheld including the IC Nurse's requirement to identify, report, investigate, and control infections and communicable diseases of patients and personnel by ensuring that a sanitary environment is maintained throughout all patient care areas and in the hospital's kitchen used to prepare patient meals.<br><br>I. All dietary staff were retrained by their Corporate Dietary LS on the requirements related to food preparation, handling, storage, and environmental cleanliness. The content was approved by the VP Nsg, PI, Regulatory Affairs prior to the training.<br>H. An IC checklist entitled: "Infection Control Environment of Care Checklist" was developed to be utilized as a standardized tool to assess for the evidence of compliance of the kitchen services with cleanliness and food safety expectations and the patient care environment. This checklist contained all of the requirements for cleanliness and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| H 901 | Continued From page 52<br>Director #41 stated the pans were used to cover cold food items; however, they should not have been stored on the floor due to the possibility of contamination.<br><br>Upon entering the dish cleaning area of the kitchen, a sign stating "Out of Order" was taped to the dishwasher. Cook #43 stated the dishwasher had been broken for the last 4 to 5 days and that staff were washing trays, pots, pans, and utensils by hand utilizing three separate sinks. Cook #43 explained the first sink was filled with water and soap, the second sink was filled with water to rinse the dishes, and the third sink had sanitizing chemicals in the water. Cook #43 further explained he would check the concentration of the chemicals in the third sink by conducting a test of the water with test strips located on top of the sink. According to Cook #43, it was important to conduct this test in order to ensure the correct amount of sanitizer was added when washing items used by patients.<br><br>Review of the vial of test strips revealed a printed expiration date of June of 2017. Further review of the vial noted the test strips were intended for antimicrobial fruit and vegetable treatment and not for measuring the concentration of the sanitizer. Director #41 confirmed the test strips were expired. Director #41 stated he was unaware the strips were expired and stated he could not guarantee the proper amount of solution was added to the water to sanitize the dishes.<br><br>Observation of a steel countertop revealed a plastic bin filled with bananas. At the bottom of the bin were several blackened colored bananas with loosened skins, exposing the fruit to the open air. Approximately five small insects were observed flying around the bin of bananas. Director #41 identified the insects as gnats and stated he did not have time to throw out the | H 901 | food safety including assessment for temperature checks of all required dietary equipment, covered/dated food, no expired food, functioning dishwasher, clean floors, non-expired supplies, evidence of patient areas that were free of debris, clean unit floors, patient bathrooms free of dirt, hair, and all components that had been identified as deficiencies in Clear View's kitchen area and patient care areas. The Dietary department was required to update their own checklist and submit results to the Hospital Leadership and Infection Control Committee. Additionally, a checklist was devised for Hospital leadership to complete for their daily surveillance requirements related to the kitchen and patient care areas. Last, in addition to the other daily hospital/dietary area inspections, the expectation for completion and documentation of the Hospital's weekly EOC rounds led by the EOC Director but attended by Hospital LS representatives to assess for safety and cleanliness issues by the LS team and documentation of findings, tracking of actions taken was re-instituted.<br><br>J. An Interim but dedicated DON was acquired to fulfill the DON and IC responsibilities of the Hospital. This Interim DON (has extensive training in environmental surveillance and had, within the past two months been serving as the IC nurse at her former facility. This Interim DON was put in place to assume the responsibilities for DON and IC Nurse (herein referred to as the Hospital's IC Nurse from this point in this deficiency tag forward)<br><br>K. The IC Environment of Care checklist and its components described in " H" | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 901 | Continued From page 53<br>blackened bananas. Underneath the countertop was a container of bread crumbs with the lid of the container not completely sealed, allowing the gnats access to the bread crumbs.<br><br>A second countertop located next to the bin of bananas had opened and unsealed bags of cereal, shaved almonds, and sunflower seeds. None of the bags were labeled with a date of when the items had been opened or when they expired. Director #41 stated all opened packages of food were expected to be labeled with the date they came into the facility in order to know when the food items expired and needed to be discarded.<br><br>Observation of the facility's spices revealed one large container of ground white pepper and one large container of ground pepper with the date of 1/30/15 written on the containers. Director #41 stated he assumed pepper would expire but he did not know when. Director #41 then presented a copy of the guidance he was expected to use for food storage. According to the food management company's Storage Periods for Retaining Food Quality, ground spices were to be stored for 6 months.<br><br>Underneath the spice storage area was a shelf holding a one gallon bottle of "browning and seasoning sauce" with a handwritten date of "11/3" (no year was indicated). The outside of the bottle was stained with streaks of brown liquid.<br><br>Observation of a metal bin storing serving tongs, ladles, and ice cream scoopers revealed the utensils had old bits of food on them and the bottom of the metal bin was covered in food stains and crumbs.<br><br>The walk in refrigerator revealed unwrapped and uncovered food items exposed to the environment, including a package of smoked | H 901 | above was adopted as the list of performance indicators to assess for compliance with the environmental standards for cleanliness in the kitchen and hospital areas and to be used by the IC Nurse<br><br>2. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited;<br><br>A. A meeting of the GB was conducted to discuss findings from the survey pertaining to the following identified deficiencies:<br>(1) failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital's kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for dietary and hospital cleanliness, sanitation, and infection prevention; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were receiving care and nutrition in a sanitary environment.<br>The root causes were identified as follows: The DON was overseeing two facilities due to the difficulty in filling the DON position at Clear View Behavioral Health. This DON had too wide a span of control between the two hospitals to meet all requirements and, though experienced in Infection Control (IC), was not doing so at her main facility so not aware of the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| H 901 | Continued From page 54<br>ham, a package of roast beef, a pan of seasoned nuts, a package of sliced cheese, and a package of flour tortillas. Further inspection of the package of flour tortillas revealed a printed expiration date of February, 2018. Director #41 stated all food items should have been covered in order to maintain a sanitary environment. Director #41 further stated the tortillas should have been "long gone."<br><br>Several food items with expired dates or no dates written on the packaging were also observed in the walk in refrigerator. For example, a package of smoked ham revealed a date of "6/29" and a package of roast beef with a date of "5/21" noted on the packaging . In addition, a package of ham and a package roast beef were observed with no expiration date identified. According to the Storage Periods guidelines, cured pork and lunch meat was to be stored for one week. In addition, guidance documentation titled Food Product Labeling and Dating, provided from the contracted food management services company, stated once refrigerated items were removed from their original container, they were to be placed in another container and dated. Once refrigerated items were properly stored with name and dates, they needed to be used or disposed of within seven days.<br><br>Also noted in the walk in refrigerator was a pan of packaged ground beef. One of the packages included a printed "use or freeze by" date of 7/13/18 (four days prior to the date of the observation). The meat appeared discolored, and upon opening the packaging, Director #41 reported the meat smelled spoiled. Director #41 stated there was no way to tell if the meat had been frozen prior to the use by date and stated it should have been discarded. According to the Leftover Foods policy, if the meat had been previously frozen,the date an item was removed from the freezer should have been marked on | H 901 | requirements for not only patient but environmental surveillance including the cafeteria and housekeeping areas. Additionally, the Dietary Manager was inexperienced in his job and failed to seek assistance from corporate resources within his contract company. As another root cause, the Director of Environment of Care (EOC) was under-performing as relates to his job duties and not taking timely actions on infection-related issues in the environment, not escalating issues for intervention, not documenting EOC-related activities. This Director of EOC departed the hospital before the survey was over and an Interim EOC identified and appointed. An action plan was developed and M&E processes and tools proposed.<br><br>B. A meeting was held between the GB members and Hospital Leaders including the IC Nurse and Dietary Manager to examine findings, analyze root causes of the findings and delineate expectations and plan of action related to the following deficiencies cited: (1)Failure of the IC Committee, Hospital Leadership, and the IC Nurse to effectively oversee (through environmental surveillance activities) and intervene on infection control issues at the hospital resulting in the failure to maintain a sanitary environment throughout all patient care areas and in the hospital's kitchen used to prepare patient meals;(2) Failure of the facility's Dietary Manager and Environment of Care (EOC) Director to maintain standards for cleanliness, sanitation and infection prevention in the kitchen and patient care areas; (3)Failure of Hospital leadership to maintain documentation to support efforts at infection surveillance and remediation activities in order to ensure patients were | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| H 901 | Continued From page 55<br>the item.<br><br>Observations in the walk in freezer revealed the floor was stained and sticky with large crumbs noted. Unwrapped and uncovered food items including fish patties, chicken nuggets, and green beans were observed being stored in the freezer. Also noted were food items with no date indicating their expiration, including approximately 6 loaves of bread, bags of cut zucchini and cauliflower, and bags of corn dogs, hushpuppies, chicken cordon bleu, and catfish. Director #41 stated all food in the freezer should have been wrapped or covered and labeled with an expiration date. Director #41 further stated he was unsure why this was not done. According to the Leftover Foods policy, all foods placed in the freezer must be covered with aluminum foil or freezer wrap.<br><br>Observations in the dry food storage room revealed the floor was stained and sticky. An opened, uncovered, and undated box of lasagna noodles was stored in a plastic bin. One opened and uncovered box of cornbread mix revealed a printed best by date of 1/27/18 and a written date of "5/5" on the top of the box. One opened and uncovered box of Devil's Food cake mix revealed a printed best by date of 2/21/18 and a written date of "10/22" on the top of the box. Director #41 reiterated that all food items were expected to be covered and labeled with the date they were received at the facility. Director #41 stated he was unsure of if or when the Devil's Food cake mix and cornbread mix were expired.<br><br>b. On 7/17/18 at 4:42 p.m., an interview with Cook #42 was conducted. Cook #42 stated he began noticing the kitchen was becoming increasingly dirty at the beginning of summer. Cook #42 stated this was partially due to the lack of staff in the kitchen. Cook #42 stated at times he would be the only staff member in the | H 901 | receiving care and nutrition in a sanitary environment. The Leaders concurred with the assessment of the GB as relates to the root causes that were identified, the action plan and the M&E process to be used.<br><br>C. The vacant Environment of Care Director position was replaced and the employee was trained on requirements related to IC prevention and intervention as well as documentation.<br><br>D. Housekeeping vacancies were replaced through a contract service that will continue to be used daily until there is Housekeeping coverage on both shifts on a daily basis and whenever there are future housekeeping vacancy issues.<br>A competency training for contract and staff housekeepers on cleaning requirements was completed.<br><br>E. Consideration was made to add an IC policy on environment of care. Question was raised if the Dietary Services had adequate policies and it was concluded by the GB and LS teams that the IC plan needed to be the document to lead the IC nurse and it contained the requirements but, again, though credentialed as an IC Nurse, the acting DON/IC Nurse was not actively working as the IC Nurse at her own facility so not as versed in all the requirements of the IC plan that she could be. In meeting with the Corporate Dietary Company it was concluded that the policies were sufficient but were not being followed by the Hospital's Dietary Manager.<br><br>F. The IC Nurse was apprised of these associated requirements and her authority, responsibility ,and expectations | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 901 | Continued From page 56<br>kitchen, usually from around 4:00 p.m. until his shift ended at 7:30 p.m. During these times alone, Cook #42 stated he would be in charge of cooking the meals, serving the food, cleaning up the kitchen and washing the dishes. Cook #42 then said kitchen staff did the best job they could do; however, there was too much work to do and if there were more time and staff he stated the kitchen would be cleaner.<br><br>c. On 7/17/18 at 5:15 p.m., an interview with Director #41 was conducted who stated he was responsible for providing oversight to the kitchen staff. When asked how Director #41 provided oversight to ensure kitchen staff were completing necessary tasks to keep the kitchen sanitary, Director #41 presented laminated checklists titled Cleaning Schedules. The checklists were covered in food stains. Director #41 stated staff was expected to complete the tasks on the checklists daily. Items on the checklists included labeling food properly, sweeping and mopping the floors, and cleaning spills. The checklists also included areas for staff to date and initial that the tasks were completed and an area for the supervisor to sign. Director #41 then reported he had not been ensuring the checklists were completed and stated they probably hadn't been filled out for the last few months.<br><br>Director #41 said he did not know where the "ball was dropped" in maintaining a clean kitchen. Director #41 further stated the kitchen staff had been asked to complete the tasks on the checklists but they were not getting done. Director #41 then stated the department had been understaffed since he began working at the facility 2 years prior.<br><br>d. On 7/17/18 at 1:09 p.m., an interview with the Quality Coordinator (QC #1) was conducted. QC #1 explained environment of care rounding throughout the facility was conducted on a | H 901 | related to identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.<br><br>G. The IC Nurse was trained by the VP of Nursing /PI/ Regulatory Affairs, who is a DNP, FNP-BC, NP-C versed in Infection Control requirements as well as through evidence- based infection control training resources on conducting environmental checks by directly surveying the kitchen at least twice weekly to ensure cleanliness and food safety to survey the hospital units for the cleanliness of patient care areas. A competency to assess for the DON/IC Nurse's demonstrated compliance with these requirements was completed.<br><br>H. IC Committee members, Hospital Leaders, and the IC Nurse were trained by the VP Nsg, PI, Regulatory Affairs on their oversight responsibilities to ensure that IC requirements related to prevention, intervention, and control of infections specific to the dietary and patient care environments are being upheld including the IC Nurse's requirement to identify, report, investigate, and control infections and communicable diseases of patients and personnel by ensuring that a sanitary environment is maintained throughout all patient care areas and in the hospital's kitchen used to prepare patient meals.<br><br>I. All dietary staff were retrained by their Corporate Dietary LS on the requirements related to food preparation, handling, storage, and environmental cleanliness. The content was approved by the VP Nsg, PI, Regulatory Affairs prior to the training.<br>H. An IC checklist entitled: "Infection Control Environment of Care Checklist" | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 57<br>weekly basis with leadership staff, including the Chief Executive Officer (CEO #6), Chief Operating Officer (COO) #15, Director of Plant Operations #61 (Director), and the Director of Nursing and infection control nurse (DON #2). According to QC #1, the rounding consisted of walking through the facility to identify safety risks and the findings were documented in a weekly checklist created by the Director #61.<br><br>A request was made to review the checklists from 1/1/18 to 7/17/18. QC #1 then replied Director #61 resigned one day ago and staff were noticing that he had not been keeping up with his responsibilities prior to his resignation.<br><br>Approximately two hours later, at 2:52 p.m., QC #1 presented all of the checklists she could find in Director #61's office. Review of the checklists revealed only six were available from 1/1/18 to present. Findings on the checklist dated 6/28/18 and signed by COO #15 documented the kitchen and cafeteria were dirty. The checklist dated 7/16/18 and signed by COO #15 and QC #1 documented the cafeteria floor was dirty. The infection control nurse (DON #2) was not documented in attendance on either checklist. In addition, there was no further documentation noted regarding what measures were put in place to ensure the kitchen and cafeteria were cleaned.<br><br>e. On 7/18/18 at 3:27 p.m., an interview with the DON #2 was conducted. DON #2 stated in addition to her duties as the DON, she also was the designated infection control nurse at the facility as well as working as a chief nursing officer at a separately certified hospital, approximately 125 miles from the facility. DON #2 stated her role in providing infection control guidance with food services involved conducting a weekly walk through the kitchen. During these walkthroughs, DON #2 explained she would identify areas of concern, such as finding dented | H 901 | was developed to be utilized as a standardized tool to assess for the evidence of compliance of the kitchen services with cleanliness and food safety expectations and the patient care environment. This checklist contained all of the requirements for cleanliness and food safety including assessment for temperature checks of all required dietary equipment, covered/dated food, no expired food, functioning dishwasher, clean floors, non-expired supplies, evidence of patient areas that were free of debris, clean unit floors, patient bathrooms free of dirt, hair, and all components that had been identified as deficiencies in Clear View's kitchen area and patient care areas. The Dietary department was required to update their own checklist and submit results to the Hospital Leadership and Infection Control Committee. Additionally, a checklist was devised for Hospital leadership to complete for their daily surveillance requirements related to the kitchen and patient care areas. Last, in addition to the other daily hospital/dietary area inspections, the expectation for completion and documentation of the Hospital's weekly EOC rounds led by the EOC Director but attended by Hospital LS representatives to assess for safety and cleanliness issues by the LS team and documentation of findings, tracking of actions taken was re-instituted.<br><br>J. An Interim but dedicated DON was acquired to fulfill the DON and IC responsibilities of the Hospital. This Interim DON (has extensive training in environmental surveillance and had, within the past two months been serving as the IC nurse at her former facility. This Interim DON was put in place to assume | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 58<br>cans of food or expired food.<br><br>DON #2 stated she had concerns that the kitchen was not as clean as it should have been. However, DON #2 stated she was unable to provide documentation of the walkthroughs or of interventions put into place for improving the cleanliness of the kitchen because Director #61 was responsible for maintaining that information. DON #2 further stated at the other separately certified hospital she worked for, they conducted a more detailed environment of care walk through and she was unsure of why that wasn't happening at the facility.<br><br>f. On 7/26/18 at 3:32 p.m., an interview with the Chief Operating Officer (COO) #15 was conducted. COO #15 stated he conducted daily rounding in the kitchen and cafeteria in order to make sure the areas were clean. During these rounds, COO #15 stated he mentioned to staff on several occasions to do a better job wiping stainless steel counters in the kitchen and to keep the cafeteria tables and floors clean between meals. COO #15 then stated he did not keep documentation of the daily rounds and could not provide evidence of interventions put into place to improve the cleanliness of the kitchen and cafeteria.<br><br>COO #15 further explained during the rounds he would not go into the refrigerator or freezers because he trusted the contracted food services director was properly maintaining food storage in the refrigerator and freezers. COO #15 then stated it was disturbing to learn about the infection control concerns in the kitchen because there were no issues identified with patient satisfaction regarding food.<br><br>2. The facility failed to provide adequate housekeeping staff and oversight of the infection control program in order to ensure a sanitary environment throughout all patient care | H 901 | the responsibilities for DON and IC Nurse (herein referred to as the Hospital's IC Nurse from this point in this deficiency tag forward)<br><br>K. The IC Environment of Care checklist and its components described in " H" above was adopted as the list of performance indicators to assess for compliance with the environmental standards for cleanliness in the kitchen and hospital areas and to be used by the IC Nurse<br><br>3. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br>A. Performance indicators to assess for compliance with the environmental standards for cleanliness in the kitchen and hospital areas were devised and incorporated into a checklist for the IC Nurse that is entitled the Infection Control Environment of Care Checklist. The indicators for inspections to be utilized by Dietary staff were implemented and mirror the indicators of the IC Nurse specific to dietary department cleanliness and food safety standards. Additionally, a list of IC environmental indicators was devised and compiled for the Hospital Leadership specific to compliance with standards for hospital cleanliness. Last, the Hospital's weekly EOC rounds that was to be led by the EOC Director was re-instituted. Using the indicators from these data collection tools, there is ongoing assessment for compliance with the associated standards being conducted by the IC Nurse during her environmental surveillance at least twice weekly, by the Dietary Manager as | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 59<br>areas.<br><br>a. On 7/16/18 at 11:26 a.m., a tour of the geriatric unit was conducted. Dust balls, food stains, and insects, both dead and alive, were observed on the floor of the patient milieu (common area) and dining area. The therapy group room showed similar findings of dust on the floor and also a cigarette butt was found under a chair.<br><br>Observations in patient room 207 revealed piles of dust and debris in the doorway of the room and underneath the beds. A used gauze dressing was also noted on the floor of the room. Similar findings of dust and debris on the floor were found in patient room 207 and room 203.<br><br>The tour continued to the geriatric seclusion room, which revealed stains on the mattress and piles of white debris in the corner of the room. The bathroom located next to the seclusion room revealed hair and dust balls in the sink and a dirty toilet.<br><br>At 12:00 p.m., the high acuity adult unit was toured, where a strong and pungent odor of urine and body odor was immediately present in the hallway. The carpeting in the hallway was visibly dirty. Patient room 404 was particularly odorous of urine and was dirty.<br><br>The lower acuity adult unit was then toured and showed similar findings of dirty carpeting in the hallway. The group room was noted to have used cups on the counter tops and debris on the carpeting.<br><br>The tour then continued to the seclusion area on the adolescent unit. The garbage can in the bathroom located next to the seclusion room was overflowing with used paper towels and garbage on the floor next to the can. The toilet | H 901 | well as Hospital Leaders on a daily basis (S-S), and by the entire Hospital Leader/EOC team on a weekly basis.<br><br>The findings, conclusions, recommendations, and actions of the IC Nurse, the Dietary Manager, and Hospital Leadership rounds are being reported at the Hospital's Morning Leadership. This level of reporting will continue indefinitely due to the gravity of the issue that ensured from failure to be attentive to EOC surveillance.<br><br>To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to the Infection Control EOC indicators as described above are under review to assess for compliance with the standards, to determine any need for corrective actions and to assess the effectiveness of any corrective actions taken. The findings are being aggregated by the Director of Compliance/ Quality/Risk and being forwarded to the Infection Control Committee, the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings.<br><br>4. Title of the person(s) responsible for implementing the acceptable PoC: Chief Operating Officer<br><br>5.<br>Interim dedicated DON/IC Nurse in place; 8/6/18 (oriented 7/25-27/18)<br><br>M&E started 7/19/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 60<br>seat and bowl were stained and additional garbage was found on the floor next to the toilet.<br><br>At 12:30 p.m., an interview with a patient on the geriatric unit (Patient D) was conducted. Patient D stated she had been at the facility for approximately 5 days and during this time, her room had not been cleaned. Patient D further stated her daughter had to help her get set up and assist her with bathing.<br><br>At 5:15 p.m., the bathroom next to the seclusion room on the adult unit was observed and revealed the garbage can to be overflowing, with additional used paper towels and debris on the floor next to the can.<br><br>b. On 7/18/18 at 8:08 a.m., a tour of the geriatric unit was conducted. Patient room 204 revealed insects flying around the beds and a urine stained toilet seat. Also noted in patient room 204 was a used pair of paper scrubs with orange colored stains placed on top of a desk.<br><br>Upon entering patient room 201, puddles of liquid were observed on the floor as well as an odor of urine. The toilet was also stained.<br><br>On 7/18/18 at 3:28 p.m., an interview with the infection control nurse (DON #2) was conducted. DON #2 stated she was familiar with the patient in patient room 201 and stated the patient frequently urinated on the floor. DON #2 further stated it was difficult to clean the patient's room because he would become agitated and would not allow staff to clean the floor. When asked what interventions were put in place to ensure the patient's urine was not tracking throughout the rest of the unit, DON #2 stated typically no one went into the patient's room because he did not allow people in his room. DON #2 then verified that the patient used a wheelchair, which would be wheeled in and out of his room and throughout the unit. | H 901 | Weekly PI meeting with GB representative started<br>9/14/18<br><br>All items in place as of 09/21/2018 as delineated below<br><br>GB meetings:<br>7/17/18<br>7/18/18<br>7/19/18<br><br>GB/LS meetings<br>7/17/18<br>1/18/18<br>7/19/18<br><br>Interim EOC Director 7/24/18<br><br>Hskpg contract in place 7/23/18<br><br>IC Plan and<br>Policy Review<br>7/19/18<br><br>IC Nurse training<br>7/19/18<br>Hosp. LS training<br>7/19//18<br>IC Committee training<br>9/14/18<br><br>Dietary staff training:<br>7/17/18<br>7/19/18<br>8/3/18<br><br>Dietary checklist reviewed and approved<br>7/17/18<br><br>M&E in place through EOC checklist in place and IC Nurse and Hospital LS EOC Rounds::7/19/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 61<br>There was no way to ensure urine from the patient's was not being tracked and spread throughout the common areas.<br><br>c. On 7/18/18 at 8:37 a.m., an interview with Patient #1 was conducted on the geriatric unit. Patient #1 explained she had previously been a patient at the facility between one to two years ago and she had noticed the facility was much cleaner during that visit. Patient #1 stated during this current visit, she noticed patient care staff were cleaning the unit, which was not the case during her prior visit. Patient #1 then said her bathroom had not been cleaned in three days.<br><br>d. At 12:36 p.m., a tour of the adolescent and adult units was conducted. Observations in patient room 403 revealed insects flying around one of the beds. Also during this tour, several bathrooms in patient rooms were noticeably soiled. For example, toilet seats and toilet bowls stained with fecal matter, urine, and/or blood were observed in patient rooms 401, 402, 403, 406, 408, 506, and 605. A used Band-Aid was observed in the shower drain in patient room 408. Observations of the shower curtains revealed a pink and dark gray colored residue at the bottom of the curtains in patient rooms 402, 408, and 506.<br><br>At 1:17 p.m., Mental Health Technician (MHT) #36, who was present during the tour on the lower acuity adult unit, was interviewed. MHT #36 said she was unsure of what the pink residue at the bottom of the shower curtain in patient room 506 was. She stated the bathroom needed to be cleaned and the shower curtain needed to be replaced because it "looked gross" and was unsanitary for patients who used the bathroom every day.<br><br>MHT #36 then explained she would usually call for housekeeping to request areas needing cleaning; however, since there were currently no | H 901 | Contract with cleaning service 7/23/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 62<br>housekeepers on staff, she was not sure who was responsible for cleaning patient rooms. MHT #36 said if she had time, she would use disinfectant wipes to clean the countertops, sinks, shower and toilet. MHT #36 stated she had not received training on how to clean patient bathrooms.<br><br>On 7/18/18 at 3:28 p.m., an interview with the infection control nurse (DON #2) was conducted. DON #2 stated she was told by Director #61 that the pink discoloration at the bottom of the shower curtains was not mold. DON #2 stated she did not know how Director #61 had concluded the discoloration was not mold or if there was any documentation of how the conclusion was determined. DON #2 further stated she was unaware if any testing had been done on the shower curtains to determine what the cause of the discoloration was.<br><br>e. On 7/20/18 at 10:22 a.m., an interview with Patient E and Patient C was conducted on the high acuity adult unit. Patient E stated he arrived at the facility three or four days prior and Patient C stated he had been at the facility for about one week. Patient C stated when he arrived, the unit smelled like urine and his room was in "horrible" condition. Patient C stated the toilet was stained upon his arrival and that he had to clean his room, including washing the trash can by soaking it in the shower, because it was "filthy."<br><br>f. On 7/21/18 at 1:15 p.m., a tour of the high acuity adult unit was conducted. Observations in patient room 407 revealed a plastic cap, used to cover the needle of a syringe, next to the mattress of a patient's bed. RN #57, who was present for the observation, stated he was not sure how long the cap had been in the room. He further stated it should have been discarded because the tip of plastic cap contained sharp edges patients could have used to harm | H 901 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 63<br>themselves.<br><br>g. Review of an Environment of Care Risk Assessment, conducted on 12/28/17, identified the carpeting in the facility as an infection control risk. The assessment documented routine carpet shampooing was in place to reduce this risk. On 7/18/18 at 2:42 p.m., a request was made for documentation showing how often the carpeting had been shampooed.<br><br>During an interview with the infection control nurse (DON #2) on 7/18/18 at 3:28 p.m., she stated the environment of care staff were responsible for shampooing the carpeting and that she was responsible for ensuring the carpets were clean. DON #2 stated she was unsure of when the last time the carpeting was shampooed. No evidence was provided prior to the conclusion of the survey to show how often the carpeting was expected to be shampooed and when it had been done in order to decrease the facility's identified infection control risk.<br><br>h. A review of the Housekeeping Schedule from 4/1/18 to 7/31/18 was conducted. All housekeeping shifts were scheduled between the hours of 6:00 a.m. to 2:30 p.m. In April, there were no housekeepers scheduled from 4/27/18 through 4/30/18 and only one housekeeper scheduled on 4/1/18-4/8/18, 4/13/18-4/15/18, 4/20/18-4/22/18, and 4/25/18-4/26/18. In May, there were no housekeepers scheduled on Sundays. On all other days in May, except on 5/30/18, there was only one housekeeper scheduled, which was the same staff member (Housekeeper #53). In June, there were no housekeepers scheduled on 6/3/18 and 6/17/18. In addition, there was only one housekeeper scheduled on 6/218, 6/5/18, 6/7/18, 6/9/18, 6/16/18, 6/19/18, 6/21/18, 6/24/18, 6/26/18, 6/28/18, and 6/30/18. In July, there were no housekeepers scheduled on Sundays. In addition, there was only one | H 901 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 64 | H 901 | | |

housekeeper scheduled on 7/7/18 and 7/14/18.

According to the current staff roster, there were only two housekeepers listed as being employec by the facility (Housekeeper #53 and #54). On 7/26/18 at 3:32 p.m., the COO #15 stated one of the two housekeepers was on maternity leave while the other housekeeper had resigned the prior week, resulting in the facility not having any current housekeepers on staff.

g. A review of the monthly Infection Control Safety Meeting minutes, from 1/18/18 to 6/21/18, was conducted. The meeting held on 3/15/18 included discussion of Director #61 reaching out to a separately certified hospital to see if one of their staff members would come to the facility to help train housekeepers. However, there was no follow up documentation noted to show if a staff member had come to the facility to assist in training.

During the Infection Control Safety Meeting held on 6/21/18, a RN from a separately certified hospital was going to begin supporting the infection control program at the facility; however, her scheduled start date was not until 7/27/18.

Also discussed during the 6/21/18 meeting was the low retention rate of housekeepers and how staff would be assisting in the emptying of trash and cleaning of units. A subsequent meeting with the MHTs and nurses was planned for 7/10/18 and 7/12/18 to discuss assisting with housekeeping duties while the facility was struggling to maintain housekeepers.

Review of the MHT and Nurse's Meeting Agenda, held on 7/10/18 and 7/12/18, revealed no documentation on what types of housekeeping duties MHTs and RNs were expected to perform or how staff would be trained on cleaning the facility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 65<br>h. On 7/18/18 at 6:04 a.m., an interview was conducted with Mental Health Technician (MHT) #51, who was assigned to work the night shift on the adolescent unit. MHT #51 explained cleaning responsibilities for night shift MHTs included cleaning the nurses station and the countertops in the group therapy rooms. MHT #51 stated it was his understanding that patient rooms were cleaned during the day shift; however, he was not sure how that was getting done because there currently was no janitorial staff employed at the facility.<br><br>MHT #51 then stated he was also responsible for cleaning up after patients when they had accidents. MHT #51 explained he had noticed an increase in having to clean patient care areas and patient rooms of fecal matter, urine and menstrual blood; however, he had not received training on how to ensure he was properly cleaning patient rooms and patient care areas. MHT #51 further stated it would have been important to receive training on cleaning in order to help stop the spread of disease potentially found in bodily fluids.<br><br>i. On 7/18/18 at 3:27 p.m., an interview with the DON #2 was conducted. DON #2 stated in addition to her duties as the DON, she also was the designated infection control nurse at the facility as well as working as a chief nursing officer at a separately certified hospital, approximately 125 miles from the facility.<br><br>DON #2 stated her role as the infection control nurse mostly involved conducting hand hygiene audits. She explained she would watch staff performing hand hygiene on the camera monitors from her office or at her home. If she identified a hand hygiene breach, she would notify the staff member for coaching by text message, phone call, or in person if she was at the facility. DON #2 stated she did not maintain documentation of the coachings nor did she | H 901 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 66 | H 901 | | |

conduct any trending from the hand hygiene audit data collected on potential patterns identified during the audits.

Upon reviewing the infection control concerns identified during tours conducted throughout the survey, DON #2 stated she was responsible for providing oversight of interventions taken for pest control at the facility. DON #2 said it was important to keep the facility free of insects because they could spread bacteria. DON #2 then stated a pest control company was contracted to provide services at the facility; however, she did not know how often they came to the facility.

DON #2 explained MHTs and RNs had been asked to help clean patient rooms and other areas of the facility due to the short staffing of housekeepers. DON #2 stated other than a brief discussion on the use of antimicrobial wipes for cleaning, there had been no other training provided to staff on how to properly clean. DON #2 further stated there was nothing being done at the facility to ensure patient rooms were being adequately cleaned.

DON #2 then stated she was involved in conducting weekly infection control rounding throughout the facility with Director #61 in order to identify infection control risks. DON #2 explained Director #61 was responsible for maintaining documentation on the rounds; however, Director #61 had recently resigned and DON #2 was unsure of where the documentation was.

A request was made to review the checklists from 1/1/18 to 7/17/18. Quality Coordinator (QC #1) replied Director #61 resigned one day ago and staff were noticing that he had not been keeping up with his responsibilities prior to his resignation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 67 | H 901 | | |

Approximately two hours later, at 2:52 p.m., QC #1 presented all of the checklists she could find in Director #61's office. Review of the checklists revealed only six were available from 1/1/18 to present. DON #2's signature was documented on the sign in sheet in only one of the six available checklists, dated 2/28/18.

j. On 7/26/18 at 3:32 p.m., an interview was conducted with COO #15, who provided leadership oversight to all department directors at the facility. COO #15 explained the culmination of losing three housekeepers and the Director of Plant Operations resulted in a negative impact of the general cleanliness of the facility. COO #15 stated he felt the patient rooms were cleaned appropriately once the MHTs provided help with cleaning, although the geriatric unit proved to be more difficult to clean when the housekeeping department was short staffed.

COO #15 then stated he participated in daily and weekly rounding at the facility to conduct general observations and to talk with patients about how things were going. COO #15 stated he did not necessarily go into patient rooms during the roundings. COO #15 further stated he did not maintain documentation on the findings identified in the daily roundings and that Director #61 was responsible for taking notes during the weekly rounding.

After reviewing the infection control concerns identified during the tours conducted throughout the survey, COO #15 stated he did not think the environment was sanitary. COO #15 then reiterated the facility experienced a string of bad luck by losing three housekeepers.

Review of the Infection Control Committee Structure policy read, the infection control committee will be responsible for the initiation and supervision of an active, hospital-wide

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 901 | Continued From page 68<br>infection control program which will include: procedures for infection prevention, surveillance, and control in relation to the inanimate hospital environment, including practices in disinfection, housekeeping, laundry, engineering and maintenance, food sanitation, and waste management. The facility was unable to provide evidence or show how the Committee actively participated in and supervised its infection control program to ensure a sanitary environment. | H 901 | | |
| A 1058 | 6.104(1)(j) PR-PRP Restraints<br><br>"The health care entity shall develop and implement a policy regarding patient rights. The policy shall ensure that each patient or, where appropriate, patient designated representative has the right to:<br><br>(j) be free of the inappropriate use of restraints. Inappropriate use includes improper application of a restraint or the usage of a restraint as a means of coercion, discipline, convenience, or retaliation by staff. A health care entity that does not use restraints shall include a written statement in their policies and procedures to that effect. A health care entity that does use restraints shall develop and implement policies and procedures regarding:<br><br>(i) the provision of training on the use of restraints.<br><br>(ii) ongoing individual patient assessment to determine: when a medical condition or symptom indicates use of restraint to protect the patient or others from harm; the least restrictive intervention; and the discontinuation of the intervention at the earliest possible time.<br><br>(iii) documentation of the use of restraint in the patient ' s medical record." | A 1058 | | 09/21/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

NAME OF PROVIDER OR SUPPLIER: **CLEAR VIEW BEHAVIORAL HEALTH**

STREET ADDRESS, CITY, STATE, ZIP CODE: **4770 LARIMER PARKWAY JOHNSTOWN 80534**

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 69<br><br>This REGULATION is not met as evidenced by:<br>Based on interviews and document review, the facility failed to ensure seclusion was discontinued at the earliest possible time. In 1 of 9 restraint or seclusion medical records reviewed, there was no documentation the seclusion was discontinued when the patient's behavior was not threatening to themselves or others (Patient #8). In addition, the facility failed to ensure Qualified Registered Nurses (QRN) evaluated patients to determine the need to continue or terminate the seclusion or restraints within one hour of the application in 8 of 9 restraint records reviewed (Patients #2, #3, #4, #5, #8, #9, #12, and #13) and failed to ensure the accuracy of the restraint documentation in 4 of 9 restraint records reviewed (Patients #5, #8, #9, and #13). Furthermore, the facility failed to ensure a physician order was obtained for each instance of restraint or seclusion and additional orders for incidents extending more than one hour in 3 of 9 records reviewed in which restraints or seclusion was implemented (Patients #2, #5, and #8).<br><br>These failure resulted in patients not being assessed within one hour of the application of restraints or seclusion by a qualified professional. These failures also resulted in the patient remaining in seclusion longer than needed.<br>In addition, these failures resulted in patients being placed in restraints or seclusion without a physician determining the appropriateness for each restraint episode.<br><br>Findings include:<br><br>Facility policy:<br><br>According to the Seclusion and Physical Restraint Hold Policy, restraint or seclusion | A 1058 | 1.The procedure for implementing the Plan of Correction (PoC), for each deficiency cited:<br>A. A Governing Board meeting was held to discuss the findings from the survey related to the Hospital's failure to obtain a physician's order for each incident of Seclusion or Restraint (S/R) or additional orders for incidents extending greater than one hour in accordance with the hospital's policy. The root cause of this deficiency was concluded as follows: It was observed that the hospital's policy on Seclusion and Restraint (S/R) exceeded the CMS requirements related to the time limitations for S/R orders. It was also observed that the current policy did not address some of the other requirements expected. The VP of Nursing/PI/Regulatory (VP N/P/R) noted that the policy being used at the Hospital had been replaced with a more comprehensive one that delineated the time limits, described the requirements related to obtaining orders, and more. Failure to use the most recent S/R policy was felt to be a contributing root cause to this deficiency. The GB noted that the policy being used was the one that had been implemented with the Hospital's opening in 2015. Further, the DON who is no longer at the Hospital had been given the requirement to disseminate the policy to her nursing team but it was evident that this was not accomplished. It was decided that compliance with S/R requirements including adherence to time limitations needed to be enforced using the hospital policy for S/R used by Strategic Behavioral Health's other facilities. This policy was approved for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 70<br>must be used only until the emergency safety situation has ceased and the patient's safety and safety of others can be insured, even if the restraint or seclusion order has not expired. When the patient has regained control, he/she will be removed from seclusion/restraint by the nurse. Restraint or seclusion are only utilized in an emergency when a patient's behavior presents imminent danger to the patient, staff or others. Problematic behavior which does not present an immediate risk to the patient, staff or others shall be addressed by less restrictive strategies.<br><br>The Registered Nurse (RN) shall conduct a face to face evaluation within one hour of initiation. The RN providing the one hour face-to-face evaluations will be trained to evaluate the patient's medical and behavioral condition to determine the need to continue or terminate the seclusion or restraint. This training will be provided during orientation and annually thereafter. The face-to-face assessment must be documented in the medical record. The QRN will assess the patient in restraints or seclusion at least every hour or more frequently as warranted by the patient's condition.<br><br>Once a restraint or seclusion is initiated, the registered nurse (RN) has to obtain a telephone or written order from the psychiatrist as soon as possible, but within one hour of implementation. Restraints or seclusion must be used in an emergency only until the safety situation has ceased and the patient's safety and safety of others can be insured. When the patient has regained control, he/she will be removed from seclusion or restraints by the RN. Once a restraint or seclusion has been initiated, the RN must obtain an order. A new order must be obtained to renew for an additional one hour in the event the restraint or seclusion is extended from the original one hour order. | A 1058 | implementation by Clear View Behavioral Health's Governing Board.<br><br>B. A meeting was conducted between the GB and Hospital/MS leaders to review the findings, further discuss the root cause and to identify expectations related to the requirement to obtain a C. physician's order for each incident of Seclusion or Restraint (S/R) and the need to adhere to the elements within Clear View Behavioral Health's policy on S/R including the time limitations. One Leadership team member added to the cause of the deficiency that staff did not seem to know the requirements related to Seclusion and Restraint despite this being covered at the time of annual competencies. The reasons to this discovery were discussed. It was theorized that while the Handle with Care training is reviewed every 6 months that the specifics of even the obsolete S/R policy might not be getting reviewed annually. The competency being used was reviewed and it was determined that the questions on S/R did not encompass the areas where staff could not properly demonstrate compliance or answer questions.<br><br>C. The existing policy on Seclusion/Restraint was reviewed and consideration was given by the Interim DON and VP of Nursing/PI/Regulatory Affairs if more policies needed to be added.<br>It was decided that the current S/R policy that had erroneously not been in place at the Hospital needed to be implemented but no other policies needed to be developed.<br><br>D. Using the correct policy and procedure on Seclusion and Restraint (S/R), all | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 71<br>Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior which jeopardizes the staff and patient.<br><br>According to the Qualified Registered Nurse (QRN) Training Policy, QRNs provide timely and quality review of patients in seclusion or restraints and effective guidance to staff. There is special training to the staff designated as a QRN. QRNs can provide one hour face-to-face medical and behavioral evaluations only after they have completed the training and demonstrated competency. QRN training includes: use of behavioral criteria for discontinuation of seclusion or restraints and how to help patients in meeting these criteria, evaluation of patients' immediate situation, reaction to the intervention and need to continue or terminate the seclusion or restraint, mental status examination, physical assessment of patients and proper documentation on the Face to Face form. All QRN training is documented, including dates of completion and competency. In addition, ongoing feedback regarding any documentation and/or incident is reviewed with the QRN by the medical director or designee on a timely basis.<br><br>1. The facility failed to ensure seclusion was discontinued at the earliest possible time when Patient #8 was no longer exhibiting behaviors in which harm could occur.<br><br>a. Review of Patient #8's medical record revealed she was admitted on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. Patient #8 was placed in restraints or seclusion 20 times during her hospitalization.<br><br>According to the Restrictive Intervention | A 1058 | pertinent Hospital and Medical staff were inserviced on the policy in full including the following elements:<br>-The time limits that a person is allowed to be in S/R by age category.<br>-Actions to be taken by the RN when a patient goes into S/R (including obtaining a MD order).<br>-The requirement that S/R is to be maintained only until the patient is meeting criteria for release.<br>-Should a patient stabilize, come out of S/R and require S/R again - a new order from the MS member is required.<br><br>E. The correct policy on “Seclusion and Restraint” was implemented for use at the hospital.<br><br>F. A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as delineated below.<br><br>G. The annual competency on Seclusion/Restraint was revised to be more comprehensive and to encompass a review of the above areas where staff were not following the required processes.<br><br>A Governing Board meeting was held to discuss the findings from the survey related to the Hospital’s failure to ensure seclusion is discontinued at the earliest possible time. The root cause of this deficiency was concluded as follows: It was observed that the hospital’s current policy on Seclusion and Restraint (S/R) did not clearly delineate some “lessons learned” related to seclusion/restraint over the prior years including time limitations and that S/R needed to be discontinued at the earliest time possible and not based | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1058 | Continued From page 72<br>Observation Assessment Flow Sheet (RI Flowsheet) on 6/28/18, Patient #8 was placed in seclusion for hitting staff and peers. Patient #8 was in seclusion from 6:10 p.m. to 7:10 p.m. Patient #8's behavior was documented as sitting or lying quietly for the entirety of her seclusion by Mental Health Technician (MHT) #31. According to the policy, the patient should have been released when she regained control of her behavior.<br><br>b. On 7/25/18 at 4:27 p.m., an interview with MHT #31 was conducted. MHT #31 stated a staff member had to monitor the patient at all times while in seclusion. MHT #31 stated the decision to release a patient from seclusion was made by the nurse or physician, but the MHT had input based on the patient's behavior. MHT #31 explained the patient needed to be calm, non threatening and able to be around other patients and staff as behaviors required for seclusion release. Additionally, MHT #31 stated lying quietly would be an identified behavior that would warrant seclusion release.<br><br>MHT #31 stated she remembered Patient #8 as she was on a behavior plan. MHT #31 further explained that due to the behavior plan, when Patient #8 was placed in seclusion she was required to spend one full hour in seclusion regardless of her exhibited behavior. This was in contrast to the policy which required patients to be released when they regained control of their behavior. MHT #31 stated the practice of keeping patients in seclusion for one full hour had become common practice in the facility.<br><br>MHT #31 was unable to provide the behavior plan that mandated Patient #8 remain in seclusion for one full hour regardless of her behavior.<br><br>c. The RI Flowsheet revealed on 6/26/18, Patient #8 was placed in seclusion for | A 1058 | on the time limitations given in an order. The VP of Nursing/PI/Regulatory (VP N/P/R) noted that the policy that was currently being used at the Hospital had been replaced with a more comprehensive one that delineated the time limits, described the need to discontinue S/R at the earliest point, and more. Failure to use the most recent S/R policy was felt to be a contributing root cause to this deficiency. The GB noted that the policy being used was the one that had been implemented with the Hospital's opening in 2015. Further, the DON who is no longer at the Hospital had been given the requirement to disseminate the policy to her nursing team but it was evident that this had not been accomplished. It was decided that compliance with S/R requirements including adherence to discontinuing S/R at the earliest time possible needed to be enforced using the hospital policy for S/R used by Strategic Behavioral Health's other facilities. This policy was approved for implementation by Clear View Behavioral Health's Governing Board.<br><br>A. A meeting was conducted between the GB and Hospital/MS leaders to review the finding and to identify expectations related to the requirement that seclusion is discontinued at the earliest possible time. One Leadership team member added to the cause of the deficiency that staff did not seem to know the requirements related to Seclusion and Restraint despite this being covered at the time of annual competencies. The possible reasons to this discovery were discussed and it was theorized that the annual competency may not be specific enough to the requirements. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 73<br>attempting to tie bed linens and a shower curtain around her neck. Patient #8 was in seclusion from 11:28 a.m. to 12:35 p.m. Patient #8's behavior was documented as lying quietly on the floor at 11:45 a.m., and lying on the floor for the remainder of the seclusion by MHT #38. No aggressive or harmful behaviors were documented. Patient #8 was not released from seclusion when her behavior no longer warranted intervention.<br><br>The RI Flowsheet revealed on 6/17/18, Patient #8 was placed in seclusion because she hit staff and called 911. Patient #8 was in seclusion from 12:45 p.m. to 1:45 p.m., exactly one hour. Patient #8's behavior was documented as lying or sitting on the floor by MHT #38. No aggressive or harmful behaviors were documented. Patient #8 was not released from seclusion when her behavior no longer warranted intervention.<br><br>d. On 7/23/18 at 3:03 p.m., an interview with MHT #38 was conducted. MHT #38 stated MHTs continuously monitored patients when they were in seclusion and documented the patient's behavior every five minutes. MHT #38 stated patients were released from seclusion when they were no longer a threat to themselves or staff. MHT #38 reviewed Patient #8's seclusion documentation and stated lying on the floor quietly would be a reason to release her from seclusion because she was not a danger to herself or others. MHT #38 stated the nurse made the decision to release a patient from seclusion. MHT #38 stated the documentation sheets were created for one hour increments, so patients could spend an hour in seclusion based on time rather than behavior if that was what the team decided on. MHT #38 stated a patient could be required to stay in seclusion for one hour based on their behavior plan. Additionally, MHT #38 stated the behavior plan would be verbally given in the | A 1058 | C. The competency being used was reviewed and it was determined that the questions on S/R did not encompass any areas specific to reminders for staff to discontinue S/R based on patient behavior and not a time limitation.<br><br>D. The GB approved what should have been the policy in place for Seclusion and Restraint for implementation at Clear View Behavioral Health. There were no other policies that needed development.<br><br>E. In order to ensure compliance, using the correct policy on Seclusion and Restraint, all pertinent Hospital staff were inserviced on the associated requirement that seclusion is to be discontinued at the earliest possible time and is not dictated based on the time parameters for seclusion/restraint. This policy will be specifically used as part of the annual competency training as opposed to the former system of using the annual competency tool only to assess staff's knowledge related to Seclusion and Restraint.<br><br>F. A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as is delineated below.<br><br>A Governing Board meeting was held to discuss the findings from the survey related to the Hospital's failure to ensure a QRN evaluated patients to determine the need to continue or terminate the seclusion or restraints within one hour of the application and failed to ensure the accuracy of the restraint documentation. It | |

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|---|---|---|---|---|
| A 1058 | Continued From page 74<br>oncoming shift report and also by the therapist.<br><br>e. According to the RI Flowsheet on 6/20/18, Patient #8 was placed in seclusion for hitting staff. Patient #8 was in seclusion from 5:55 p.m. to 7:02 p.m. Patient #8 had no documented aggressive or harmful behaviors; therefore, it was not evident why the seclusion continued. The patient was able to use the bathroom at 6:30 p.m., with no documented adverse behaviors and was subsequently returned to seclusion for another 32 minutes. Patient #8 was not released from seclusion per policy.<br><br>f. On 7/18/18 at 6:51 a.m., an interview with MHT #48 was conducted. MHT #48 stated patients had the right to receive the least restrictive measures regarding restraints and seclusion. Additionally, staff had the ability to take patients to a quiet room to assist them to calm down in an attempt to prevent the need for seclusion.<br><br>g. On 7/26/18 at 10:59 a.m., an interview with Director of Nursing (DON) #2 was conducted. DON #2 explained patients were released from seclusion when they were calm and talking and their behavior was not a threat to themselves or others. DON #2 explained further, release from seclusion was based on behavior, not time. DON #2 reviewed Patient #8's RI Flowsheets and stated when Patient #8 was lying quietly, she should have been released from seclusion. DON #2 stated seclusion should be used for dangerous behaviors, not as a punishment. However, DON #2 stated Patient #8 was on a behavior plan to include seclusion as a behavior modifier that was discussed in rounds and should have been a part of the medical record.<br><br>DON #2 was unable to provide the aforementioned behavior plan that required Patient #8 to continue to remain in seclusion for a set time rather than based on behaviors. | A 1058 | was conveyed that the concern of this deficiency was that this failure resulted in patients not being assessed within one hour of the application of restraints or seclusion by a qualified professional. The root cause of this deficiency was concluded as follows: It was observed that the hospital's current policy on Seclusion and Restraint (S/R) did not clearly delineate the requirements of the QRN. The VP of Nursing/PI/Regulatory (VP N/P/R) noted that the policy that was currently being used at the Hospital had been replaced with a more comprehensive one that clearly delineated the role of the QRN and requirement to see the patient and complete a face to face assessment of the patient placed in seclusion or restraint within one hour of the episode, to determine their condition, to determine the need to continue or terminate the seclusion or restraints within one hour of the application, and to complete accurate restraint documentation. The GB noted that the policy being used was the one that had been implemented with the Hospital's opening in 2015. Further, the DON who is no longer at the Hospital had been given the requirement to disseminate the policy to her nursing team but it was evident that this had not been accomplished. It was decided that the correct Seclusion and Restraint policy needed to be implemented that was being used by Strategic Behavioral Health's other facilities. This policy was approved for implementation by Clear View Behavioral Health's Governing Board.<br><br>A meeting was conducted between the GB and Hospital/MS leaders to review the finding and to identify expectations related to the requirement that a QRN is to see | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1058 | Continued From page 75<br><br>2. The facility failed to ensure face to face evaluations were performed by Qualified Registered Nurses (QRNs).<br><br>a. Review of Patient #8's medical record revealed she was admitted on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. According to an Incident Report on 6/28/18, Patient #8 was placed in seclusion at 5:40 p.m. for attempting to hit staff and other patients on the unit as well as attempting to elope. Patient #8 was released from seclusion at 7:10 p.m. The face to face evaluation was performed at 7:00 p.m., by Mental Health Technician (MHT) #31. This was in contrast to the policy which required the face to face evaluation to be performed by a QRN who had additional training.<br><br>b. On 7/25/18 at 4:27 p.m., an interview with MHT #31 was conducted. MHT #31 stated registered nurses (RNs) completed the paperwork on the unit associated with seclusion and restraints. MHT #31 stated physicians or nurses made the decision when to release a patient from a restraint or seclusion with the MHTs input. MHT #31 verified she had signed the face to face evaluation for Patient #8. MHT #31 stated she did not know what a face to face evaluation was, but since she signed the evaluation she must have performed it.<br><br>Review of MHT #31's personnel file confirmed she was a mental health technician and did not have additional training to perform face to face evaluations.<br><br>c. On 7/26/18 at 10:59 a.m., an interview with Director of Nursing (DON) #2 was conducted. DON #2 verified MHTs were not permitted to perform face to face evaluations as they were not trained to do so. DON #2 stated face to face | A 1058 | the patient and provide a face to face medical and behavioral evaluation within one hour of the initiation of the Seclusion or Restraint episode and document the findings as well as the need to continue or terminate the S/R. The group concurred with the root cause theory by the GB as the source of the breakdown that led to the deficient practice. Discussion occurred if there were enough QRNs to fulfill requirements or if there were RNs who had not had QRN training yet? It was noted that unit RNs would sometimes wait on the House Supervisor to complete the assessment and if the House Supervisor was tied up, the one hour period might be exceeded.<br><br>A. The policy and procedure on Seclusion and Restraint (S/R) was reviewed and the more comprehensive version recommended by Strategic Behavioral Health was put in place as it had detailed information on the role of the QRN. The competency for QRN nurses was revised to ensure the requirements related to the need for the QRN to see all patients within one hour of their S/R event to evaluate the patient's condition and determine the need to continue or terminate the event and to document all findings were all included .<br><br>B. The list of RN's was reviewed to ensure that all RNs meeting criteria for QRN training are trained. All eligible RNs meeting criteria for QRN status were trained on the QRN requirements.<br><br>C. In order to ensure compliance, all pertinent Hospital (QRN) staff were inserviced on the associated requirement that a one-hour face to face assessment is to be completed within one hour for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 76<br>evaluations were performed to assess the patient's mental and physical condition to ensure patient safety. DON #2 further stated the patient would not be appropriately assessed if a MHT performed the face to face evaluation.<br><br>d. According to the Face to Face Evaluation record on 6/17/18, Patient #8 was placed in restraints and seclusion from 12:50 p.m. to 1:45 p.m. The face to face evaluation was performed at 1:50 p.m. There was no signature of who performed the evaluation; therefore, there was no way to know which staff performed the evaluation or to confirm staff qualifications.<br><br>Additionally, Patient #8 was placed in a physical restraint due to punching and kicking staff on 6/3/18. According to the Face to Face evaluation record, Patient #8 was restrained from 1:30 p.m. to 1:45 p.m. The face to face evaluation was documented by Registered Nurse (RN) #32 at 2:55 p.m.<br><br>On 7/23/18 at 5:07 p.m., an interview with RN #32 was conducted. RN #32 stated a nurse was required to perform a face to face evaluation every time a patient was restrained or secluded to evaluate the patient's condition and determine when they could be released. RN #32 stated MHTs were unable to perform face to face evaluations because it was part of the nurse's role. RN #32 stated there was no special training for nurses to perform face to face evaluations and verified that she had not had any special training.<br><br>Review of the QRN Restraint and Seclusion Proctoring Records provided by Quality Coordinator (QC) #1 revealed RN #32 had not been trained on how to perform face to face evaluations; therefore, was not qualified to do so per the facility policy.<br><br>e. According to the Face to Face evaluation | A 1058 | assessment of the patient and determination of whether the S/R even should be continued or terminated and the requirement for full documentation of the event. These QRNs completed a competency to demonstrate knowledge related to the identified deficiency. It was further communicated that not only the House Supervisor could do the face to face assessment but other RNs on the unit were expected to do the same (as long as that RN did not make the decision to initiate the S/R episode and if so, a second RN was required to function as the QRN).<br>D. A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as is identified below.<br><br>2. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited:<br>A. A Governing Board meeting was held to discuss the findings from the survey related to the Hospital’s failure to obtain a physician’s order for each incident of Seclusion or Restraint (S/R) or additional orders for incidents extending greater than one hour in accordance with the hospital’s policy. The root cause of this deficiency was concluded as follows: It was observed that the hospital’s policy on Seclusion and Restraint (S/R) exceeded the CMS requirements related to the time limitations for S/R orders. It was also observed that the current policy did not address some of the other requirements expected. The VP of Nursing/PI/Regulatory (VP N/P/R) noted that the policy being used at the Hospital had been replaced with a more | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 77<br>record on 6/3/18, Patient #8 was placed in a physical restraint due to punching and kicking staff from 8:35 p.m. to 8:40 p.m. The face to face evaluation was documented by RN #22 at 8:40 p.m.<br><br>Review of the QRN Restraint and Seclusion Proctoring Records revealed RN #22 had not been trained on how to perform face to face evaluations.<br><br>f. According to the History and Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic. Review of the Incident Report revealed Patient #5 was placed in restraints and seclusion on 4/2/18 from 9:33 a.m. to 1:20 p.m. The face to face evaluation was documented by Nursing Supervisor (NS) #16 at 1:10 p.m.<br><br>Review of the QRN Restraint and Seclusion Proctoring Records provided by QC #1 revealed NS #16 had not been trained on how to perform face to face evaluations.<br><br>g. Review of Patient #13's medical record revealed she was admitted to the facility on 7/15/18 with suicide ideations and a plan to hang herself, cut herself or overdose on medication. According to the Incident Report on 7/24/18 at 4:00 p.m., Patient #13 was restrained for self harming behavior of scratching herself. The restraint occurred from 4:00 p.m. to 5:10 p.m. The face to face evaluation was documented as performed at 6:10 p.m. by RN #58.<br><br>Review of the QRN Restraint and Seclusion Proctoring Records revealed RN #58 had not been trained on how to perform face to face evaluations. | A 1058 | comprehensive one that delineated the time limits, described the requirements related to obtaining orders, and more. Failure to use the most recent S/R policy was felt to be a contributing root cause to this deficiency. The GB noted that the policy being used was the one that had been implemented with the Hospital's opening in 2015. Further, the DON who is no longer at the Hospital had been given the requirement to disseminate the policy to her nursing team but it was evident that this was not accomplished. It was decided that compliance with S/R requirements including adherence to time limitations needed to be enforced using the hospital policy for S/R used by Strategic Behavioral Health's other facilities. This policy was approved for implementation by Clear View Behavioral Health's Governing Board.<br><br>B. A meeting was conducted between the GB and Hospital/MS leaders to review the findings, further discuss the root cause and to identify expectations related to the requirement to obtain a physician's order for each incident of Seclusion or Restraint (S/R) and the need to adhere to the elements within Clear View Behavioral Health's policy on S/R including the time limitations. One Leadership team member added to the cause of the deficiency that staff did not seem to know the requirements related to Seclusion and Restraint despite this being covered at the time of annual competencies. The reasons to this discovery were discussed. It was theorized that while the Handle with Care training is reviewed every 6 months that the specifics of even the obsolete S/R policy might not be getting reviewed annually. The competency being used was reviewed and it was determined that | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1058 | Continued From page 78<br>Record review showed similar findings of untrained staff conducting the face to face evaluations or no staff signature present on the face to face evaluations for Patients #2, #3, #4, #9 and #12.<br><br>h. On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 explained nurses were specifically trained to perform face to face evaluations after they had been employed by the facility for one year. DON #2 stated nurses received additional training to become Qualified Registered Nurses (QRNs) in order to perform face to face evaluations. DON #2 stated she reviewed the face to face evaluations to ensure they were filled out completely, but she did not audit the signatures to ensure the face to face evaluations were performed by a QRN. DON #2 stated RN #13 and RN #32 were qualified to perform face to face evaluations.<br><br>However, on 7/26/18 at 4:47 p.m., DON #2 confirmed the QRN Restraint and Seclusion Proctoring Records provided by QC #1 were the only verified staff trained to perform the one hour face to face evaluations. Review of the QRN qualified staff list did not include RN #13 or RN #32.<br><br>3. The facility failed to ensure face to face evaluations were conducted within one hour of initiation of restraints or seclusion to determine the need to continue or terminate the intervention.<br><br>a. According to the History & Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic. Patient #5 was discharged on 4/10/18 and was placed in a restraint or seclusion eight times throughout her hospitalization. The face to face | A 1058 | the questions on S/R did not encompass the areas where staff could not properly demonstrate compliance or answer questions.<br><br>C. The existing policy on Seclusion/Restraint was reviewed and consideration was given by the Interim DON and VP of Nursing/PI/Regulatory Affairs if more policies needed to be added.<br>It was decided that the current S/R policy that had erroneously not been in place at the Hospital needed to be implemented but no other policies needed to be developed.<br><br>D. Using the correct policy and procedure on Seclusion and Restraint (S/R), all pertinent Hospital and Medical staff were inserviced on the policy in full including the following elements:<br>-The time limits that a person is allowed to be in S/R by age category.<br>-Actions to be taken by the RN when a patient goes into S/R (including obtaining a MD order).<br>-The requirement that S/R is to be maintained only until the patient is meeting criteria for release.<br>-Should a patient stabilize, come out of S/R and require S/R again - a new order from the MS member is required.<br><br>E. The correct policy on “Seclusion and Restraint” was implemented for use at the hospital.<br><br>F. A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as delineated below. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 79<br>evaluation was performed only four of eight times within one hour of initiation of the restraint or seclusion according to policy. For example,<br><br>According to an Incident Report on 4/2/18, Patient #5 was restrained and given emergency medications for trying to tip her wheelchair over and run over staff with her wheelchair. Patient #5 was restrained from 9:33 a.m. to 1:10 p.m. NS #16 documented the face to face evaluation at 1:10 p.m., which was 3 hours and 37 minutes after initiation of the restraint. Patient #5 had an additional incident of being restrained on 4/1/18 at 9:56 p.m. According to the Incident Report, she was restrained from 9:56 p.m. to 10:40 p.m. The face to face evaluation was performed at 11:15 p.m., which was 1 hour and 21 minutes after initiation of the restraint. Both face to face evaluations should have occurred within one hour of initiation of the restraint in order to evaluate the need to continue or terminate the restraint according to the policy.<br><br>Record review showed Patient #5 was restrained for wrapping a blanket around her neck and then becoming aggressive with staff for intervening on 3/27/18 at 8:05 p.m. until 8:40 p.m. There was no time documented to indicate when the face to face occurred; therefore, there was no way to verify the evaluation was completed within the one hour timeframe.<br><br>b. Review of Patient #13's medical record revealed she was admitted to the facility on 7/15/18 with suicide ideations and a plan to hang herself, cut herself or overdose on medication. According to the Incident Report on 7/24/18 at 4:00 p.m., Patient #13 was restrained for self harming behavior of scratching herself. The restraint occurred from 4:00 p.m. to 5:10 p.m. The face to face evaluation was performed at 6:10 p.m., which was 2 hours and 10 minutes after initiation of the restraint. The evaluation did not occur within the one hour timeframe outlined | A 1058 | G. The annual competency on Seclusion/Restraint was revised to be more comprehensive and to encompass a review of the above areas where staff were not following the required processes.<br><br>A Governing Board meeting was held to discuss the findings from the survey related to the Hospital's failure to ensure seclusion is discontinued at the earliest possible time. The root cause of this deficiency was concluded as follows: It was observed that the hospital's current policy on Seclusion and Restraint (S/R) did not clearly delineate some "lessons learned" related to seclusion/restraint over the prior years including time limitations and that S/R needed to be discontinued at the earliest time possible and not based on the time limitations given in an order. The VP of Nursing/PI/Regulatory (VP N/P/R) noted that the policy that was currently being used at the Hospital had been replaced with a more comprehensive one that delineated the time limits, described the need to discontinue S/R at the earliest point, and more. Failure to use the most recent S/R policy was felt to be a contributing root cause to this deficiency. The GB noted that the policy being used was the one that had been implemented with the Hospital's opening in 2015. Further, the DON who is no longer at the Hospital had been given the requirement to disseminate the policy to her nursing team but it was evident that this had not been accomplished. It was decided that compliance with S/R requirements including adherence to discontinuing S/R at the earliest time possible needed to be enforced using the hospital policy for S/R used by Strategic Behavioral Health's other facilities. This policy was approved | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|

A 1058

Continued From page 80

in the policy.

c. Review of Patient #8's medical record revealed she was admitted on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. According to the Incident Report on 6/28/18, Patient #8 was placed in seclusion from 5:40 p.m. 7:10 p.m. for attempting to hit staff and other patients on the unit as well as attempting to elope. The face to face evaluation was performed at 7:00 p.m., which was 1 hour and 20 minutes after the seclusion was initiated.

d. Record review showed similar findings of instances where face to face evaluations were not conducted within the one hour timeframe for Patient #9.

e. On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 stated face to face evaluations were performed to assess the patient's mental and physical condition in order to ensure patient safety. Furthermore, the QRN was required to perform the face to face evaluation within one hour of initiating restraints or seclusion. DON #2 explained nurses were specifically trained to perform face to face evaluations after they had been employed by the facility for one year. DON #2 stated she reviewed the face to face evaluations to ensure they were filled out completely, but did not review if they were performed within the one hour timeframe.

4. The facility failed to obtain a new physician order for each instance of restraint or seclusion, and an additional order for each incident that extended longer than a one hour time period.

a. According to the History and Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt by

A 1058

for implementation by Clear View Behavioral Health's Governing Board.

A. A meeting was conducted between the GB and Hospital/MS leaders to review the finding and to identify expectations related to the requirement that seclusion is discontinued at the earliest possible time. One Leadership team member added to the cause of the deficiency that staff did not seem to know the requirements related to Seclusion and Restraint despite this being covered at the time of annual competencies. The possible reasons to this discovery were discussed and it was theorized that the annual competency may not be specific enough to the requirements.

C. The competency being used was reviewed and it was determined that the questions on S/R did not encompass any areas specific to reminders for staff to discontinue S/R based on patient behavior and not a time limitation.

D. The GB approved what should have been the policy in place for Seclusion and Restraint for implementation at Clear View Behavioral Health. There were no other policies that needed development.

E. In order to ensure compliance, using the correct policy on Seclusion and Restraint, all pertinent Hospital staff were inserviced on the associated requirement that seclusion is to be discontinued at the earliest possible time and is not dictated based on the time parameters for seclusion/restraint. This policy will be specifically used as part of the annual competency training as opposed to the former system of using the annual

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 81<br>attempting to roll her wheelchair into traffic. According to the Physician Order on 4/2/18 at 9:36 a.m., Registered Nurse (RN) #16 received a verbal order from Physician #14 for restraints or seclusion for up to one hour for aggressive behaviors of tipping herself backwards in her wheelchair and trying to run over staff with the same wheelchair.<br><br>Review of the Restrictive Intervention Observation Assessment Flow Sheet (RI flowsheet) revealed Patient #5 was restrained on 4/2/18 from 9:45 a.m. to 11:50 a.m. (a total of two hours and five minutes). Patient #5 was seen by Physician #14 at 11:45 a.m., then released from restraints at 11:50 a.m. to use the bathroom, but refused.<br><br>Further review of the RI flowsheet revealed Patient #5 was restrained a second time, 50 minutes later, from 12:40 p.m. to 1:20 p.m. There was no additional order obtained for the extended time when the patient was first placed in restraints or the second incidence of restraints. This was in contrast to the policy which stated to obtain a new order for each additional hour of restraints and each incident of restraints or seclusion.<br><br>b. On 7/25/18 at 11:03 a.m., an interview with Physician #14 was conducted. Physician #14 reviewed Patient #5's RI Flowsheet, dated 4/2/18 and stated there should have been an additional order for restraints after the first hour. Upon further review, Physician #14 stated an additional order for restraints should have been obtained once the patient was released from restraints for 50 minutes and then restrained again. Additionally, Physician #14 stated there were no behaviors documented on the 4/2/18 RI Flowsheet to warrant the second incident of restraints.<br><br>c. Review of Patient #8's medical record | A 1058 | competency tool only to assess staff's knowledge related to Seclusion and Restraint.<br><br>F. A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as is delineated below.<br><br>A Governing Board meeting was held to discuss the findings from the survey related to the Hospital's failure to ensure a QRN evaluated patients to determine the need to continue or terminate the seclusion or restraints within one hour of the application and failed to ensure the accuracy of the restraint documentation. It was conveyed that the concern of this deficiency was that this failure resulted in patients not being assessed within one hour of the application of restraints or seclusion by a qualified professional. The root cause of this deficiency was concluded as follows: It was observed that the hospital's current policy on Seclusion and Restraint (S/R) did not clearly delineate the requirements of the QRN. The VP of Nursing/PI/Regulatory (VP N/P/R) noted that the policy that was currently being used at the Hospital had been replaced with a more comprehensive one that clearly delineated the role of the QRN and requirement to see the patient and complete a face to face assessment of the patient placed in seclusion or restraint within one hour of the episode, to determine their condition, to determine the need to continue or terminate the seclusion or restraints within one hour of the application, and to complete accurate restraint documentation. The GB noted that the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 82<br>revealed she was admitted on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. Review of the Incident Report revealed Patient #8 was placed in seclusion on 6/20/18 from 5:55 p.m. to 7:02 p.m. (one hour and seven minutes). According to the Physician Order on 6/20/18 at 5:35 p.m., Registered Nurse (RN) #13 received a verbal order from Physician #50 for restraints or seclusion for up to two hours for aggressive behaviors of banging her head against the wall, suicide gesture and punching, hitting and biting staff. The preprinted order form noted intervention time of seclusion or restraints was not to exceed one hour for adolescents. Patient #8 was 14 years old. No additional order was obtained for the extended seclusion time, which was in contrast to the policy.<br><br>d. According to the H&P documented on 7/12/18 at 3:40 p.m., Patient #2 was admitted to the facility on 7/12/18 due to manic, hostile, and psychotic behaviors in addition to expressing suicidal and homicidal ideations. Review of the RI Flowsheet, dated 7/16/18, revealed Patient #2 was restrained and escorted to seclusion for attacking staff. She remained in seclusion from 10:10 a.m. to 1:21 p.m. (a total of three hours and eleven minutes).The Physician Order for restraints and seclusion was obtained on 7/16/18 at 10:13 a.m. for one hour of intervention, but no additional order was obtained for the extended seclusion time that occurred.<br><br>e. On 7/25/18 at 4:27 p.m., an interview with Mental Health Technician (MHT) #31 was conducted. MHT #31 stated the decision to release a patient from restraints or seclusion was made by the nurse or physician, but MHTs had input based on the patient's behavior. Additionally, MHT #31 stated patients stayed in seclusion or restraints for a maximum of one | A 1058 | policy being used was the one that had been implemented with the Hospital's opening in 2015. Further, the DON who is no longer at the Hospital had been given the requirement to disseminate the policy to her nursing team but it was evident that this had not been accomplished. It was decided that the correct Seclusion and Restraint policy needed to be implemented that was being used by Strategic Behavioral Health's other facilities. This policy was approved for implementation by Clear View Behavioral Health's Governing Board.<br><br>A meeting was conducted between the GB and Hospital/MS leaders to review the finding and to identify expectations related to the requirement that a QRN is to see the patient and provide a face to face medical and behavioral evaluation within one hour of the initiation of the Seclusion or Restraint episode and document the findings as well as the need to continue or terminate the S/R. The group concurred with the root cause theory by the GB as the source of the breakdown that led to the deficient practice. Discussion occurred if there were enough QRNs to fulfill requirements or if there were RNs who had not had QRN training yet? It was noted that unit RNs would sometimes wait on the House Supervisor to complete the assessment and if the House Supervisor was tied up, the one hour period might be exceeded.<br><br>A. The policy and procedure on Seclusion and Restraint (S/R) was reviewed and the more comprehensive version recommended by Strategic Behavioral Health was put in place as it had detailed information on the role of the QRN. The competency for QRN nurses was revised | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 83<br>hour. MHT #31 explained behaviors required for release from restraint or seclusion included the patient was calm, non-threatening and able to be around other patients and staff.<br><br>f. On 7/25/18 at 2:48 p.m., an interview was conducted with Nursing Supervisor (NS) #16, who stated her role was to ensure the hospital was functioning effectively and ran smoothly. NS #16 stated an order was required for each emergency intervention of a restraint or seclusion. NS #16 further stated a restraint order was valid as long as staff needed it, which was in contrast to the policy of requiring a physician order after one hour or for each additional incidence of restraint or seclusion.<br><br>g. On 7/26/18 at 10:59 a.m., an interview with Director of Nursing (DON) #2 was conducted. DON #2 stated seclusion should be used for dangerous behaviors such as self-harming, not as a punishment. DON #2 stated an order for seclusion or restraint was valid for up to four hours, which was in contrast to the facility policy. | A 1058 | to ensure the requirements related to the need for the QRN to see all patients within one hour of their S/R event to evaluate the patient's condition and determine the need to continue or terminate the event and to document all findings were all included .<br><br>B. The list of RN's was reviewed to ensure that all RNs meeting criteria for QRN training are trained. All eligible RNs meeting criteria for QRN status were trained on the QRN requirements.<br><br>C. In order to ensure compliance, all pertinent Hospital (QRN) staff were inserviced on the associated requirement that a one-hour face to face assessment is to be completed within one hour for assessment of the patient and determination of whether the S/R even should be continued or terminated and the requirement for full documentation of the event. These QRNs completed a competency to demonstrate knowledge related to the identified deficiency. It was further communicated that not only the House Supervisor could do the face to face assessment but other RNs on the unit were expected to do the same (as long as that RN did not make the decision to initiate the S/R episode and if so, a second RN was required to function as the QRN).<br>D. A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as is identified below.<br><br>3. The monitoring and tracking procedures that will be implemented to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 84 | A 1058 | ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br>A. The following performance indicators have been implemented to assess for compliance with the requirements specific to Seclusion/Restraint have been implemented.<br>(1) Every S/R event has a corresponding MD order (initial episodes and should a patient be removed and returned to S/R for repeat behaviors of danger to self or others.<br>(2) Evidence that the patient is removed from S/R at earliest opportunity and based on behavior and not time limitation<br><br>Using the two indicators and the patient's Seclusion/Restraint packet, data from the ongoing assessment for compliance with established standards for S/R episodes is being conducted on a daily basis (S-S). The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday.<br><br>To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to these indicators under review to assess for compliance and evidence of effectiveness in the corrective actions taken. The findings are being aggregated by the Quality Coordinator and being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 85 | A 1058 | Board at each of their respective meetings.<br><br>This M&E process will continue indefinitely as Seclusion/Restraint is considered to be a high risk process.<br><br>.The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br><br>The following performance indicator was implemented to track compliance with this requirement:<br>-The patient is removed from S/R at earliest opportunity and based on behavior and not time limitation. Knowledge of a S/R episode will be forwarded to the DON through the House Supervisor's report, the Morning meeting (M-F), and the Incident Report system to ensure that all episodes of S/R are captured. The patient's seclusion and restraint record is being reviewed including the S/R observations documented by the MHT to see if the patient is demonstrating behaviors indicative of meeting criteria for the patient's release from S/R. The findings are being recorded on the tracking tool for "Seclusion and Restraint episodes" and information is transferred to the Clear View Hospital Scorecard of CMS and State deficiencies.<br>Using this indicator, data from the ongoing assessment for compliance with the patient being removed at the earliest time from S/R versus a time limitation is being conducted on a daily basis (Sunday -Saturday). | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 86 | A 1058 | The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday.<br><br>To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to indicators under review to assess for compliance and evidence of effectiveness in the corrective actions taken. This indicator on evidence of the timely release of patients from S/R episodes is based on patient behavior and not time limitations is included in this review and reporting.<br><br>The findings are being aggregated by the Director of Compliance/Quality/Risk and being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings<br><br>The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br>The following performance indicators were implemented to track compliance with this requirement:<br>- QRN sees patient within 1 hour of S/R event<br>-QRN documents one hour face to face assessment on QRN S/R assessment tool and signs/dates document | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| A 1058 | Continued From page 87 | A 1058 | The knowledge of a S/R episode is being forwarded to the DON through the House Supervisor's report, the Morning meeting (M-F), and the Incident Report system to ensure that all episodes of S/R are captured. The patient's seclusion and restraint record is being reviewed including the time of the start of the S/R event against the QRN nurse's time of assessment and completion of same, as is recorded on the QRN Assessment tool. The findings are being recorded on the tracking tool for "Seclusion and Restraint episodes" and information is transferred to the Clear View Hospital Scorecard of CMS and State deficiencies.<br><br>Using the two indicators, data from the ongoing assessment for compliance with the patient who is placed in S/R being seen by a QRN within one hour of the event and findings documented is being collected and analyzed on a daily basis (Sunday -Saturday). The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday. To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to indicators under review to assess for compliance and evidence of effectiveness in the corrective actions taken.<br><br>These indicators on evidence of a QRN seeing the patient within one hour and documentation of findings are included in this review and reporting. The findings | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1058 | Continued From page 88 | A 1058 | are being aggregated by the Director of Nursing and are being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings<br><br>4. Title of the person(s) responsible for implementing the acceptable PoC: Director of Nursing<br><br>5.<br>GB meeting:<br>8/1/18<br>8/14/18<br>8/16/18<br>9/11/18<br><br>GB/LS meeting:<br>8/1/18<br>9/7/18<br>9/11/18<br><br>Implementation of Policy<br>New policy for Seclusion & Restraint approved by GB on 9/10/18 (but its use for training started on 8/6/18 and continues as of 9/21/18)<br><br>Training of QRN staff on QRN requirements<br>9/21/18<br><br>M&E started:<br>8/1/18<br><br>PI meeting with GB attendee started:9/14/18<br><br>All items in place as of 09/21/2018 | |
| A 1062 | 6.104(1)(l) PR-PRP Care delivered<br><br>The health care entity shall develop and | A 1062 | | 09/21/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1062 | Continued From page 89<br>implement a policy regarding patient rights. The policy shall ensure that each patient or, where appropriate, patient designated representative has the right to:<br><br>(I) care delivered by the health care entity in accordance with the needs of the patient<br><br>This REGULATION is not met as evidenced by:<br>Based on interviews and document reviews, the facility failed to ensure appropriate staffing was maintained to meet the mental health needs of the facility's psychiatric patients. Specifically, the facility failed to ensure the prescribed treatments were consistently provided to patients in 13 of 13 records reviewed (Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13).<br><br>These failures resulted in psychiatric patients not receiving necessary treatments required to progress the patient towards improved symptom management, independence, and achieving their mental health and health care goals.<br><br>Findings Include:<br><br>Policy:<br><br>The Program Therapies Overview policy read, therapies would be available to all patients in the program. The program offered a variety of therapeutic services for individuals aged 12 and older who suffer from acute or chronic psychiatric disorders. Each patient received care from an interdisciplinary team of mental health professionals. Under the direction of a psychiatrist, members of the team include psychologists, psychiatric nurses, therapists, mental health technicians, dieticians, and recreation therapists who assess the patient's needs, develop an individualized treatment plan to address those needs and implement the | A 1062 | 1. . The procedure for implementing the Plan of Correction (PoC), for each deficiency cited:<br>A. The GB meeting was held to discuss the findings from the survey related to the Hospital's failure to ensure that appropriate staffing was maintained to meet the mental health needs of the facility's patients and to ensure the prescribed treatments were consistently provided to patients. The meeting, further, was used to identify and assess root causes of the findings from the survey and propose strategies to address the deficiencies identified. Root causes for lack of compliance with this requirement were concluded to be due to the lack of effective leadership within the Clinical Therapeutic Services team (and who did not assist therapists) , lack of effective resource allocation, lack of monitoring and enforcement of group therapy sessions, and lack of provision of alternative therapy to patients who did not attend groups. It was concluded that the bulk of the psycho-educational groups are led by the therapists however nursing staff is also responsible for group therapy.<br>B. Based on this GB meeting, a meeting was conducted between the GB and Hospital leaders to review the findings and identify expectations related to the following areas identified as deficient and to be corrected: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|

A 1062

Continued From page 90

therapy program.

Psychoeducational groups provided a central theme the therapist or other qualified staff used to elicit appropriate observations and interventions. The purpose of process group therapy was to: help patients identify problems in relating to others; develop interpersonal skills; provide a healing, emotional experience for patients; decrease patient isolation through sharing problems with others; and to alleviate anxiety connected with stressors.

Reference:

According to the daily program schedule for each unit, there was a seeking safety group each morning, which could be replaced once a week by a nutritionist. Each afternoon, each unit had a process group scheduled, to be led by the therapist. In addition, each unit was scheduled for recreation therapy daily. Additional groups were offered on each unit led by the nursing staff.

1. The facility failed to ensure therapy groups were provided consistently to patients to support the improvement of psychiatric symptoms and skill development.

a. On 7/19/18 at 9:26 a.m., a tour of the facility was taken. Mental Health Technician (MHT) #37 was present on the adolescent (600) unit. She stated she had just led the Why Try group. MHT #37 stated the therapist should have been there to lead the next group, Seeking Safety, which was scheduled to begin at 9:15 a.m., but the therapist had not yet arrived. MHT #37 had not been made aware she needed to lead the Seeking Safety group, but stated she would have led a different group that was like the therapist group. MHT #37 stated, "It is kind of the same," and planned to lead a group called Tree of Life. At 9:50 a.m., another MHT arrived

A 1062

-The need to ensure appropriate staffing is maintained to meet the mental health needs of the facility's patients as evidenced by the consistent provision of therapy groups, as ordered by the provider.
-The need for the Hospital to ensure the prescribed treatments are consistently provided to patients, as ordered, with specific reference to .therapy groups.

This group of GB and Hospital/MS LS concurred with the identified root causes and added that the group schedules were not posted in all required areas and those posted were not accurate. Further, staff were independently re-prioritizing and not following group schedules, MHT's were being pulled by the Lead MHT off the units for transport without collaborating with the DON and resulting in the perception of being short-staffed.

C. The policies related to group therapy and documentation as well as the current group schedules were reviewed. It was assessed that the policy was current. The group schedule, however, was not current and the perceived schedule was not being followed. A change was made in Clinical Therapy leadership. The Lead MHT was re-directed to cease his practice immediately and schedule trips through the DON, who could oversee that staffing remains adequate and meeting all patient care requirements.

D. The existing staffing on all units for Clinical Therapy and Nursing MHTs and RNs was examined by the Interim Director of Clinical Services and the Interim Director of Nursing and CEO to ensure staffing needs for patient needs and acuity is consistently maintained. The source of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1062 | Continued From page 91<br>and taught the group. The therapist never arrived.<br><br>b. On 7/18/18 at 8:37 a.m., an interview was conducted with Patient #1, on the geriatric (200) unit, who stated groups had been canceled during the last few days because the staff were busy cleaning and "goofing around." She stated yesterday, on 7/17/18, there were only 2 groups held when there were supposed to be 5 groups scheduled.<br><br>According to the daily program schedule for the 200 unit, there were 2 groups scheduled to be led by the therapists: Seeking Safety at 10:30 a.m. and Process Group at 2:15 p.m. In addition, Recreation Therapy was scheduled at 9:30 a.m., and the Nursing Group was scheduled for 3:30 p.m. MHTs were scheduled to lead 5 groups throughout the day: Goal Group at 9:00 a.m., Topic Group at 12:15 p.m., Journal Time at 1:15 p.m., Structured Exercise at 5:30 p.m., and Wrap Up Group at 6:30 p.m.<br><br>Review of Patient #1's medical record revealed Patient #1 attended the nursing group and the psychoeducation group on 7/17/18. There was no documentation in the medical record the process group or any of the groups led by the mental health technicians (MHTs) were held on 7/17/18.<br><br>On 7/20/18 at 9:03 a.m., an interview was conducted with Patient A on the adult (500) unit. Patient A explained he was admitted to the facility for alcohol detoxification, after recently stopping opiate and heroin use for chronic pain related to an accident. Patient A stated his primary complaint was the quality of the therapy. Patient A stated the groups were unhelpful and were typically offered "on the fly." Patient A stated he needed an experienced therapist who was able to talk to him about his addiction and how he could prevent relapse after he was | A 1062 | this deficiency was, again, attributed to lack of effective resource allocation of staff (and not a shortage of staff) so no new positions had to be added but expectations with the new Interim Director of Clinical Services and the Lead MHT for staff allocation to ensure adherence to group schedules was emphasized by the CEO, Quality Coordinator and Interim Director of Nursing.<br><br>E. All pertinent Hospital staff were inserviced on the associated requirements and expectations to be followed that relate to conducting groups, as scheduled, providing alternative group therapy, documenting the patient's response to treatment that was provided, and communicating with the DON or House Supervisor on conflicting patient priorities.<br><br>F. The Group schedules were assessed for accuracy against any input learned during training and were re-printed and re-posted in all patient care areas.<br><br>G. Daily Monitoring and Evaluation activities were implemented to ensure evidence of correction of the deficiencies and early identification of any problems as described below. Staff not meeting compliance are being addressed through the Hospital's progressive disciplinary process.<br><br>2. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited:<br>A. The GB meeting was held to discuss the findings from the survey related to the Hospital's failure to ensure that appropriate staffing was maintained to meet the mental health needs of the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1062 | Continued From page 92<br>discharged. Patient A stated the groups had been led by inexperienced staff who did not offer any therapy specific to his situation.<br><br>c. Review of Patient #8's medical record revealed she was admitted to the adolescent unit on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. Patient #8 remained at the facility until she was discharged on 7/3/18.<br><br>Review of the Final Ancillary Orders revealed an order was placed by Physician #21 on 6/3/18 for Patient #8 to attend group therapy. The orders also revealed, on 6/4/18, Therapist #39 created action steps for Patient #8 which included daily groups to explore self-soothing strategies, coping skills for depression and suicidal thoughts, and daily attendance of recreation therapy.<br><br>Review of the Initial Psychiatric Evaluation, written 6/3/18 at 4:25 p.m., revealed Physician #40 determined engagement in groups and therapy was a criteria for Patient #8's discharge from inpatient treatment.<br><br>Review of the Therapy Group Notes revealed no documentation the psychoeducation group was held on 6/4/18, 6/10/18, 6/12/18, 6/14/18, 6/18/18, 6/19/18, 6/20/18, 6/21/18, 6/22/18, 6/25/18, 6/26/18, 6/27/18, and 6/29/18. Review of the Therapy Group Notes also revealed no documentation the process group occurred on 6/4/18, 6/11/18, 6/12/18, 6/14/18, 6/18/18, 6/19/18, 6/22/18, 6/23/18, 6/25/18, 6/26/18, 6/27/18, 6/28/18, 6/29/18, and 7/2/18. There was no documentation Patient #8 had access to the psychoeducation group on 13 days or the process group on 14 days of her 30 day admission.<br><br>d. Review of Patient #6's Discharge Summary | A 1062 | facility's patients and to ensure the prescribed treatments were consistently provided to patients. The meeting, further, was used to identify and assess root causes of the findings from the survey and propose strategies to address the deficiencies identified. Root causes for lack of compliance with this requirement were concluded to be due to the lack of effective leadership within the Clinical Therapeutic Services team (and who did not assist therapists) , lack of effective resource allocation, lack of monitoring and enforcement of group therapy sessions, and lack of provision of alternative therapy to patients who did not attend groups. It was concluded that the bulk of the psycho-educational groups are led by the therapists however nursing staff is also responsible for group therapy.<br>B. Based on this GB meeting, a meeting was conducted between the GB and Hospital leaders to review the findings and identify expectations related to the following areas identified as deficient and to be corrected:<br>-The need to ensure appropriate staffing is maintained to meet the mental health needs of the facility's patients as evidenced by the consistent provision of therapy groups, as ordered by the provider.<br>-The need for the Hospital to ensure the prescribed treatments are consistently provided to patients, as ordered, with specific reference to .therapy groups.<br><br>This group of GB and Hospital/MS LS concurred with the identified root causes and added that the group schedules were not posted in all required areas and those posted were not accurate. Further, staff were independently re-prioritizing and not following group schedules, MHT's were | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1062 | Continued From page 93<br>revealed she was admitted to the geriatric (200) unit on 12/29/17 with a diagnosis of bipolar II disorder, recurrent depression, severe without psychosis, and insomnia. Patient #6 remained at the facility until she was discharged on 1/19/18.<br><br>Review of the Interdisciplinary Treatment Plan (ITP) for Patient #6 revealed a short-term goal for therapy services which stated psychoeducation therapy would have been offered daily to assist Patient #6 in identification of triggers and warning signs for depression and suicidal ideation. Psychoeducation therapy would also have been offered to assist Patient #6 with self-soothing techniques she would have used when depressed. The ITP revealed a short-term goal for daily recreational therapy to encourage health coping skills and promote positive leisure awareness for Patient #6. Review of the Adult Admission Orders revealed Physician #21 ordered group therapy, family session, individual therapy, and recreation therapy for Patient #6.<br><br>Review of the Recreation Therapy Notes revealed no documentation the recreation therapy group was held on 12/30/17, 1/1/18, 1/3/18, 1/5/18, 1/6/18, 1/7/18, 1/8/18, 1/10/18, 1/14/18, 1/15/18, and 1/17/18. There was no documentation Patient #6 had access to the recreation therapy group on 11 days of her 22 day admission. Review of the Therapy Group Notes revealed no documentation the psychoeducation group was held on 1/3/18, 1/10/18, 1/12/18, and 1/15/18.<br><br>e. According to the History and Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt. Patient #5 was discharged on 4/10/18.<br><br>Review of the Final Ancillary Orders for Patient | A 1062 | being pulled by the Lead MHT off the units for transport without collaborating with the DON and resulting in the perception of being short-staffed.<br><br>C. The policies related to group therapy and documentation as well as the current group schedules were reviewed. It was assessed that the policy was current. The group schedule, however, was not current and the perceived schedule was not being followed. A change was made in Clinical Therapy leadership. The Lead MHT was re-directed to cease his practice immediately and schedule trips through the DON, who could oversee that staffing remains adequate and meeting all patient care requirements.<br><br>D. The existing staffing on all units for Clinical Therapy and Nursing MHTs and RNs was examined by the Interim Director of Clinical Services and the Interim Director of Nursing and CEO to ensure staffing needs for patient needs and acuity is consistently maintained. The source of this deficiency was, again, attributed to lack of effective resource allocation of staff (and not a shortage of staff) so no new positions had to be added but expectations with the new Interim Director of Clinical Services and the Lead MHT for staff allocation to ensure adherence to group schedules was emphasized by the CEO, Quality Coordinator and Interim Director of Nursing.<br><br>E. All pertinent Hospital staff were inserviced on the associated requirements and expectations to be followed that relate to conducting groups, as scheduled, providing alternative group therapy, documenting the patient's response to treatment that was provided, and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1062 | Continued From page 94<br>#5, revealed an order from Physician #21 placed on 3/18/18 at 5:00 a.m. to initiate therapeutic activities per assessment and program schedule. Physician #21 placed a second order, also on 3/18/18 at 5:00 a.m., for process groups and education groups per the program schedule.<br><br>According to the Group Process Notes for Patient #5, the psychoeducation group was not held on 4/6/18 due to the number of discharges. On 4/8/18 and 4/9/18, "no therapy" was documented for the seeking safety psychoeducation group. No explanation was provided why the group was not held.<br><br>Review of the medical records revealed similar findings for Patients #2, #3, #4, #7, #9, #10, #11, #12, and #13 in which groups were not conducted as ordered.<br><br>f. An interview was conducted with Mental Health Technician (MHT) #44 on 7/23/18 at 9:35 a.m. She stated it was important for MHTs to encourage patients to go to therapy groups. She stated attending groups was an important part of preparing patients to be ready for discharge. Sticking to a routine schedule was necessary because consistency was important for these patients.<br><br>MHT #44 stated groups were sometimes canceled or shortened. This may have happened when there were a lot of discharges and when therapists would come in late. She stated when groups didn't occur there may also have been a mix up of who was supposed to lead the group.<br><br>g. On 7/24/18 at 4:34 p.m., an interview was conducted with MHT #34 who stated groups may not be held or documented when there was a unit disruption. MHT #34 gave an example of one time she had 17 patients to lead in a group, | A 1062 | communicating with the DON or House Supervisor on conflicting patient priorities.<br><br>F. The Group schedules were assessed for accuracy against any input learned during training and were re-printed and re-posted in all patient care areas.<br><br>G. Daily Monitoring and Evaluation activities were implemented to ensure evidence of correction of the deficiencies and early identification of any problems as described below. Staff not meeting compliance are being addressed through the Hospital's progressive disciplinary process.<br><br>3. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br>A. Performance indicators to asses for compliance with these requirements have been implemented as follows:<br>- Documentation of groups or alternative therapy per each patient per schedule<br>- Group schedule is followed for prior day<br>-MHT staffing requirements are being met<br><br>Using these indicators, data analysis is being conducted on a daily basis (S-S). The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| A 1062 | Continued From page 95<br>and she just didn't have "enough of me" to complete it. MHT #34 stated sometimes the therapists were late for groups or the groups were intertwined so two groups occurred as one.<br><br>h. On 7/23/18 at 9:50 a.m., an interview was conducted with Therapist #46 who stated she was the primary therapist on the geriatric unit. Therapist #46 stated the therapists led two daily groups on each unit: the psychoeducation group and the process group. The purpose of the psychoeducation groups was education-based and focused on learning coping skills, based on the theme of the day, and other mental health strategies. The purpose of the process group was to allow patients an opportunity to talk through issues they were experiencing, get more information, and share experiences with other patients.<br><br>Therapist #46 stated these groups were important because they provided a therapeutic contact for patients to support the healing process and gave patients tools to help them stay healthy after discharge.<br><br>Therapist #46 stated, at times, the primary therapist was unavailable to lead groups. In that case, the group was canceled or if possible taught by another staff member. Therapist #46 stated the therapy team was short-staffed.<br><br>i. On 7/26/18 at 1:58 p.m., an interview was conducted with Director of Clinical Services (Director) #47. She stated she had worked at the facility for two months. She stated groups were led at the facility by mental health technicians (MHTs), nurses, nutritionists, therapists, and recreation therapists. Director #47 stated she was responsible for the recreation therapy, psychoeducation, and process groups on the inpatient units. | A 1062 | To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to these indicators under review to assess for compliance with the corrective actions taken pursuant to these deficiencies are being presented at this meeting to ensure evidence of effectiveness in the corrective actions taken and to determine if additional actions need to be taken. The findings are being aggregated by the Quality Coordinator and being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings.<br>This M&E process will continue indefinitely as it is assessed to be a pivotal set of indicators for the Hospital given the focus on therapy groups as a major component of patient treatment.<br><br>4. Title of the person(s) responsible for implementing the acceptable PoC: Director of Clinical Services<br><br>5.<br>GB/LS meetings held:<br>7/17/18<br>7/18/18<br>7/19/18<br>8/1/18<br>9/7/18<br>9/11/18<br><br>Policy review:<br>7/17/18-7/20/18<br><br>Staffing analysis | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1062 | Continued From page 96<br>Director #47 stated she was aware, since her arrival, the psychoeducation and process groups were not always held as scheduled. She was not aware of how often these two groups had been canceled as she did not track this information. Director #47 stated she was in the process of reworking the scheduling process to ensure all groups were held as scheduled. Director #47 stated she was short on staffing and had been aggressively addressing staffing since assuming her role in May, 2018. Director #47 stated it was her expectation going forward that every group was held every day.<br><br>Director #47 stated the purpose of the groups was to give patients an opportunity to practice and learn skills to be effective in the community. It was important for patients to have time to practice these skills before they were discharged out into the community. | A 1062 | started: 7/19/18<br><br>Training conducted on groups<br>8/14/18<br>9/10/18<br><br>M&E started:<br>8/1/18<br><br>PI meeting with GB attendance started on:<br>9/14/18 | |
| A 1066 | 6.104(1)(n) PR-PRP Safe setting<br><br>The health care entity shall develop and implement a policy regarding patient rights. The policy shall ensure that each patient or, where appropriate, patient designated representative has the right to:<br><br>(n) receive care in a safe setting.<br><br>This REGULATION is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to provide care in a safe setting. Specifically, the facility failed to investigate patient falls, which potentially resulted in patient injury, and failed to ensure a safe environment of care by not identifying and reducing ligature risks. Further, the facility failed to investigate suicide attempts and ensure interventions were implemented to prevent further suicide attempts. These failures resulted in patient injuries not being investigated and | A 1066 | 1. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited:<br>A. A Governing Board meeting was held to discuss the findings from the survey related to the Hospital's failure to related to deficiencies related to failure to investigate patient falls to determine whether patients were injured, experienced a change in medical | 09/21/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: CLEAR VIEW BEHAVIORAL HEALTH | | STREET ADDRESS, CITY, STATE, ZIP CODE: 4770 LARIMER PARKWAY JOHNSTOWN 80534 | |

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|---|---|---|---|---|
| A 1066 | Continued From page 97<br>multiple suicide attempts not being investigated.<br><br>Findings Include:<br><br>Policy:<br><br>The Fall Reduction Policy read, the facility was committed to the safety of its patients. All falls were referred to a physician for further follow-up and evaluation. Any fall which occurred was reviewed for trending, prevention, and demographics (where, when, and why).<br><br>The Assessment and Reassessment of the Patient policy read, each patient was reassessed every shift. Reassessment was completed by the RN as needed and with a change of patient condition.<br><br>The Completion of Incident Reports policy read, the risk manager reviewed and categorized all incident reports. The risk manager conducted an investigation and followed-up as necessary.<br><br>The Safety Plan policy read, the facility had an active safety plan to outline operation processes designed to manage staff activities to reduce health care errors, the risk of human injury, and provide a safe physical environment for patients, personnel, and visitors. An error was an unintentional act either of omission or commission or an act which did not achieve its intended outcome. A critical event was an event which resulted in or had the potential to cause serious harm or death, even if the outcome was not serious harm or death. A critical event analysis attempted to determine the underlying causes of critical events and whether there was reasonable potential for performance improvement to reduce the likelihood of such events in the future.<br><br>A. The facility failed to investigate patient falls to determine whether patients were injured, | A 1066 | condition, or required a higher level of care for two patients who had a fall while at the facility; failure to investigate suicide attempts within the facility to ensure appropriate measures were put in place to prevent further suicide attempts; failure to identify safety hazards for patients at risk for intentional harm including flexible shower hose extenders, plastic bags, corded bed alarms, and oxygen tubing and to put processes in place to mitigate these risks; and failure to ensure policies and procedures had been followed to ensure safe patient care. The root causes for this deficiency were identified as follows:<br>1.) Not all patient care staff were properly adhering to or all leadership aware of requirements specific to the following hospital policies and procedures:<br>(A)Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status<br>(B)Assessment of the patient at Admission and Following a fall, including falls assessment, reporting and documentation expectations even when a patient is repeatedly precipitating the fall;<br>(C)Maintaining safety of the environment including: securing doors when patient is not in the room; monitoring and restricting equipment that could be used for ligatures including shower wands and oxygen tubing; banning plastic bags (including “baggies”) from the patient units, and monitoring medication administration of patients to ensure that they completely swallow their medications so no “cheeking” occurs; lack of consistent level of oversight of the patient care environment for safety issues; and<br>(D)Lack of staff’s consistent completion of Incident Reports for all unusual events outside of the patient’s normal course of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| A 1066 | Continued From page 98 | A 1066 | | |

Continued From page 98

experienced a change in medical condition, or required a higher level of care in 2 of 2 medical records reviewed for patients who had a fall while at the facility (Patients #5 and #9).

1. The facility was made aware of patient injuries when Patient #9 was transferred to an acute care hospital. However, the facility failed to investigate and determine if the injuries resulted from a fall which occurred at the facility four days prior to the patient's emergent transfer.

a. Review of the Comprehensive Psychosocial Assessment Tool, dated 12/31/17 at 10:58 p.m., revealed Patient #9 was brought to the facility by ambulance from the Emergency Department (ED) at an acute care hospital. Patient #9 was admitted with a diagnosis of unspecified schizophrenia.

On 1/1/18 at 12:24 p.m., Nurse Practitioner (NP) #9 completed the History and Physical (H&P) for Patient #9. Review of the H&P revealed NP #9 reviewed diagnostic data which noted Patient #9 had a negative x-ray for a possible fracture related to left hip and pelvic pain. Patient #9 was cleared by NP #9 to participate in the program including activity as tolerated.

Review of the imaging results, provided to the facility by the sending acute care hospital, documented an x-ray of the left hip and pelvis showed no evidence of an acute fracture, dislocation, and showed normal alignment on 12/31/17 at 5:22 p.m.

b. Review of a Health Pre-Incident Review Report (incident report) written by Registered Nurse (RN) #13 revealed Patient #9 had an unwitnessed fall on 1/2/18 at 1:30 p.m. RN #13 documented Patient #9 was in bed and was later found lying on the floor. Review of the incident report revealed RN #13 documented

**Provider's Plan of Correction (A 1066):**

care- some which rose to the level and would have required a Critical Events Analysis. Lack of verbal communication by staff to House Supervisors on unusual patient occurrences for the shift.

2.)The new Quality Coordinator was not familiar with all requirements of the Critical Events/Reporting & Analysis process.

3.) The Director of Nursing was challenged with the temporary oversight of the two Colorado facilities due to the recent departure of the Nursing Leader for Clear View Behavioral Health. This was not intended to be an ongoing organizational structure

B. A meeting was held between the GB and Hospital/MS leaders to review the findings, discuss root causes, and identify expectations related to the following areas identified as deficient and to be corrected: The need to ensure all patient falls are reviewed to determine if the patient was injured, experienced a change in medical condition, or required a higher level of care in order to implement strategies to prevent similar occurrence; the need to investigate suicide attempts within the facility to ensure appropriate measures are put in place to prevent further suicide attempts and to ensure policies and procedures were followed to ensure safe patient care; the need to identify safety hazards for patients at risk for intentional harm including flexible shower hose extenders, plastic bags, corded bed alarms, and oxygen tubing to put processes in place to mitigate these risks; and the need to observe patients per hospital policies and procedures related to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 99<br>Patient #9 had no apparent injuries. It was not evident how RN #13 determined the patient had no injuries as there was no documented nursing assessment.<br><br>RN #13 documented he reported the fall to Nursing Supervisor (NS) #16 and to Physician #17. The physician's response area of the incident report was marked not applicable (n/a). The area of the incident report for supervisor review was not completed. The incident report was signed as reviewed by Risk Manager #18 on 1/3/18. There was no additional documentation to show the facility investigated the patient's fall to determine if the patient sustained any injuries and if policies and processes had been followed.<br><br>c. On 7/25/18 at 9:27 a.m., an interview was conducted with RN #13 who stated he recalled taking care of Patient #9 the day he fell. RN #13 stated he typically took the patient's vital signs to see whether they had changed after a fall and documented them in the fall packet. However, on review of the medical record, RN #13 was unable to locate the complete fall packet which included a patient assessment, vital signs and physician notification. RN #13 stated Patient #9's fall was unwitnessed. RN #13 stated all fall documentation should have been located in the medical record and he was responsible for putting it in the record.<br><br>On 7/19/18 at 4:20 p.m., an interview was conducted with Director of Nursing (DON) #2 who stated she would have expected to see a physical assessment, vital signs, and physician notification after the fall. DON #2 stated she was unable to find this documentation in the patient's medical record.<br><br>d. Review of the physician's medical progress notes, dated 1/3/18 at 8:30 a.m., showed no evidence the patient was assessed for injuries | A 1066 | constant observation. The Hospital/MS leaders concurred with the GB's assessment of the major root causes for this deficiency.<br><br>C. Examine policies and procedures to identify new policies needed, revisions to same. P&P's related to: Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status, Assessment of the patient at Admission , Assessment and Management of a Patient Fall, Safety of the patient environment including: securing doors when patient is not in the room; monitoring and restricting equipment that could be used for ligatures including shower wands and oxygen tubing; banning plastic bags (including "baggies") from the patient units, and monitoring medication administration of patients to ensure that they completely swallow their medications so no "cheeking" occurs; lack of consistent level of oversight of the patient care environment for safety issues; and Incident Reporting including communication of same by staff to House Supervisors on unusual patient occurrences for the shift were assessed. A policy for Use of the ADA Showerheads was developed. The prohibition of baggies on the units was added to the policy and procedures for Patient Nourishments and Unit Safety Searches.<br><br>D. Conduct training of pertinent Hospital and Medical staff on the above requirements. Pursuant to the findings, the following training was conducted for the corresponding Root Causes.<br>Root Cause # 1. Need for education of policies and procedures and evaluation of processes specific to: | |

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|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 100<br>from his fall and no documentation the NP was even aware of the patient's fall the previous day. NP #27 documented Patient #9 reported pain "all over" and was shaking when she touched him with the stethoscope for examination. NP #27 documented Patient #9 was asking for Percocet, but her plan for managing the patient's chronic polyarthralgias (joint pain) was to continue Tylenol 650 mg every 6 hours as needed and no narcotics were to be given.<br><br>On 7/26/18 at 9:04 a.m., an interview was conducted with medical Nurse Practitioner (NP) #26 who stated it was important the medical providers were notified of significant events involving patients so the cause of the event could be investigated and any necessary treatments could be implemented to help correct the problem. NP #26 stated if he was notified of a significant event regarding a patient, his next step would be to evaluate the patient. NP #26 stated he would enter a followup note in the medical record, and this was important so the next person who worked with the patient knew what had occurred and what was done. NP #26 stated if a patient fell, he would expect the RN to make sure the patient was breathing, take the patient's vital signs, call the physician to report any injuries, the circumstances of the fall, and any medications given. NP #26 would expect to be called immediately with that information to guide his triage and help him look for the cause of the fall and alter his treatment plan.<br><br>NP #26 reviewed the medical provider progress notes for Patient #9. NP #26 stated he was unable to determined if NP #27 was aware of Patient #9's fall on 1/2/18 based on her progress notes. He stated her progress note, dated 1/3/18, did not address the patient's mobility. NP #26 stated it was important to reassess a patient after a fall to make sure the patient remained safe in the facility's care. If the patient was not reassessed, there was a risk the | A 1066 | (A)Levels of Observation of the patient<br>(1)All patient care Nursing Staff, Medical Staff as well as all Hospital Leadership who are responsible for making Patient Safety Rounds were re-educated on:- the requirements related to Constant Observation of the patient with the specific points of emphasis including that:<br>(a)Close Observation status , means the maintenance of a line of sight of the patient at all times with no more than three patients on close observation by one staff member at any given time, or above;<br>(b) Close Observation means constant visual line of sight of the patient including when they are in the bathroom or shower.<br><br>Standing outside of the patient's bedroom when the patient is in the bathroom does not afford a line of sight of the patient . (c) Close Observation shall be utilized for patients who are on oxygen, as ordered by the patient's physician or when utilizing other devices are in use by the patient that may pose a potential ligature risk . (d) In order to accomplish Close Observation on more than one patient and no more than three patients, the patients must be in a contiguous area whose view of the patient is unobstructed. (e) Documentation of this observation shall occur every 15 minutes. (f) Staff are never to leave the patient(s) on Close Observation without relief<br><br>(2)All patient care Nursing Staff as well as all Hospital Leadership who are responsible for making Patient Safety Rounds were re-educated on the requirements related to 15 minute checks with the specific points of emphasis that:<br>(a)The check is to be accomplished within each 15 minute increment of time and | |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1066 | Continued From page 101<br>patient could have been injured more than the staff thought. NP #26 stated the facility should have done more followup and "looked a little harder." NP #26 stated he was not involved with any tracking or trending of incidents at the facility. NP #26 stated it was important to investigate incidents to reflect and possibly implement corrections.<br><br>e. A progress note, on 1/6/18 at 2:25 a.m. written by RN #22, revealed Patient #9 awoke at 1:30 a.m. shouting he was having chest pain and asking for his defibrillator. RN #22 documented she entered Patient #9's room with the mental health technician (MHT) and found the patient mildly responsive (only responding to loud commands), diaphoretic (sweating heavily), shaking, and visibly clutching his chest in pain. RN #22 documented Patient #9 stated his defibrillator was going off constantly. Patient #9 had an elevated heart rate of 115 beats-per-minute and a low oxygen saturation level of 82 percent. Oxygen was placed on Patient #9, a code white (medical emergency) was called, Physician #21 was contacted and an order was obtained to call 911. An ambulance transported Patient #9 to an acute care hospital at approximately 2:00 a.m.<br><br>Review of the Medical Transfer Monitoring Tool, documented by RN #22 on 1/6/18 at 2:45 a.m., revealed Patient #9 had arrived at the receiving facility and was admitted with fractures to his left ribs, numbers 2 through 5, and a left pelvic fracture. This was a new finding as compared to the imaging results, provided to the facility by the sending acute care hospital, which documented an x-ray of the left hip and pelvis showed no evidence of an acute fracture, dislocation, and showed normal alignment on 12/31/17 at 5:22 p.m.<br><br>On 7/26/18 at 1:55 p.m., a second interview was conducted with DON #2 who stated the | A 1066 | recorded real time on the Patient Safety Check form; (b) That the ideal process is to vary when, within the 15 minutes that the staff reviewing the patient will return so that there is no predictability of same; (c) That if another work duty is assigned, the staff is to have a replacement assume the 15 -minute checks before leaving the patient care area. Patients are not to be left unattended; (d) That this expectation for completing 15 minute checks per requirements will be enforced through the Hospital's progressive disciplinary process.<br><br>(3)All patient care Nursing Staff as well as all Hospital Leadership were re-educated on the requirements related to 1:1 observation with specific points of emphasis on indications and how, while an RN may increase the level of monitoring of a patient, they may not decrease a patient's level of care without a Medical Staff order.<br><br>B)Assessment of the patient at Admission and Following a fall, including reporting and documentation expectations<br>(1)All Hospital and Medical staff who assess the patient on admission were inserviced on the expectation to: (a) On the patient's admission, the nurse completes an assessment of the patient that encompasses visualization of any areas that the patient reports have been injured and that the medical provider's history and physical encompasses inspection within the physical exam of any areas of injury reported.<br><br>(2)All Nursing staff (RNs, LPNs and MHTs) who are involved in patient care were educated that, in the event of a patient injury (or possible injury including | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1066 | Continued From page 102<br>investigation for Patient #9 should have been handled differently. DON #2 stated she remembered talking about the patient, but she could not locate any record of an investigation. DON #2 stated it was possible Patient #9's fall may have been the reason he was spending a lot of time crawling and scooting on the floor. DON #2 stated an investigation would have been helpful to determine if the patient's injury occurred at the facility and what could have been done to prevent the injury.<br><br>f. Review of the incident report, completed for the patient's transfer on 1/6/18 and documented by RN #22, described Patient #9's transfer to the acute care hospital. Nursing Supervisor (NS) #24 had responded to the code white and signed the incident report. RN #22 documented she had notified Physician #21 of the incident. Director of Nursing (DON) #2 signed she had reviewed the incident report on 1/8/18, and Risk Manager #18 signed she had reviewed the incident on 1/8/18 and documented no further action was necessary. The incident report did not identify the rib or pelvic fractures discovered after Patient #9's transfer.<br><br>On 7/26/18 at 7:56 a.m., an interview was conducted with Registered Nurse (RN) #22 who stated she recalled Patient #9 and she was his nurse the night he was transferred. RN #22 stated she called the acute care hospital to inquire as to whether the patient was returning to the facility. RN #22 stated she spoke to a nurse who reported Patient #9 had been admitted to the hospital with fractured ribs and a fractured pelvis. RN #22 stated this was a pretty big finding, and supervisors needed to know. RN #22 stated it was important someone other than her knew, because they would want to know how the patient got those injuries. RN #22 stated she passed this information on to Nursing Supervisor (NS) #24 but she probably hadn't documented it. RN #22 stated she did notify | A 1066 | that of a patient fall), the following steps are to be taken in accordance with the policy and procedure entitled: "Care of the Patient after a Patient Injury" with emphasis on the following processes:<br>-Assess the situation.<br>- Assess whether or not the patient is injured<br>-Follow the acronym for "Airway, Breathing, Circulation" to ensure that the patient does not have a respiratory or cardiac emergency.<br>- Identify any bleeding and apply pressure to the site;<br>-Obtain patient vital signs;<br>-Do not move the patient's limbs, or change their position, especially if the patient complains of pain or a limb is being held in an unusual position unless for safety.<br>- Notify the House Supervisor immediately upon the event.<br>-Notify the patient's attending physician for any orders and document orders received or, if no orders given, document same. - Notify the patient's family, as approved by the patient.<br>Contact EMS.<br>-Continue to monitor the vital signs of the patient until EMS arrives.<br>- Interview any patients or staff who may have observed the event,<br>-Ensure that attending physician and/or Medical Provider see patient within 24 hours of patient injury, that they inspect the areas of injury and that they document findings, conclusions, recommendations, actions.<br>-Treat all falls as potential sources of injury, even if there is a question of the patient's behavior contributing to the fall. This includes full assessment for injury as with any other patient fall. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1066 | Continued From page 103<br>Physician #21 the patient was transferred, but did not recall if she notified the physician about the patient's rib and pelvic fractures "after the fact."<br><br>g. On 7/19/18 at 2:46 p.m., an interview was conducted with Director of Quality (Director) #25 who stated she was not aware of the results of the investigation into Patient #9's transfer. Director #25 stated the incidents were reviewed by Risk Manager #18 who was no longer working at the facility. Any further investigation of the incidents, for Patient #9's fall and transfer, were requested. On 7/19/18 at 4:08 p.m., Director #25 returned and stated she did not know what was done to investigate Patient #9's fall or the injury discovered after his transfer out of the facility. Director #25 stated she could not locate any notes from Risk Manager #18. Director #25 stated Risk Manager #18 reported to her, but Director #25 would not have been made aware unless there were any outstanding concerns.<br><br>During a meeting with Quality Coordinator (QC) #1, Director #25, Chief Operating Officer (COO) #15, Chief Executive Officer (CEO) #6, and DON #2, on 7/19/18 at 4:45 p.m., the facility was asked to provide documentation on how they followed up and investigated Patient #9's injuries which were identified upon his transfer and subsequent admission to an acute care hospital. On 7/19/18 at 5:14 p.m., QC #1 reported there was no documentation of any further investigation into the cause of Patient #9's fractured ribs and pelvis.<br><br>2. The facility failed to ensure all of Patient #5's falls were documented and investigated.<br><br>a. According to the Nursing Assessment note, on 4/8/18 at 8:15 p.m. by RN #13, Patient #5 fell backwards in her chair, hitting her head on a shelf. RN #13 also documented Patient #5 hit | A 1066 | ( 3) All MS were apprised of this occurrence instructed on the need to pursue additional imaging studies (i.e. magnetic resonance imaging) when x-ray results are negative but with patient continued report of pain based on the incidence of false negative results of radiological studies. In support, studies show that X-ray missed a number of fractures and that MRI revealed many fractures undetected by X-ray as follows: 13 patients (14%) had 23 fractures (6 hip, 17 pelvic) undetected by X-ray but confirmed by MRI and 15 patients (16%) with X-rays that did reveal fractures had MRIs that depicted additional breaks missed by X-ray (“Inaccuracies Common in Diagnostic X-Rays for Hip and Pelvic Fractures” Nancy Fowler Larson; March 23, 2010 https://www.medscape.com/viewarticle/719016?pa=9TEh%2BEsvvN0UPRLj7%2BKMyVV1XZK59H0Beg7XAFpVinq0cg%2BOuRiefvDZ5jTERpIRX8MwC0EECwzp432Skuf9qw%3D%3D)<br><br>(4)All House Supervisors were instructed on the expectation to increase staffing in accordance with patient acuity. Such example includes instances of patient injury when either the patient is transported for evaluation and staff must accompany the patient or if the patient is retained and requires increased monitoring to assess for stability.<br><br>C)Maintaining safety of the environment including: securing doors when patient is not in the room, monitoring equipment that could be used for ligatures including shower wands and oxygen tubing, banning plastic bags (including “baggies”) from the patient units, monitoring medication administration of patients to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE: **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|

A 1066

Continued From page 104

her head on a similar occasion but no bruises were seen. RN #13 documented he did not fill out a fall investigation packet "as patient does this often." RN #13 noted he notified the nurse practitioner on call.

Review of NP #27's Progress Notes, on 4/9/18 at 12:38 p.m. and 4/10/18 at 8:10 a.m., revealed there was no documentation of the fall which occurred on 4/8/18 at 8:15 p.m. There was no indication NP #27 had been made aware of the most recent fall.

b. On 7/25/18 at 9:27 a.m., an interview with RN #13 was conducted. RN #13 stated after a fall he would assess the patient for injuries and fill out an incident report. RN #13 stated an incident report should have been completed every time a patient fell so an investigation could be conducted to determine why the patient fell and what interventions could be implemented to prevent another fall.

RN #13 stated he did not have to fill out a fall packet each time Patient #5 fell because she had a behavior plan in place based on her known behavior of tipping her wheelchair backwards. RN #13 further stated once a patient had a specific behavior identified, the treatment plan was changed and staff would no longer complete a fall packet. RN #13 stated Patient #5 was suicidal and impulsive.

RN #13 reviewed Patient #5's medical record. RN #13 was unable to locate a behavior plan which had been put in place and removed the requirement of completing a fall packet. RN #13 confirmed an incident report was not completed for Patient #5's fall on 4/8/18 at 8:15 p.m., but should have been.

c. On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 stated after a patient fell staff were expected to perform a

A 1066

ensure that they completely swallow their medications so no “cheeking” occurs, and unit rounds to ensure all safety measures are maintained.

(1)Securing Doors

(a) All patient care, EOC, and Housekeeping staff, were educated on the policy related to Patient Rooms with specific reference to expectations that the patient room doors are to be locked when the room is vacant or patients are out of the room; and that patients are never to be locked in their room.

(2)Monitoring Ligature Concerns
Shower Heads

(a)All patient care staff were instructed that all ADA shower heads were relocated to the med room and are now required to be checked in and out with the nurse using the “Removable Showerhead Check Out Sheet”. Staff were also instructed that the ADA shower heads maintained on a unit, were now reduced to a total of one per each nursing unit for ease in counting their presence or absence.

(b) Staff were instructed that no patient on moderate to high level of suicide risk will be left alone with the ADA showerhead. Staff have been instructed to remain in attendance at all times that the ADA shower head is being utilized. Patients at low level of suicide risk are being maintained on the every 15- minute frequency of review and staff instructed that this frequency is maintained even when the patient is located in the bathroom.

(c )Staff were instructed on the policy and procedure related to the patient’s Use of the ADA showerhead” whereby they are tc sign the ADA showerhead out for use on the and immediately back in (within 15 minutes of the completion of the patient’s

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1066 | Continued From page 105<br>physical assessment to ensure there were no injuries, notify the provider, and fill out a fall investigation packet. DON #2 stated a physical assessment was important to perform after a fall to identify an injury and send the patient to a higher level of care if needed. DON #2 stated an incident report should be completed each time a patient fell.<br><br>DON #2 reviewed Patient #5's record and stated RN #13 did not fill out an incident report; therefore, she was unaware Patient #5 had a fall on 4/8/18. DON #2 stated there was no investigation performed after the fall.<br><br>B. The facility failed to investigate suicide attempts within the facility to ensure appropriate measures were put in place to prevent further suicide attempts and to ensure policies and procedures had been followed to ensure safe patient care.<br><br>The Suicide Precautions Policy read, the facility was to provide for the safety and well-being of each individual patient found to be at risk for harm to themselves. The Suicide Risk Monitoring Tool will be the standard tool used by staff to evaluate all patients deemed to be at risk for self harm. The level of observation of the patient is determined by the findings from the suicide monitoring tool. The patient will be rated with a low, medium or high score, but the score is not intended to replace the assessment and judgement of the skilled clinician.<br><br>For patients scored low: place on 15 minute checks, contraband search once on day shift and once on evening shift, suicide risk tool every 24 hours, daily re-evaluation by physician for appropriateness of level of care and placement<br><br>Medium score: place on 15 minute checks or close observation depending on the degree of | A 1066 | shower and, for patients on 15 minute checks, as the check is completed. The Nurse (RN or LPN) is now receiving the ADA showerhead and securing it in the Medication Room.<br><br>(3) Corded Fall Alarms<br>(a)All Fall alarms with cords were removed from Clear View Behavioral Health Hospital and patient care staff instructed that cordless alarms are to be used instead on a go-forward basis.<br><br>(4)Use of Oxygen with tubing<br>The Hospital's unit bed assignment policy was amended to state that patients on oxygen should not have a roommate on medium or high suicide risk without close observation status or above.<br><br>(a) Patients who have oxygen tubing should be monitored at least every 15 minutes to ensure safety of patients. Patient Care staff have, further, been instructed that: Close Observation status meaning, maintenance of a line of sight of the patient at all times with no more than three patients on close observation by one staff member at any given time, or above, shall be utilized for patients who are on oxygen, as ordered by the patient's physician. Documentation of this observation shall occur every 15 minutes<br><br>(5)Discontinuation of use of Plastic Baggies in Pt. care areas<br>(a) While large plastic bags used as trash liners were banned from the unit some years ago, "baggies" used for sandwiches have now also been banned from patient care areas. All Dietary and Patient care staff have been | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| A 1066 | Continued From page 106<br>lethality, contraband search once on day shift and once on evening shift, suicide risk tool every 12 hours, progress note documentation every shift related to the status of the patient, daily re-evaluation by physician for appropriateness of level of care and placement.<br><br>High score: place on 15 minute checks or 1:1 observation depending on the degree of lethality, contraband search once on day shift and once on evening shift, suicide risk tool every 8 hours, progress note documentation every shift related to the status of the patient, daily re-evaluation by physician for appropriateness of level of care and placement, the RN will discuss findings from the Suicide Risk Tool to verify the most appropriate care.<br><br>According to the Practice Guidelines for Levels of Observations Policy, guidelines for 1:1 would include seclusion, restraint or emergency use of medication, actively attempting to or imminent harm to self or others, acting on suicidal ideation, hallucinations, demonstrated unpredictable or impulsive behavior placing themselves or others at risk, patient failed line of sight observations, unsafe at a lower level, status post suicide attempt for 24 hours.<br><br>Guidelines for step down to every 15 minute checks from a 1:1 include: no verbalization or denial to harm self or others, no attempts to harm self or others for 24 hours based on previous unpredictable behavior, adequate impulse control, patient expresses insight into behavior.<br><br>According to the Critical Event Review and Reporting Policy, a critical event was an event which resulted in or had the potential to cause serious harm or death, even if the outcome was not serious harm or death, includes attempted suicide and falls with significant injury. | A 1066 | apprised of this requirement through inservice or written memorandum.<br><br>(6) Patient Observation of Medication Administration<br>(a) All Nursing staff who administer medications and staff that monitor patients have been instructed on the expectations related to observing the patient following the administration of medications to ensure that no “cheeking” of medications occurs.<br><br>(7) Environmental Safety Rounds 3X per shift by MHTs<br>(a) All Nursing staff (RNs and MHTs) who are involved in patient care have been educated on the expectations related to ensuring a safe patient population and the expectations related to the MHT’s conduct of environmental safety rounds at the start, middle, and the end of every shift. The off-going MHT is rounding together with and signing off to the oncoming MHT to communicate that there are no patient safety hazards present on the unit, as delineated on the Environmental Safety Rounds check sheet. The oncoming MHT is then signing that they are accepting the unit and, in doing so, there are no patient safety issues of concern and all requirements are met, as delineated on the Environmental Safety check list for MHTs.<br><br>8) Hourly Rounds by RNs<br>Following the conduct of training for all RNs within nursing care units where patients are occupied on expected requirements for unit walkthroughs, RN unit rounds in patient care areas have been implemented to occur hourly in order to better ensure a safe patient | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1066 | Continued From page 107<br><br>A critical event analysis attempted to determine the underlying causes of critical events and whether there was reasonable potential for performance improvement to reduce the likelihood of such events in the future. Adverse patient occurrences may be identified through occurrence reporting. The Performance Improvement (PI) coordinator determines if an event meets the definition of a critical event and initiates the critical event analysis within 30 days of knowledge of the event.<br><br>1. The facility failed to investigate two suicide attempts by Patient #5 to ensure patient safety. In addition, the facility failed to increase Patient #5's level of observation to prevent future suicide attempts.<br><br>a. According to the H&P, documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic. On 3/18/18 at 6:14 a.m., Physician #21 performed an Evaluation of Risk and added Patient #5 had previous suicide attempts by hanging and numerous suicide gestures such as swallowing rubber gloves.<br><br>According to an incident report, dated 3/27/18 at 8:00 p.m., Patient #5 had a blanket wrapped around her neck in a threat to harm herself. Patient #5 was restrained and required emergency intramuscular (IM) medication administrations of Zyprexa (antipsychotic medication), Ativan (relieves anxiety) and Benadryl (causes drowsiness).<br><br>According to the incident report, Director of Nursing (DON) #2 reviewed the incident on 3/28/18 at 10:10 a.m. with no further actions documented. On 4/3/18 at 12:07 p.m., Quality Coordinator (QC) #1 reviewed the incident report and documented it as minor incident. QC | A 1066 | environment and engage with the patients to assess for any pain, patient care concerns, or other issues, and to observe MHTs to ensure that they are completing their 15-minute checks and patient observation practices per policy. Realtime intervention is occurring on any unsafe item or situation seen and a notation placed by the RN on their rounds sheet that the physical environment has been secured or patient intervention has been made to ensure that object for<br><br>(a) potential self-harm has been removed or situation remedied. The RN is documenting these findings on the review form entitled: “Nursing Hourly Rounds”<br><br>(9)Ligature Risk Assessment<br>(a) Environmental Services and LS staff were instructed of the requirement to complete an updated ligature risk assessment conducted to assess all patient areas with special focus on patient rooms and bathrooms. This was accomplished.<br><br>(10)Environmental Safety Rounds 3X per shift by MHTs<br>(a) All Nursing staff (RNs and MHTs) who are involved in patient care were educated on the expectations related to ensuring a safe patient population and the expectations related to the MHT’s conduct of environmental safety rounds at the start, middle, and the end of every shift. The off-going MHT is now rounding together with and signing off to the oncoming MHT to communicate that there are no patient safety hazards present on the unit, as delineated on the Environmental Safety Rounds check sheet. The oncoming MHT is then signing | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1066 | Continued From page 108<br>#1 further documented the incident was reviewed in the daily safety meeting and wrote she would "continue to monitor."<br><br>There was no documentation the facility investigated the incident according to its Critical Event Review and Reporting policy to classify the suicide attempt as a critical event and determine whether there was a potential for performance improvement to reduce the likelihood of such event in the future.<br><br>According to the RN Mental Status Assessment, completed by RN #29 on 3/27/18 at 5:49 p.m. (approximately 2 hours before her suicide attempt), Patient #5 was impulsive, had poor insight and judgement and was banging her head on the wall and kicking the door. Patient #5 required multiple attempts at redirection of her behavior.<br><br>According to the policy Practice Guidelines for Levels of Observations Policy, noted above, this behavior could indicate a need for 1:1 (1 staff member with 1 patient at all times) observation status based on actively attempting to harm herself.<br><br>However, according to the ancillary orders, Patient #5 was only to be monitored every 15 minutes on 3/27/18 at the time she attempted suicide. Patient #5 was not changed to a 1:1 after the suicide attempt, which was in contrast to the observation guideline policy.<br><br>b. Record review revealed Patient #5 had a second suicide attempt on 4/7/18 at 6:20 p.m. According to the RN Mental Assessment, Patient #5 gagged and vomited up a plastic bag. RN #3 gave Patient #5 Thorazine (antipsychotic medication that can reduce anxiety) and told her to stay in the milieu (common area) so she could be observed. However, Patient #5 was not observed and went to her room where staff | A 1066 | that they are accepting the unit and, in doing so, there are no patient safety issues of concern and all requirements are met, as delineated on the Environmental Safety check list for MHTs.<br><br>(11)Hourly Rounds by RNs<br>(a) Following the conduct of training for all RNs within patient care areas on expected requirements for unit walkthroughs, RN rounds for all nursing units are now being conducted hourly in order to better ensure a safe patient environment. Realtime intervention is occurring on any unsafe item or situation seen and a notation placed by the RN on their rounds sheet that the physical environment has been secured to ensure that an object for potential self-harm has been removed or other situation remedied.<br><br>(12)Supervision of Rounding by MHTs and RNs<br>(a) 100% persons participating as House Supervisors and Administrators on Call (AOC) have been instructed on the requirement that they receive a report per shift on:<br>-the RN's evidence of hourly rounding and results of same, and -the findings from the daily monitoring of the environment by the MHT for any potential or actual breaches in safety and confirmation that actions have been taken to remove the unsafe item from the environment (Attachment "D").<br><br>(D)Lack of completion of Incident Reports for all unusual events outside of the patient's normal course of care- some which rose to the level and would have required a Critical Events Analysis.<br>(1) All Nursing staff (RNs, LVNs, and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1066 | Continued From page 109<br>found her with a sheet tied tightly around her neck and had difficulty removing it. There was no change in observation status after the patient attempted self harm, by swallowing a plastic bag, to potentially reduce the likelihood of additional suicide attempts.<br><br>According to an incident report dated 4/8/18 at 8:10 a.m., DON #2 completed a review of the incident. DON #2 documented Patient #5 was attempting to harm herself and attacked staff when they intervened. On 4/9/18 at 2:08 p.m., QC #1 signed the incident report and checked it as a major incident. QC #1 wrote Patient #5 was placed on a 1:1 observation status after the incident and staff followed policy and procedure. QC #1 documented she would "continue to monitor." There was no documentation the facility investigated the incident according to its policy to determine the underlying causes of the suicide attempts as a critical event and whether there was a potential for performance improvement to reduce the likelihood of such event in the future.<br><br>c. On 7/25/18 at 11:03 a.m., an interview with Physician #14 was conducted. Physician #14 stated Patient #5 threatened suicide often. Physician #14 was unable to remember if there was a discussion to implement the use of a suicide blanket (a tear-resistant blanket that is used to prevent an individual from forming a noose to commit suicide) during the interdisciplinary discussions as an intervention to prevent Patient #5's suicide attempts.<br><br>According to the policy, a critical event analysis should have been conducted for each suicide attempt. There was no documentation that an investigation occurred.<br><br>On 7/26/18 at 8:01 a.m., an interview with QC #1 was conducted. QC #1 stated a patient tying a sheet around their neck would be considered | A 1066 | MHTs) who are involved in patient care have been educated on the expectations for communication of unusual patient events through the Incident Reporting system as well as for their need to fully document the event including description of the event, patient response, persons notified, actions taken and follow-up<br>(2) Nursing staff (RNs and MHTs) have been instructed on the expectation that a Root Cause Analysis is to be held for every patient event that leads to significant patient injury or that causes a substantial change in the patient's treatment plan as per the definition in the policy and procedure on "Root Cause Analyses"<br>(3) The Nursing Supervisor report system has been revised whereby key events occurring on each unit are being conveyed on the report and its contents retained for comparison with the Incident Reports to ensure that all unusual events have been identified and addressed.<br>Root Cause # 2. The new Quality Coordinator was not familiar with all requirements related to the Critical Events Reporting and Analysis<br>-The Quality Coordinator was instructed by the VP Nursing/PI/Regulatory Affairs and the CEO and COO by the VP of Corporate Compliance on the requirements related to when a Root Cause Analysis (RCA) is expected. Included in these instructions is the requirement that the meeting must be conducted within 30 days of knowledge of the event and that the VP of Corporate Compliance or VP Nursing/PI/Regulatory Affairs must be on the call or present at the meeting to ensure all elements are addressed.<br>-A requirement was implemented that all patient injuries or sentinel events that | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1066 | Continued From page 110<br>a suicide attempt and confirmed there had been no further investigation conducted on Patient #5's suicide attempts.<br><br>On 7/26/18 at 10:59 a.m., an interview with DON #2 was conducted. DON #2 stated she was unable to perform all of her duties because she was just trying to address issues as they arose. DON #2 was currently acting as the director of nursing for two hospitals approximately 125 miles apart. DON #2 stated her role in incident report review was to ensure the report was complete, and determine if staff required education.<br><br>On 7/26/18 at 1:59 p.m., a follow up interview with DON #2 was conducted. DON #2 stated an investigation should have been completed on all suicide attempts. DON #2 stated the compliance manager made the decision on when to perform an investigation. DON #2 confirmed there had not been an investigation on either of Patient #5's two suicide attempts. DON #2 stated Patient #5's observation status should have increased after she was gagging on the plastic bag to prevent the subsequent suicide attempt.<br><br>DON #2 stated staff were trained how to perform suicide risk assessments during initial training. DON #2 stated she did not perform audits to ensure nurses were performing assessments correctly to ensure appropriate interventions and observations were in place or to ensure staff were performing suicide assessments at the correct interval according to the policy.<br><br>2. The facility failed to monitor Patient #13 while she was on line of sight. This resulted in an unwitnessed suicide attempt while the patient was on constant observation status.<br><br>a. On review of Patient #13's medical record, the patient was transferred to the facility on | A 1066 | occur at the Hospital will be reported by the Quality Coordinator to the VP of Corporate Compliance or VP Nursing/PI/Regulatory within 24 hours of receipt of notification of the event for tracking of completion of the Sentinel Event.<br>3-Sentinel event meetings were held for the patient safety issues raised including the patient with an injury that was transferred to the ED and the patient who attempted self harm with a sheet while in the bathroom and the patient who swallowed the baggie.<br><br>Root Cause #3. The Director of Nursing was challenged with the temporary oversight of the two Colorado facilities due to the recent departure of the former Director of Nursing for Clear View Behavioral Health.<br>Pursuant to this observation, a fully dedicated Interim Director of Nursing for Clear View Behavioral Health was identified and put in place and trained on the requirements related to the deficiencies noted in this Plan of Correction. This position will remain in place until a new Director of Nursing for Clear View Behavioral Health has been selected and oriented. The Director of Nursing for Peak View Behavioral Health will support the efforts of this Interim DON as she adjusts and responds to the patient care needs that were identified during this survey.<br>D. E. A daily Monitoring and Evaluation (M&E) activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as delineated below.<br><br>2. The procedure for implementing the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1066 | Continued From page 111<br>7/15/18, after she stated she was going to kill herself. On 7/15/18 at 9:24 a.m., a comprehensive psychosocial assessment was completed. Patient #13 was documented as depressed and anxious and endorsing suicide with a plan to hang herself, cut herself or overdose on medication. At 9:47 a.m., an evaluation risk was completed and Patient #13 was identified as at an imminent risk for suicide.<br><br>Review of the psychiatric progress notes for 7/21/18 and 7/23/18, revealed Patient #13 continued to endorse suicide with a plan but she would not disclose the plan.<br><br>On 7/22/18 at 10:50 p.m., the RN documented in the progress note, Patient #13 reported suicidal thoughts with a plan to overdose on medications. The patient reported she had "some pills saved up that I was going to take." The patient then gave the RN a crushed yellow powder substance rolled up in a paper wrapper. When asked what pills they were, the patient reported they were "mine and other peoples." Patient #13 identified the crushed medications as Vistaral (an anti-anxiety medication), Xanax (used to treat anxiety and panic disorder) and Ativan (used to treat anxiety with sedative properties). The RN documented Patient #13 had been "cheeking [pretending to swallow medications while hiding them in the mouth] random medications."<br><br>On 7/23/18 at 8:30 a.m., the physician ordered Patient #13 on line of site observation.<br><br>According to the policy, Levels of Observation, line of sight patients must be in sight of a staff member at all times. When the patient uses the bathroom the staff member will remain outside the bathroom door and visually check on the patient. Staff assigned to LOS must hand-off responsibility for maintaining observation of the assigned patient. | A 1066 | Plan of Correction (PoC), for each deficiency cited:<br>A. A Governing Board meeting was held to discuss the findings from the survey related to the Hospital's failure to related to deficiencies related to failure to investigate patient falls to determine whether patients were injured, experienced a change in medical condition, or required a higher level of care for two patients who had a fall while at the facility; failure to investigate suicide attempts within the facility to ensure appropriate measures were put in place to prevent further suicide attempts; failure to identify safety hazards for patients at risk for intentional harm including flexible shower hose extenders, plastic bags, corded bed alarms, and oxygen tubing and to put processes in place to mitigate these risks; and failure to ensure policies and procedures had been followed to ensure safe patient care. The root causes for this deficiency were identified as follows:<br>1.) Not all patient care staff were properly adhering to or all leadership aware of requirements specific to the following hospital policies and procedures:<br>(A)Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status<br>(B)Assessment of the patient at Admission and Following a fall, including falls assessment, reporting and documentation expectations even when a patient is repeatedly precipitating the fall;<br>(C)Maintaining safety of the environment including: securing doors when patient is not in the room; monitoring and restricting equipment that could be used for ligatures including shower wands and oxygen tubing; banning plastic bags (including "baggies") from the patient units, and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 112<br><br>b. On 7/24/18 at 12:20 p.m., an incident report documented the patient was found in her bathroom with a blanket tied around her neck which was attached to the toilet seat. The patient attempted to strangle herself after ripping off her scabs causing her to bleed.<br><br>c. During an interview, on 7/25/18 at 3:44 p.m., Mental Health Technician (MHT) #20 stated she was providing line of site (LOS) observation for Patient #13 when she attempted suicide on 7/24/18 at 12:20 p.m. In addition, her duties included conducting 15 minute checks for all other patients on the unit and in group therapy. MHT #20 stated it was busy.<br><br>MHT #20 stated Patient #13 was in her room when a therapist came in to speak with the patient, at which point the MHT left the room and carried on with other unit duties. When MHT #20 noticed the therapist had left Patient #13's room she went to check on the patient, who was already in the restroom. MHT #20 stated Patient #13 took the "opportunity" to go to the restroom with a blanket. MHT #20 stated there was no hand off or report done between her and the therapist at anytime. MHT #20 stated she was not aware if the therapist knew Patient #13 was on LOS observation.<br><br>MHT #20 stated she did not follow the patient into the restroom or visually check on Patient #13, but instead stood at the hallway door of the patient's room and did a verbal check by calling the patient's name and waiting for a response. MHT #20 then continued her duties of monitoring the hall for other patients at the same time and stated "it was hard." This was in contrast to the observation policy, which stated the staff member would visually check on patients when they were in the bathroom to ensure patient safety. | A 1066 | monitoring medication administration of patients to ensure that they completely swallow their medications so no “cheeking” occurs; lack of consistent level of oversight of the patient care environment for safety issues; and (D)Lack of staff’s consistent completion of Incident Reports for all unusual events outside of the patient’s normal course of care- some which rose to the level and would have required a Critical Events Analysis. Lack of verbal communication by staff to House Supervisors on unusual patient occurrences for the shift.<br><br>2.)The new Quality Coordinator was not familiar with all requirements of the Critical Events/Reporting & Analysis process.<br><br>3.) The Director of Nursing was challenged with the temporary oversight of the two Colorado facilities due to the recent departure of the Nursing Leader for Clear View Behavioral Health. This was not intended to be an ongoing organizational structure<br><br>B. A meeting was held between the GB and Hospital/MS leaders to review the findings, discuss root causes, and identify expectations related to the following areas identified as deficient and to be corrected: The need to ensure all patient falls are reviewed to determine if the patient was injured, experienced a change in medical condition, or required a higher level of care in order to implement strategies to prevent similar occurrence; the need to investigate suicide attempts within the facility to ensure appropriate measures are put in place to prevent further suicide attempts and to ensure policies and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

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|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| A 1066 | Continued From page 113<br>MHT #20 stated when the patient failed to respond to a verbal check, she went into the restroom and found the patient with a blanket tied around her neck. MHT #20 then used her radio to call for assistance.<br><br>d. On 7/26/18 at 1:59 p.m., an interview was conducted with DON #2. DON #2 stated facility policy did not indicate how many patients on LOS precautions one staff member could observe at one time, but felt three LOS patients for one staff member was appropriate. DON #2 was unable to explain how one staff member would be able to accomplish the LOS duties for all three patients as patients were able to be in different rooms and different areas on the units.<br><br>C. The facility failed to identify safety hazards for patients at risk for intentional harm and failed to put processes in place to mitigate the risks. These hazards included flexible shower hose extenders, plastic bags, corded bed alarms, and oxygen tubing.<br><br>1. According to the policy, Securing Of Patient Rooms When Patients Are Not Present, when a patient room is vacated and there are no patients currently occupying the room the door shall be kept locked. Multiple observations conducted throughout the facility showed there was no standard process to ensure doors to rooms were closed and locked when patients were not in their room and items which posed a ligature risk were secured and unavailable for patient harm.<br><br>a. During a tour beginning on 7/23/18 at 11:32 a.m., Lead Mental Health Technician (MHT) #33 stated anytime patients were not in their room the door was supposed to be closed in order to prevent access by unauthorized patients and to prevent patients from isolating in rooms.<br><br>b. On 7/17/18 at 12:05 p.m., a tour was | A 1066 | procedures were followed to ensure safe patient care; the need to identify safety hazards for patients at risk for intentional harm including flexible shower hose extenders, plastic bags, corded bed alarms, and oxygen tubing to put processes in place to mitigate these risks; and the need to observe patients per hospital policies and procedures related to constant observation. The Hospital/MS leaders concurred with the GB's assessment of the major root causes for this deficiency.<br><br>C. Examine policies and procedures to identify new policies needed, revisions to same. P&P's related to: Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status, Assessment of the patient at Admission , Assessment and Management of a Patient Fall, Safety of the patient environment including: securing doors when patient is not in the room; monitoring and restricting equipment that could be used for ligatures including shower wands and oxygen tubing; banning plastic bags (including "baggies") from the patient units, and monitoring medication administration of patients to ensure that they completely swallow their medications so no "cheeking" occurs; lack of consistent level of oversight of the patient care environment for safety issues; and Incident Reporting including communication of same by staff to House Supervisors on unusual patient occurrences for the shift were assessed. A policy for Use of the ADA Showerheads was developed. The prohibition of baggies on the units was added to the policy and procedures for Patient Nourishments and Unit Safety Searches. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 114<br>conducted of the 200 unit with the quality coordinator (QC #1). The 200 unit was designated for patients who were 55 years or older. Review of the daily census indicated 10 patients were on suicide precautions. Patients were observed on the unit during the tour. Observation of room 202 revealed the door to the room was open and the room was not occupied, allowing access to all patients on the unit. Noted inside the bathroom shower of room 202 was a six foot flexible metal shower hose extender wand hanging from the shower arm (a piece of pipe which connected a standard overhead shower head to the bathroom wall). The hose extender wand was long enough for patients to utilize for self-harm or harm to others.<br><br>During a subsequent tour, on 7/24/18 at 12:54 p.m., RN #11 stated the shower wand was long and if it was left in a patient's room unattended it could be wrapped around a patient's neck.<br><br>On 7/18/18 at 12:25 p.m., a tour was conducted of the 400 unit with QC #1. The unit was designated for the high acuity adult patient population. According to the mental health technician on the unit, all patients on the unit were suicidal.<br><br>Observation of room 406 revealed no patients were currently in the room and the door to the room was open, allowing access to all patients on the unit. Noted inside the bathroom shower, was a six foot flexible metal shower hose extender hanging from the shower arm.<br><br>On 7/24/18 at 1:38 p.m. Chief Operating Officer (COO) #15 and DON #2 stated there was no formal check-out or check-in process for the shower heads. Before the survey the shower heads were kept in the supply closet and upon a patient's request they were given to the patient. There was no way to ensure how long the hand | A 1066 | D. Conduct training of pertinent Hospital and Medical staff on the above requirements. Pursuant to the findings, the following training was conducted for the corresponding Root Causes.<br>Root Cause # 1. Need for education of policies and procedures and evaluation of processes specific to:<br>(A)Levels of Observation of the patient<br>(1)All patient care Nursing Staff, Medical Staff as well as all Hospital Leadership who are responsible for making Patient Safety Rounds were re-educated on:- the requirements related to Constant Observation of the patient with the specific points of emphasis including that:<br>(a)Close Observation status , means the maintenance of a line of sight of the patient at all times with no more than three patients on close observation by one staff member at any given time, or above;<br>(b) Close Observation means constant visual line of sight of the patient including when they are in the bathroom or shower.<br><br>Standing outside of the patient's bedroom when the patient is in the bathroom does not afford a line of sight of the patient . (c) Close Observation shall be utilized for patients who are on oxygen, as ordered by the patient's physician or when utilizing other devices are in use by the patient that may pose a potential ligature risk . (d) In order to accomplish Close Observation on more than one patient and no more than three patients, the patients must be in a contiguous area whose view of the patient is unobstructed. (e) Documentation of this observation shall occur every 15 minutes. (f) Staff are never to leave the patient(s) on Close Observation without relief | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 115<br>held shower hoses had been left in an open room, unattended on units with patients who were suicidal.<br><br>c. On 7/18/18 at 1:28 p.m., a tour was conducted on unit 500, an adult unit. Observation of room 504 revealed a thermal hot pack in a plastic bag and a plastic chip bag in the patient's trash can. According to QC #1 the plastic bags were not supposed to be left in patient trash cans, as it could be used for self-harm. QC #1 was unsure why and how plastic bags were located in a patient's room. On review of the daily census the unit had 14 patients who were on suicide precautions.<br><br>d. On 7/19/18 at 10:22 a.m., a tour of unit 400 was conducted. Patients were noted to be on the unit. Observations of room 408 were conducted. The room was occupied by two patients. The patient in 408A had a medical condition which required the use of oxygen at night. The medical equipment included oxygen tubing and a machine, with an electrical cord, which provided the oxygen.<br><br>The patient in 408B had been admitted to the facility due to placing a noose around her neck in an attempt to kill herself. On review of the suicide risk assessment tool for the patient in 408B, dated 7/19/18, the patient was documented as a high suicide risk.<br><br>According to the policy, Unit Bed Assignment, roommates on medium or high suicide risk will not be placed with patients requiring medical equipment or other accommodations which pose a potential risk of harm, such as oxygen equipment.<br><br>An interview was conducted with the registered nurse (RN #4) who was in charge of nursing care for the unit. RN #4 stated she was unaware the two patients were sharing a room. RN #4 | A 1066 | (2)All patient care Nursing Staff as well as all Hospital Leadership who are responsible for making Patient Safety Rounds were re-educated on the requirements related to 15 minute checks with the specific points of emphasis that: (a)The check is to be accomplished within each 15 minute increment of time and recorded real time on the Patient Safety Check form; (b) That the ideal process is to vary when, within the 15 minutes that the staff reviewing the patient will return so that there is no predictability of same; (c) That if another work duty is assigned, the staff is to have a replacement assume the 15 -minute checks before leaving the patient care area. Patients are not to be left unattended; (d) That this expectation for completing 15 minute checks per requirements will be enforced through the Hospital's progressive disciplinary process.<br><br>(3)All patient care Nursing Staff as well as all Hospital Leadership were re-educated on the requirements related to 1:1 observation with specific points of emphasis on indications and how, while an RN may increase the level of monitoring of a patient, they may not decrease a patient's level of care without a Medical Staff order.<br><br>B)Assessment of the patient at Admission and Following a fall, including reporting and documentation expectations<br>(1)All Hospital and Medical staff who assess the patient on admission were inserviced on the expectation to: (a) On the patient's admission, the nurse completes an assessment of the patient that encompasses visualization of any areas that the patient reports have been | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

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|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 116<br>stated the admission and referral (A&R) department was in charge of bed assignments for patients and they would be aware of the patient's history when making room assignments. RN #4 stated the two patients should not be roommates due to the patient's suicide attempt by strangulation.<br><br>e. A tour was conducted on unit 200 at 3:37 p.m. on 7/19/18. RN #3 stated there were patients who were on suicide precautions on the unit. Observation of room 203 was conducted and revealed the door was open. Located on the bed was a corded bed alarm (a pad which will alarm and is commonly used to notify staff when a patient is trying to get out of bed) on the bed. Also a patient, not assigned to room 203, was observed entering and leaving the room unaccompanied. RN #3 stated the cord which was approximately five feet long presented a risk for patient harm and was not found during prior room checks.<br><br>On review of the facility risk assessment, Environment Of Care, dated 12/28/17, bed alarms were not identified as a risk; therefore there were no "strategies put into place." Additionally, no risk rating and recommendations for risk reduction had been identified.<br><br>f. On 7/21/18 at 11:06 a.m., a tour was conducted of the 600 unit with Chief Executive Officer (CEO) #6. The 600 unit was designated for adolescent patients, ages 12-18, who presented with psychiatric diagnosis and complaints. Observation of room 601 revealed a sharpened pencil located on the patient's bed. According to the daily census the patient in room 601 was on suicide precautions.<br><br>During the tour, an interview was conducted with RN #11, who was in charge of nursing care for the unit. RN #11 stated the patient should not | A 1066 | injured and that the medical provider's history and physical encompasses inspection within the physical exam of any areas of injury reported.<br><br>(2)All Nursing staff (RNs, LPNs and MHTs) who are involved in patient care were educated that, in the event of a patient injury (or possible injury including that of a patient fall), the following steps are to be taken in accordance with the policy and procedure entitled: "Care of the Patient after a Patient Injury" with emphasis on the following processes:<br>-Assess the situation.<br>- Assess whether or not the patient is injured<br>-Follow the acronym for "Airway, Breathing, Circulation" to ensure that the patient does not have a respiratory or cardiac emergency.<br>- Identify any bleeding and apply pressure to the site;<br>-Obtain patient vital signs;<br>-Do not move the patient's limbs, or change their position, especially if the patient complains of pain or a limb is being held in an unusual position unless for safety.<br>- Notify the House Supervisor immediately upon the event.<br>-Notify the patient's attending physician for any orders and document orders received or, if no orders given, document same. - Notify the patient's family, as approved by the patient.<br>Contact EMS.<br>-Continue to monitor the vital signs of the patient until EMS arrives.<br>- Interview any patients or staff who may have observed the event,<br>-Ensure that attending physician and/or Medical Provider see patient within 24 hours of patient injury, that they inspect | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| A 1066 | Continued From page 117<br>have a pencil, due to being on suicide precautions as it could be used as a way to self harm.<br><br>According to RN #11, the MHTs filled out the unit pencil check out form. A check out form from 7/20/18 was provided and reviewed. According to RN #11 this was the most recent pencil check out form for the unit. The form showed the patient had checked out the pencil on 7/20/18 at 12:35 p.m., with no check in time noted. This was 23 hours prior to finding the pencil in the patient's room.<br><br>Review of the 400 unit environmental checks, completed by the day shift MHT on 7/21/18 prior to the start of the shift, showed the unit had been inspected for contraband including items which could potentially be used for self-harm. There was no indication the pencil had been identified. | A 1066 | the areas of injury and that they document findings, conclusions, recommendations, actions.<br>-Treat all falls as potential sources of injury, even if there is a question of the patient's behavior contributing to the fall. This includes full assessment for injury as with any other patient fall.<br><br>( 3) All MS were apprised of this occurrence instructed on the need to pursue additional imaging studies (i.e. magnetic resonance imaging) when x-ray results are negative but with patient continued report of pain based on the incidence of false negative results of radiological studies. In support, studies show that X-ray missed a number of fractures and that MRI revealed many fractures undetected by X-ray as follows: 13 patients (14%) had 23 fractures (6 hip, 17 pelvic) undetected by X-ray but confirmed by MRI and 15 patients (16%) with X-rays that did reveal fractures had MRIs that depicted additional breaks missed by X-ray ("Inaccuracies Common in Diagnostic X-Rays for Hip and Pelvic Fractures" Nancy Fowler Larson; March 23, 2010 https://www.medscape.com/viewarticle/719016?pa=9TEh%2BEsvvN0UPRLj7%2BKMyVV1XZK59H0Beg7XAFpVinq0cg%2BOuRiefvDZ5jTERpIRX8MwC0EECwzp432Skuf9qw%3D%3D)<br><br>(4)All House Supervisors were instructed on the expectation to increase staffing in accordance with patient acuity. Such example includes instances of patient injury when either the patient is transported for evaluation and staff must accompany the patient or if the patient is retained and requires increased monitoring to assess for stability. | |

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|---|---|---|---|---|
| A 1066 | Continued From page 118 | A 1066 | C)Maintaining safety of the environment including: securing doors when patient is not in the room, monitoring equipment that could be used for ligatures including shower wands and oxygen tubing, banning plastic bags (including "baggies") from the patient units, monitoring medication administration of patients to ensure that they completely swallow their medications so no "cheeking" occurs, and unit rounds to ensure all safety measures are maintained.<br>(1)Securing Doors<br>(a) All patient care, EOC, and Housekeeping staff, were educated on the policy related to Patient Rooms with specific reference to expectations that the patient room doors are to be locked when the room is vacant or patients are out of the room; and that patients are never to be locked in their room.<br><br>(2)Monitoring Ligature Concerns<br>Shower Heads<br>(a)All patient care staff were instructed that all ADA shower heads were relocated to the med room and are now required to be checked in and out with the nurse using the "Removable Showerhead Check Out Sheet". Staff were also instructed that the ADA shower heads maintained on a unit, were now reduced to a total of one per each nursing unit for ease in counting their presence or absence.<br>(b) Staff were instructed that no patient on moderate to high level of suicide risk will be left alone with the ADA showerhead. Staff have been instructed to remain in attendance at all times that the ADA shower head is being utilized. Patients at low level of suicide risk are being maintained on the every 15- minute frequency of review and staff instructed | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1066 | Continued From page 119 | A 1066 | that this frequency is maintained even when the patient is located in the bathroom.<br>(c )Staff were instructed on the policy and procedure related to the patient's Use of the ADA showerhead" whereby they are to sign the ADA showerhead out for use on the and immediately back in (within 15 minutes of the completion of the patient's shower and, for patients on 15 minute checks, as the check is completed. The Nurse (RN or LPN) is now receiving the ADA showerhead and securing it in the Medication Room.<br><br>(3) Corded Fall Alarms<br>(a)All Fall alarms with cords were removed from Clear View Behavioral Health Hospital and patient care staff instructed that cordless alarms are to be used instead on a go-forward basis.<br><br>(4)Use of Oxygen with tubing<br>The Hospital's unit bed assignment policy was amended to state that patients on oxygen should not have a roommate on medium or high suicide risk without close observation status or above.<br><br>(a) Patients who have oxygen tubing should be monitored at least every 15 minutes to ensure safety of patients. Patient Care staff have, further, been instructed that: Close Observation status meaning, maintenance of a line of sight of the patient at all times with no more than three patients on close observation by one staff member at any given time, or above, shall be utilized for patients who are on oxygen, as ordered by the patient's physician. Documentation of this observation shall occur every 15 minutes | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| A 1066 | Continued From page 120 | A 1066 | (5)Discontinuation of use of Plastic Baggies in Pt. care areas<br>(a) While large plastic bags used as trash liners were banned from the unit some years ago, “baggies” used for sandwiches have now also been banned from patient care areas. All Dietary and Patient care staff have been apprised of this requirement through inservice or written memorandum.<br><br>(6) Patient Observation of Medication Administration<br>(a) All Nursing staff who administer medications and staff that monitor patients have been instructed on the expectations related to observing the patient following the administration of medications to ensure that no “cheeking” of medications occurs.<br><br>(7) Environmental Safety Rounds 3X per shift by MHTs<br>(a) All Nursing staff (RNs and MHTs) who are involved in patient care have been educated on the expectations related to ensuring a safe patient population and the expectations related to the MHT’s conduct of environmental safety rounds at the start, middle, and the end of every shift. The off-going MHT is rounding together with and signing off to the oncoming MHT to communicate that there are no patient safety hazards present on the unit, as delineated on the Environmental Safety Rounds check sheet. The oncoming MHT is then signing that they are accepting the unit and, in doing so, there are no patient safety issues of concern and all requirements are met, as delineated on the Environmental Safety check list for MHTs. | |

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|---|---|---|---|---|
| A 1066 | Continued From page 121 | A 1066 | 8) Hourly Rounds by RNs<br>Following the conduct of training for all RNs within nursing care units where patients are occupied on expected requirements for unit walkthroughs, RN unit rounds in patient care areas have been implemented to occur hourly in order to better ensure a safe patient environment and engage with the patients to assess for any pain, patient care concerns, or other issues, and to observe MHTs to ensure that they are completing their 15-minute checks and patient observation practices per policy. Realtime intervention is occurring on any unsafe item or situation seen and a notation placed by the RN on their rounds sheet that the physical environment has been secured or patient intervention has been made to ensure that object for<br><br>(a) potential self-harm has been removed or situation remedied. The RN is documenting these findings on the review form entitled: “Nursing Hourly Rounds”<br><br>(9)Ligature Risk Assessment<br>(a) Environmental Services and LS staff were instructed of the requirement to complete an updated ligature risk assessment conducted to assess all patient areas with special focus on patient rooms and bathrooms. This was accomplished.<br><br>(10)Environmental Safety Rounds 3X per shift by MHTs<br>(a) All Nursing staff (RNs and MHTs) who are involved in patient care were educated on the expectations related to ensuring a safe patient population and the expectations related to the MHT’s conduct | |

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|---|---|---|---|---|
| A 1066 | Continued From page 122 | A 1066 | of environmental safety rounds at the start, middle, and the end of every shift. The off-going MHT is now rounding together with and signing off to the oncoming MHT to communicate that there are no patient safety hazards present on the unit, as delineated on the Environmental Safety Rounds check sheet. The oncoming MHT is then signing that they are accepting the unit and, in doing so, there are no patient safety issues of concern and all requirements are met, as delineated on the Environmental Safety check list for MHTs.<br><br>(11)Hourly Rounds by RNs<br>(a) Following the conduct of training for all RNs within patient care areas on expected requirements for unit walkthroughs, RN rounds for all nursing units are now being conducted hourly in order to better ensure a safe patient environment. Realtime intervention is occurring on any unsafe item or situation seen and a notation placed by the RN on their rounds sheet that the physical environment has been secured to ensure that an object for potential self-harm has been removed or other situation remedied.<br><br>(12)Supervision of Rounding by MHTs and RNs<br>(a) 100% persons participating as House Supervisors and Administrators on Call (AOC) have been instructed on the requirement that they receive a report per shift on:<br>-the RN's evidence of hourly rounding and results of same, and -the findings from the daily monitoring of the environment by the MHT for any potential or actual breaches in safety and confirmation that actions have been taken to remove the | |

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|---|---|---|---|
| | 064027 | | 07/27/2018 |

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|---|---|
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|---|---|---|---|---|
| A 1066 | Continued From page 123 | A 1066 | unsafe item from the environment (Attachment “D”).<br><br>(D)Lack of completion of Incident Reports for all unusual events outside of the patient’s normal course of care- some which rose to the level and would have required a Critical Events Analysis.<br>(1) All Nursing staff (RNs, LVNs, and MHTs) who are involved in patient care have been educated on the expectations for communication of unusual patient events through the Incident Reporting system as well as for their need to fully document the event including description of the event, patient response, persons notified, actions taken and follow-up<br>(2) Nursing staff (RNs and MHTs) have been instructed on the expectation that a Root Cause Analysis is to be held for every patient event that leads to significant patient injury or that causes a substantial change in the patient’s treatment plan as per the definition in the policy and procedure on “Root Cause Analyses”<br>(3) The Nursing Supervisor report system has been revised whereby key events occurring on each unit are being conveyed on the report and its contents retained for comparison with the Incident Reports to ensure that all unusual events have been identified and addressed.<br>Root Cause # 2. The new Quality Coordinator was not familiar with all requirements related to the Critical Events Reporting and Analysis<br>-The Quality Coordinator was instructed by the VP Nursing/PI/Regulatory Affairs and the CEO and COO by the VP of Corporate Compliance on the requirements related to when a Root Cause Analysis (RCA) is expected. Included in these instructions is the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 124 | A 1066 | requirement that the meeting must be conducted within 30 days of knowledge of the event and that the VP of Corporate Compliance or VP Nursing/PI/Regulatory Affairs must be on the call or present at the meeting to ensure all elements are addressed.<br>-A requirement was implemented that all patient injuries or sentinel events that occur at the Hospital will be reported by the Quality Coordinator to the VP of Corporate Compliance or VP Nursing/PI/Regulatory within 24 hours of receipt of notification of the event for tracking of completion of the Sentinel Event.<br>3-Sentinel event meetings were held for the patient safety issues raised including the patient with an injury that was transferred to the ED and the patient who attempted self harm with a sheet while in the bathroom and the patient who swallowed the baggie.<br><br>Root Cause #3. The Director of Nursing was challenged with the temporary oversight of the two Colorado facilities due to the recent departure of the former Director of Nursing for Clear View Behavioral Health.<br>Pursuant to this observation, a fully dedicated Interim Director of Nursing for Clear View Behavioral Health was identified and put in place and trained on the requirements related to the deficiencies noted in this Plan of Correction. This position will remain in place until a new Director of Nursing for Clear View Behavioral Health has been selected and oriented. The Director of Nursing for Peak View Behavioral Health will support the efforts of this Interim DON as she adjusts and responds to the patient care needs that were identified | |

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|---|---|---|---|---|
| A 1066 | Continued From page 125 | A 1066 | during this survey.<br>D. E. A daily Monitoring and Evaluation (M&E) activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems as delineated below.<br><br>3. The Monitoring and tracking procedures that will be implemented to ensure that PoC is effective and that the specific deficiency cited remains corrected and in compliance.<br>Performance indicators to assess for compliance with these requirements have been implemented as follows:<br>(1.) Staff's Adherence to Policies and Processes<br>(A) Levels of Observation<br>To ensure compliance with the levels of observation, using the form entitled: "Nursing Hourly Rounds", RN rounds are being conducted hourly on patient care units where patients are occupied to better ensure a safe patient environment including compliance with patients on all levels of observation. Realtime intervention is occurring on any Level of Observation not being accomplished per requirement whereby the RN or trained delegate intervenes and accomplishes the required observation (15-minute checks, Constant Observation, or 1:1) to ensure the patient's safety until another staff member can be obtained. A notation of this intervention is being placed by the RN on their rounds sheet that the patient observation has been accomplished and the patient is safe. The rounds sheets are being submitted to the House Supervisor at the end of each shift to ensure their completion.<br>1. ( B) Assessment of the Admitted Patient and Assessment of patients post | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
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|---|---|---|---|---|
| A 1066 | Continued From page 126 | A 1066 | falls<br>Compliance with assessment of a patient assessment and post fall is being monitored as follows:<br>Patient Assessments<br>100% of Medical Records of patients admitted are being reviewed by the DON or trained delegate to assess for presence of patient report of pain injury. Patient reports of pain or injuries are assessed against evidence per documentation of inspection and examination of the site by (a) the Nurse and (2)the MS member<br>Patient Falls<br>30 Medical Records are being assessed per month against Incident reports received to ensure that incident reports were received for all patient falls. .<br>Patient Falls with Injury<br>100% of Medical Records of patients sustaining injury and requiring transfer to the ED for medical evaluation after an injury OR for a decline in medical condition will be reviewed by the Medical Staff's Credentials/Peer Review Committee with the (Interim) Director of Nursing as an attendee to determine:<br>(a) Was the process for management of the patient injury followed as delineated in Steps a-n?<br>(b) Was there timely notification of the patient's provider by the nursing staff of the patient occurrence?<br>(c) Was there timely assessment of the patient by the patient's attending physician or the patient's medical provider a notation of any injuries and actions taken?<br>(d) Was there a timely recognition in any decline in the patient's condition and appropriate response by the Medical and Nursing staff of this decline?<br>C) Maintaining safety of the environment<br>Patient doors<br>RN rounds are being conducted hourly | |

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|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| A 1066 | Continued From page 127 | A 1066 | using the Nursing Hourly Rounds sheet in patient care areas to ensure that the patient room doors are locked per requirements. Documentation of review for compliance with this requirement is being accomplished by the RN. Realtime and intervention is occurring on any rooms that are open but vacant to better ensure the patient's safety. A notation of this intervention is being placed by the RN on their rounds sheet that the patient room door was found unlocked but secured per requirement. The rounds sheets containing review of compliance with the locked doors when the rooms are vacant is being submitted to the House Supervisor at the end of each shift to ensure their completion. The results of the daily rounding by RNs to assess for compliance with Patient Safety items including compliance with doors being locked when patients are not present is being forwarded to the DON and presented at the Morning Meeting of Hospital Leaders, M-F. On nights and weekends, the results from the completion of the rounding f or compliance with patient doors being locked when patients are not present is being communicated to the AOC who then submits the findings to the DON for the aggregation of results. Additionally, the results of the daily rounding by the Hospital Leadership, which encompasses observation that patient room doors are locked when vacant, is being forwarded to the COO. On nights and weekends, the results from the completion of the rounding by the Hospital Leadership is being communicated to the AOC who then will forward same to the COO (see discussion below on reporting of results).<br><br>Monitoring to ensure restriction of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 128 | A 1066 | equipment posing a potential ligature including shower wands and oxygen tubing and that might pose a choking or overdose hazard including plastic bags “baggies” and lack of compliance with medication administration processes. MHTs are completing a unit round using the form entitled Environmental Checks by MHTs to assess environmental safety at the start, middle, and end of their shift to look for ligature and patient safety hazards. Any items identified are being immediately removed from the environment and an incident report made of the occurrence. The oncoming MHT is being required to round with the off-going MHT to “accept” the unit, and sign that the unit has been accepted and, in doing so, is designating that the unit is free from any patient safety items as delineated on the check sheet. This assessment is being accomplished on a daily basis. Because of the importance of this issue, staff found out of compliance with completing this procedure and maintaining the requirements are being addressed on a progressive disciplinary basis. Additionally, on nights and weekend shifts, these findings are being collected by the House Supervisor and communicated by the House Supervisor to the Administrator on call as well as communication that actions have been taken to remove any identified unsafe items from the environment. Using the same Environmental Check form by MHTs, the same monitoring process is being applied to ensure there are no Corded Fall Alarms, that patients on oxygen do not have a roommate on medium or high suicide risk without close observation status, that there are no plastic bags including baggies in the patient care environment. RNs are | |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| A 1066 | Continued From page 129 | A 1066 | conducting hourly rounds (using the Nursing Hourly Rounds) to ensure compliance with safety requirements using their newly developed standardized patient safety tool. Environmental Safety rounds of the MHT and RN are being submitted each day to the House Supervisor to be forwarded to the DON for aggregation, analysis and report of findings, as described below.<br><br>Assessment for compliance with patients taking medications per policy<br>Pursuant to the findings related to a patient stating that she had been cheeking medications, compliance with the aspect of the medication administration process related to observation of the patient is being accomplished as follows:<br><br>In each nursing area, the (Interim) Director of Nursing or trained delegate is now observing patients in person or per camera on a daily basis that are being administered medications to assess for compliance that the patient's mouth is being checked to ensure that no "cheeking" occurs post medication administration. The results of the assessment for the compliance with requirements is being forwarded presented by the (Interim) Director of Nursing for aggregation and analysis as described following this delineation of indicators.<br><br>D) Monitoring for compliance with staff's consistent completion of Incident Reports<br>On a Monday through Friday basis, the DON or trained delegate and Director of Compliance/ Quality/ Risk are comparing the unusual events captured on the Supervisor's report to the Incident Reports received to ensure that all patient events | |

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|---|---|---|---|
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|---|---|---|---|---|
| A 1066 | Continued From page 130 | A 1066 | have been properly annotated in the patient's Medical Record, through the Incident Report System, and to conduct any required Root Cause Analysis meetings.<br><br>The Quality Coordinator is summarizing these findings and presenting same to the Morning Meeting of Hospital Leadership results from Friday, Saturday, and Sunday are being incorporated into Monday's meeting). Staff found out of compliance are being addressed on a progressive disciplinary basis.<br><br>On nights and weekends, the House Supervisor is assessing for the receipt of information related to unusual patient events during shift reports and comparing to the receipt of Incident Reports, that are completed and received (by the end of the shift) and forwarded to the Quality Coordinator<br><br>(2.) Monitoring to ensure Quality Coordinator is compliant with Critical events reporting and analysis process<br><br>All patient injuries or sentinel events are now being reported by the Quality Coordinator to the VP of Corporate Compliance or VP Nursing/PI/Regulatory within 24 hours of receipt of notification of the event for tracking of completion of the Sentinel Event. VP Corporate Compliance or VP Nursing/PI/Regulatory Affairs is now required to be present on the call or at the RCA meeting to ensure all elements are addressed.<br><br>(3.) Compliance with Dedicated Director of Nursing at Clear View Behavioral Health | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 131 | A 1066 | The Chief Executive Officer is monitoring and reporting to the Regional Vice President on a monthly basis that there is an Interim Director of Nursing dedicated to the Clear View Behavioral Health at all time until a specific Director of Nursing for Clear View Behavioral Health is named. The status of this position is being reported at the monthly Quality/PI Council Meeting and the quarterly Governing Board meetings<br><br>Using the indicators, as noted above, data collection and analysis is being conducted on a daily basis (S-S) with the exception of the indicator on falls where 30 Medical Records are being assessed per month against Incident reports received to ensure that incidentreports were received for all patient falls and the CEO's report on the selection and hire of a permanent Director of Nursing, the findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday.<br><br>To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to these indicators under review to assess for compliance with the corrective actions taken pursuant to these deficiencies are being presented at this meeting to ensure evidence of effectiveness in the corrective actions taken and to determine if additional actions need to be taken. The findings are being aggregated by the Quality | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| A 1066 | Continued From page 132 | A 1066 | Coordinator and being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings.<br>This M&E process will continue indefinitely as these are high risk areas if processes are not correctly followed.<br><br>4. Title of person responsible for implementing the acceptable plan of correction:<br>B. (1) Staff's lack of adherence to P&P's and processes<br>(a)Adherence and knowledge of the associated policies and procedures for: Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status:<br>Responsible Person: (Interim) Director of Nursing<br><br>(b)Assessment of the pt. Admission and Following a fall, including falls assessment, reporting and documentation expectations even when a patient is repeatedly precipitating the fall;<br>Responsible Person: (Interim) Director of Nursing<br>c)Maintenance of safety of the environment including: securing doors when patient is not in the room, monitoring and restricting equipment that could be used for ligatures including shower wands and oxygen tubing, banning plastic bags (including "baggies") from the patient units, and monitoring medication administration of patients to ensure that they completely swallow their medications so no "cheeking" occurs, lack of consistent level of oversight of the patient care environment for safety issues; and (d)Lack of staff's consistent | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| A 1066 | Continued From page 133 | A 1066 | completion of Incident Reports for all unusual events outside of the patient's normal course of care- some which rose to the level and would have required a Critical Events Analysis. Lack of verbal communication by staff to House Supervisors on unusual patient occurrences for the shift.<br>Responsible Person: (Interim) Director of Nursing<br><br>(2)Compliance with all requirements of the Critical events /Reporting & Analysis process.<br>Responsible Person: Quality Coordinator<br><br>(3) Individual Director of Nursing for oversight of Clear View Behavioral Health.<br>Responsible Person: Chief Executive Officer<br><br>Overall person responsible for the implementation and monitoring of all elements: Quality Coordinator<br><br>5.<br><br>GB meeting held:<br>7/17/18<br>7/18/18<br>7/19/18<br><br>GB/LS meeting held:<br>7/17/18<br>7/18/18<br>7/19/18<br>Policy review:<br><br>Staffing analysis started<br>7/19/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| A 1066 | Continued From page 134 | A 1066 | Training on EOC safety conducted:<br>7/20/18<br>7/24/18<br><br>Training of QC Coordinator:<br>7/26/18<br>7/30/18<br><br>M&E started:<br>8/1/18<br><br>PI meeting with GB attendance started on:<br>9/14/18<br><br>All items in place as of<br>09/21/2018<br><br>Policy review<br>7/18/18-7/20/18<br><br>Training on Patient Safety Rounds<br>7/31/18<br>8/1/18<br>8/7/18<br><br>Training on 1:1 s<br>7/31/18<br><br>Assessment of the patient at Admission and following a fall<br>7/25/18<br><br>Training on steps to take in the event of a patient injury/fall<br>7/25/18<br><br>Levels of Observation training<br>7/20/18<br>7/24/18<br>7/31/18<br><br>Staffing grid and indications for increasing staffing<br>8/1/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| A 1066 | Continued From page 135 | A 1066 | Training on securing<br>Doors<br>8/1/18<br><br>Training on safety procedures in the use of<br>Showerheads<br>7/20/18<br>7/24/18<br><br>Safety measures with<br>Corded alarms<br>7/20/20/18<br><br>Safety measures wtih<br>Oxygen tubing<br>7/20/18 &<br>7/24/18<br><br>Baggies discontinued<br>8/15/18<br><br>Process to assess if patients are cheeking medications started<br>8/16/18<br><br>Environmental safety rounds of MHTs started<br>8/1/18<br><br>Process for hourly rounding by RNs<br>8/1/18<br><br>Risk Assessment completed:<br>08/01/2018<br><br>Environmental<br>Safety rounds by MHTs<br>8/1/18<br><br>Hourly Rounds by RN<br>8/1/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| A 1066 | Continued From page 136 | A 1066 | House Supervisor rounding for patient safety in place as of:<br>8/1/18<br><br>Training on<br>Communication of incidents<br>7/25/18<br><br>Training on RCAs<br>7/25/18<br><br>Training of Quality Coordinator<br>7/26/18 and<br>7/27/18<br><br>Management and reporting of patient injuries to Hospital Corp.<br>implemented<br>7/27/18<br><br>Interim DON/IC Nurse in place<br>8/6/18<br>(oriented 7/25-27/18)<br><br>M&E activities all in place as of:<br>8/1/18 | |
| H 1201 | IV.12.101(1) Nursing: Providing Service<br><br>There shall be a nursing department. The nursing department shall be organized formally to provide complete, effective care to each patient.<br><br>This REGULATION is not met as evidenced by:<br>Based on observations, interviews and document review the facility failed to adjust nursing personnel staffing to accommodate patient care needs for 13 of 13 records reviewed | H 1201 | 1. The procedure for implementing the Plan of Correction (PoC), for each deficiency | 09/21/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 1201 | Continued From page 137<br>(Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13). This resulted in an unwitnessed suicide attempt while a patient was on constant observation status (Patient #13). The facility failed to ensure 15 minute patient safety checks were completed as ordered for all records reviewed. The facility failed to ensure adequate housekeeping staff was maintained to perform sanitization of the facility, but instead placed the housekeeping duties and the patient care duties on the mental health technicians without providing extra resources to accommodate the extra workload. Additionally, the facility failed to ensure nursing groups were provided consistently to provide health-related education and support the improvement of psychiatric symptoms and skill development for patients in 9 of 13 medical records reviewed (Patients #1, #2, #3, #4, #5, #6, #7, #8, #11) and failed to provide regular showers or baths to patients in 6 of 6 medical records reviewed for patients on the geriatric (200) unit (Patients #1, #3, #4, #5, #6, and #9). These multiple failures affected all patients receiving care in the facility.<br><br>Policy:<br><br>The Staffing Plan for Provision of Care policy read, nursing staffing will be sufficient to promptly recognize untoward changes in a patient's condition and to intervene appropriately utilizing nursing, medical or hospital staff and shall be based upon identified minimum staffing requirements by unit, actual patient needs asses through use of the acuity tool. This acuity staffing system shall be based upon objective assessment tools which qualify the number of nursing staffing members needed to fulfill patient needs on each unit. The procedure for staffing is as follows, the staffing plans for the unit are on file in the charge nurse binder in the nurses station. Staffing is based upon patient census and acuity. Staffing schedules for the nursing department to include registered nurses | H 1201 | A. A Governing Board meeting was held to discuss<br>the findings from the survey related to the following nursing-related issues that were identified: -Failure of the facility to adjust nursing personnel staffing to accommodate patient care needs; -Failure to ensure 15 minute patient safety checks were completed as ordered for patients reviewed.-Failure to ensure adequate housekeeping staff was maintained to perform sanitization of the facility, but instead placed the housekeeping duties and the patient care duties on the mental health technicians without providing extra resources to accommodate the extra workload. -Failure to ensure nursing groups were consistently provided; -Failure; to provide evidence of regular showers or baths to patients.<br>The root causes for this deficiency were identified as follows:<br>1.) Not all patient care staff were properly adhering to or all leadership aware of requirements specific to the following hospital policies and procedures and guidelines: (A)P&P on Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status; (B) Staffing guidelines; (C)Policy on Patient Schedules, (D) P&P on Patient Hygiene/Showers for the patient who needs assistance, (E) Provision of nursing care of the patient. 2) Shortage in Housekeeping personnel resulted in MHTs being asked to assume some related duties. 3)This, coupled with the unauthorized use by the Lead MHT to have MHTs go on trips, led to MHT staffing occurring under plan, for some units/shifts and groups not occurring per schedule or patient observations per | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 1201 | Continued From page 138 | H 1201 | | |

and mental health technicians. Variances between projected needs and actual staffing are described, acknowledged and justified according to census and acuity. The provision of nursing care is evaluated on an annual basis as a preliminary activity to the budgeting process.

The Hospital Plan for Provision of Nursing Care policy read, staffing, both in numbers and competency, will be sufficient at all times to ensure, emergency and safety requirements for patient care are met.

The Observation policy read, a minimum of fifteen-minute observations is required for all patients. The patient is observed at minimum, every fifteen minutes by a designated staff member to monitor for safety, behavioral changes and to indicate clients location.

The Levels of Observation policy read, the purpose was to ensure a safe environment for the patients within the facility. Line of sight (LOS) patients must be in sight of a staff member at all times and 15-minute checks documented. When a patient uses the restroom the staff member must remain outside the door and visually check the patient. The safety of the patient must be the main consideration. Staff assigned to LOS must hand-off responsibility for maintaining observations of the assigned patients.

The Program Therapies Overview policy read, therapies would have been available to all patients in the program. The program offered a variety of therapeutic services for individuals aged 12 and older who suffer from acute or chronic psychiatric disorders. Each patient received care from an interdisciplinary team of mental health professionals. Under the direction of a psychiatrist, members of the team include psychologists, psychiatric nurses, therapists, mental health technicians, dieticians, and

requirements. Actions were proposed to correct this deficiency including: (A)Training on the P&Ps related to Patient Levels of Observation, Patient Schedules, Patient Hygiene, and Provision of Nursing Care; (B)Obtaining a contract for a cleaning company to service the hospital until the housekeeping staffing was, again, at full par and the practice of using MHTs on specific days to function as housekeepers was discontinued; and (C) the revision of the Staffing guidelines to make them more specific regarding when staffing is to be increased and to enforce that other departments cannot take MHTs off of the schedule for housekeeping or outside trips.

B. A meeting was conducted between the GB and Hospital/MS leaders to review the findings as noted in “A” of 392 and to convey the following expectations: The need to consistently staff the nursing units according to patient needs and acuity;-The need to ensure 15 minute patient safety checks are done on a consistent basis; -The need to not utilize MHTs beyond the patient care capacity without providing the extra resources needed to accommodate the additional workload and need to require trips to go through the DON versus allowing the Lead MHT to take MHT’s off of the units for trips; -the need to ensure nursing groups are provided consistently and per schedule; and the need to provide evidence that patient hygiene per regular showers or baths is being provided to patients who need assistance with same. The LS group concurred with the identified root cause and added as a root cause the lack of a dedicated nursing leader available to the one site since the departure of the prior DON and the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: CLEAR VIEW BEHAVIORAL HEALTH | | STREET ADDRESS, CITY, STATE, ZIP CODE: 4770 LARIMER PARKWAY JOHNSTOWN 80534 | |

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|---|---|---|---|---|

H 1201

Continued From page 139

recreation therapists who assess the patient's needs, develop an individualized treatment plan to address those needs and implement the therapy program.

The Bathing of Patients policy read, staff were to assist patients who were unable to be independent with their bathing needs and to assist and encourage independent patients to maintain appropriate personal hygiene practices. Patients who needed assistance had staff assist with hygiene needs as required, including offering a shower/bath every other day or as needed if indicated. Document the completion of a bath in the patient medical record.

References:

According to the staffing matrix provided by the Director of Nursing, unit 200 will have one nurse and two mental health technicians. Unit 300 will have one nurse and two mental health technicians. Unit 400 will have one nurse and two mental health technicians. Unit 500 will have one nurse and two mental health technicians. Unit 600 will have one nurse and one mental health technicians. Unit 700 will have one nurse and one mental health technician.

The inpatient group therapy daily schedule established the theme for all groups offered on a given day of the week for each of the hospital's 4 units. While the schedule was different for each unit, every unit was scheduled for a daily nursing group to teach and reinforce health-related topics and led by the nurse.

In addition, the mental health technicians (MHTs) were scheduled to lead six groups each day on each unit: goal group (to set individual goals for the day), topic group (to explore the theme of the day through guided discussion and activity), structured exercise (to reinforce

H 1201

experience of challenges in filling the position. This group added as an expectation and action step the selection of an Interim dedicated DON for the Hospital

C. Policies were examined to identify the need for new polices or the revision of existing ones. The following were reviewed:
The P&P on Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status;
Patient Hygiene, and Provision of Nursing Care. The policies were retained and were not revised as the source of this deficiency was attributed to lack of compliance with the policies, as written.
A contract was obtained for housekeeping personnel to service the hospital until the housekeeping staffing was, again, at full par and the practice of using MHTs on specific days to function as housekeepers was discontinued;
An Interim Director of Nursing (DON) was obtained to serve in a dedicated role to the Hospital until a permanent DON is identified and oriented to his/her role.
The Staffing guidelines were revised to make them more specific regarding when staffing is to be increased as follows:
1.The baseline staffing on all units at Clear View Behavioral Health is as follows:
Unit 200 – Geriatric -16 beds
Days and nights
1-9 patients = 1 nurse, 1 MHT
10-16 = 1 nurse , 2 MHT's
Unit 300 – Closed – 16 beds
Days and nights
1-9 patients = 1 nurse, 1 MHT
10-16 = 1 nurse, 2 MHT's
Unit 400 –Adult– 18 beds

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 1201 | Continued From page 140<br>healthy outlets for emotions), journal time (to provide a time of quiet reflection through journaling), community meeting (to discuss milieu-related topics), and wrap up group (to reflect back on daily goals and progress made during the day).<br><br>1. The facility failed to ensure necessary staffing to meet the needs of patients to include constant observations of patients. This resulted in an unwitnessed suicide attempt while the patient was on constant observation status (Patient #13).<br><br>a. On review of Patient #13's medical record, the patient was transferred to the facility on 7/15/18, after she stated she was going to kill herself. On 7/15/18 at 9:24 a.m., a comprehensive psychosocial assessment was completed. Patient #13 was documented as depressed and anxious and endorsing suicide with a plan to hang herself, cut herself or overdose on medication. At 9:47 a.m., a risk evaluation was completed and Patient #13 was identified as an imminent risk for suicide.<br><br>Review of the psychiatric progress notes, dated 7/21/18 and 7/23/18, revealed Patient #13 continued to endorse suicide with a plan but she would not disclose the plan.<br><br>On 7/22/18 at 10:50 p.m., the registered nurse (RN) documented in the progress note, Patient #13 reported suicidal thoughts with a plan to overdose on medications. The patient reported she had "some pills saved up that I was going to take." The patient then gave the RN a crushed yellow powder substance rolled up in a paper wrapper. When asked what pills they were, the patient reported they were "mine and other peoples." Patient #13 identified the crushed medications as Vistaril (an anti-anxiety medication), Xanax (used to treat anxiety and panic disorder) and Ativan (used to treat anxiety | H 1201 | Days and nights<br>1-9 patients = 1 nurse, 2 MHT<br>10-18 = 1 nurse, 2 MHT's<br>Unit 500 –Adults – 18 beds<br>Days and nights<br>1-9 patients = 1 nurse, 1 MHT<br>10-18= 1 nurse, 2 MHT's<br>Unit 600 (14 beds) /700 (10 beds) – Adolescent – 24 beds<br>1-9 patients = 1 nurse, 2 MHT's<br>10-24 = 1 nurse 2 MHT's<br>This basic grid is maintained if patients meet the following criteria over the past 1-2 shifts:<br>-Are able to perform own ADL's<br>-No command hallucinations<br>-No impulsive behaviors<br>-15 minute checks<br>-No current history of active SI or self harm while in the hospital<br>-No aggressive behaviors<br>-No medical dressings/care<br>Guidelines for Increasing Staff to the Core staffing:<br>Additional MHT(s) is (are) added to each unit in the following situations:<br>- A patient is on 1:1 level of observation for danger to self or others<br><br>-A Constant Observation level is required for patients displaying disruptive, actively psychotic, or aggressive or impulsive behavior on the unit, or who are at medium suicide risk. Note: One MHT can perform Constant Observation on up to only 3 patients if they are located within the same area and if none of the other patient parameters are met within the three Constant Observation patients that they are caring for, as delineated below)<br>-The patient has required more than two episodes of Seclusion or Restraint or Codes for the shift<br>-The patient needs transfer to the ED for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 1201 | Continued From page 141<br>with sedative properties). The RN documented Patient #13 had been "cheeking [pretending to swallow medications while hiding them in the mouth] random medications."<br><br>On 7/23/18 at 8:30 a.m., the physician ordered Patient #13 on line of site observation.<br><br>According to the policy, Levels of Observation, line of sight patients must be in sight of a staff member at all times. When the patient uses the bathroom the staff member will remain outside the bathroom door and visually check on the patient. Staff assigned to line of site (LOS) observation must hand-off responsibility for maintaining observation of the assigned patient.<br><br>b. On 7/24/18 at 12:20 p.m., an incident report documented the patient was found in her bathroom with a blanket tied around her neck which was attached to the toilet seat. The patient attempted to strangle herself after ripping off her scabs causing her to bleed.<br><br>Review of the daily census for 7/24/18, the day in which Patient #13 attempted suicide, revealed the unit had a total of seven patients; two patients were on LOS observations, Patient #13 and Patient #B. There were only two mental health technicians (MHTs) assigned to the unit to perform the constant LOS duties, group therapy and continuous monitoring of all other patients on the unit.<br><br>c. During an interview, on 7/25/18 at 3:44 p.m., Mental Health Technician (MHT) #20 stated she was providing line of site (LOS) observation for Patient #13 when she attempted suicide on 7/24/18 at 12:20 p.m. In addition, her duties included conducting 15 minute safety checks for all other patients on the unit and conducting group therapy. MHT #20 stated it was busy.<br><br>MHT #20 stated Patient #13 was in her room | H 1201 | further care<br>-More than one patient requires full assistance with ADL's during the shift<br>-The patient is fully dependent on others for their care needs<br>This (these) additional MHT (s) may concomitantly serve as the person on the CO or the 1:1 status and a patient with the other patient parameters (excluding CO or 1:1) described as long as only one patient is assigned to this MHT staff member.<br><br>**What was intended as this statement is that the same MHT who is serving on a 1:1 or Constant Observation (CO) status may provide the activities of daily living (shower/bath) of the patient who needs assistance and an additional MHT is not needed to perform those duties for the specific patient as long as the MHT continues to fulfill the responsibilities of the 1:1 or CO status. While implied by the definition of a CO status, if the MHT is performing ADLs on a patient who is on CO, they would not be expected to perform CO status of any other patients at the same time as the line of sight requirement could not be met.<br><br>To further clarify the intent of this statemen, if a MHT is being added to assist with ADLs on a patient on the unit, and that patient is not on CO or 1:1 status, the MHT may assist with ADLs for more than one patients.<br><br>If the MHT is not being added due to the need of 1:1 or CO status, they may care for more than one patient.<br>An additional nurse is added per each unit in any of the following situations:<br>-At least one patient has complex medical | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 1201 | Continued From page 142<br>when a therapist came in to speak with the patient, at which point the MHT left the room and carried on with other unit duties. When MHT #20 noticed the therapist had left Patient #13's room she went to check on the patient, who was already in the restroom. MHT #20 stated Patient #13 took the "opportunity" to go to the restroom with a blanket. MHT #20 stated there was no hand off or report done between her and the therapist at anytime. MHT #20 stated she was not aware if the therapist knew Patient #13 was on LOS observation.<br><br>MHT #20 stated she did not follow the patient into the restroom or visually check on Patient #13, but instead stood at the hallway door of the patient's room and did a verbal check by calling the patient's name and waiting for a response. MHT #20 then continued her duties of monitoring the hall for other patients at the same time and stated "it was hard."<br><br>This was in contrast to the observation policy, which stated the staff member would visually check on patients when they were in the bathroom to ensure patient safety.<br><br>MHT #20 stated when the patient failed to respond to a verbal check, she went into the restroom and found the patient with a blanket tied around her neck.<br><br>d. On 7/26/18 at 1:59 p.m., an interview was conducted with Director of Nursing (DON) #2. DON #2 stated facility policy did not indicate how many patients requiring LOS precautions one staff member could safely observe at one time; however, she felt three LOS patients for one staff member was appropriate. DON #2 was unable to explain how one staff member would be able to accomplish the LOS duties for all three patients if patients were in different rooms and different areas on the unit simultaneously. | H 1201 | care needs requiring frequent nursing assessment, dressing changes, breathing treatments, or more<br>-Two or more patients are on complex or large volumes of medications to be administered during the shift (10 or more-seen on the Gero unit, at times)<br>-Psychiatric patient complexity exists on the unit whereby there are multiple concomitant episodes of Seclusions or Restraints, 1:1's and Constant Observation episodes and patient acting-out behaviors occurring.<br>--CIWAS or other protocols are required on more than one patient per shift.<br>The additional nurse may address multiple patient parameters, as delineated above and is not restricted to only addressing one of these patient situations. The Hospital will use this staffing guideline to staff the hospital and continue to replace any unfilled positions to ensure compliance with same.<br><br>D. Group schedules for all units were reviewed for accuracy and re-printed and re-posted.<br><br>E. Training was conducted for all pertinent Nursing staff on the following: expectations for compliance specific to staffing, compliance with 15 minute checks, Constant Observation, and 1:1 status; not utilizing nursing staff for non-nursing duties without providing extra resources to accommodate the extra workload and not taking MHTs off units for trips or housekeeping; nursing groups occurring, as scheduled; and patient hygiene requirements for patients who need assistance with baths/showers and documentation of such.<br><br>F. A daily Monitoring and Evaluation | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 1201 | Continued From page 143 | H 1201 | | |

2. The facility failed to ensure 15 minute patient safety checks were completed as ordered for all records reviewed.

a. Review of Patient #8's medical record revealed the patient was admitted on 6/3/18, after she stated she was going to break her neck in an attempt to kill herself. On 6/3/18 at 12:16 p.m., a comprehensive psychosocial assessment was completed. Patient #8 was documented as manic and euphoric. Patient #8 was placed on every 15 minute safety checks.

Review of the safety check reports for Patient #8 showed a total of 110 safety checks were documented as being missed from 6/3/18 until the patient was discharged on 7/3/18 at 10:09 a.m. Examples of missed checks included:

On 6/4/18 at 3:18 a.m., the patient was checked on. The next check was documented 24 minutes later at 3:42 a.m. by Registered Nurse (RN) #22. RN #22 continued to document every 15 minute checks until 7:47 a.m. during which time three more safety checks were missed. The reason for the missed every 15 minute safety checks was documented as "unit disruption". Review of the daily shift assignment for 6/4/18 showed RN #22 was assigned to medications, admissions, discharges, code blue response and hall monitor from 5:00 a.m. until 7:30 a.m. There was no MHT or additional staff scheduled from 5:00 a.m. until 7:30 a.m. for the unit.

On 6/12/18 at 4:49 p.m., Patient #8 had a documented safety check. The next check was not documented until 54 minutes later at 5:43 p.m. The reason for the missed interval was "unit disruption."

On 6/24/18 at 6:31 a.m. a safety check was documented. The next check was documented 24 minutes later at 6:55 a.m. with the reason for

activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems, as delineated below.

2. The procedure for implementing the Plan of Correction (PoC), for each deficiency

A. A Governing Board meeting was held to discuss
the findings from the survey related to the following nursing-related issues that were identified: -Failure of the facility to adjust nursing personnel staffing to accommodate patient care needs; -Failure to ensure 15 minute patient safety checks were completed as ordered for patients reviewed.-Failure to ensure adequate housekeeping staff was maintained to perform sanitization of the facility, but instead placed the housekeeping duties and the patient care duties on the mental health technicians without providing extra resources to accommodate the extra workload. -Failure to ensure nursing groups were consistently provided; -Failure; to provide evidence of regular showers or baths to patients.
The root causes for this deficiency were identified as follows:
1.) Not all patient care staff were properly adhering to or all leadership aware of requirements specific to the following hospital policies and procedures and guidelines: (A)P&P on Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status; (B) Staffing guidelines; (C)Policy on Patient Schedules, (D) P&P on Patient Hygiene/Showers for the patient who needs assistance, (E) Provision of nursing care of the patient. 2) Shortage in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|

H 1201

Continued From page 144

the missed check as "RN only one on the floor taking vitals". Review of the daily shift assignments, for 6/24/18, revealed no staff were assigned to complete the safety checks and hall monitoring from 7:00 p.m. until 9:00 p.m. and then again from 1:00 a.m. until 7:30 a.m.

This was in contrast to the staffing matrix provided by the DON, which stated the unit should have one MHT and one RN at all times.

b. On 7/25/18 at 7:54 a.m., an interview was conducted with RN #10 who documented the missed patient safety checks on 6/24/18. RN #10 stated 15 minutes checks were done for safety, to include making sure patients were not attempting to hurt themselves or someone else.

On review of Patient #8's safety checks for 6/24/18, RN #10 stated the mental health technician (MHT) was needed for another unit which left her as the sole staff member for the unit. RN #10 stated this was not the first time she had been left alone on the unit. RN #10 stated staffing was a concern due to turnover with nursing and MHTs.

On 7/26/18 at 1:59 p.m., an interview was conducted with Director of Nursing (DON) #2. DON #2 stated there should be at least one RN and one MHT on the unit at all times. This was also outlined in the staffing matrix provided earlier by DON #2.

DON #2 reviewed the daily shift assignment from 6/24/18 and stated she was unaware RN #10 was the only staff member on the unit for all patient care and stated "it was not best practice."

c. On review of Patient #5's medical record, the patient was admitted on 3/17/18 due to worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic.

H 1201

Housekeeping personnel resulted in MHTs being asked to assume some related duties. 3)This, coupled with the unauthorized use by the Lead MHT to have MHTs go on trips, led to MHT staffing occurring under plan, for some units/shifts and groups not occurring per schedule or patient observations per requirements. Actions were proposed to correct this deficiency including: (A)Training on the P&Ps related to Patient Levels of Observation, Patient Schedules, Patient Hygiene, and Provision of Nursing Care; (B)Obtaining a contract for a cleaning company to service the hospital until the housekeeping staffing was, again, at full par and the practice of using MHTs on specific days to function as housekeepers was discontinued; and (C) the revision of the Staffing guidelines to make them more specific regarding when staffing is to be increased and to enforce that other departments cannot take MHTs off of the schedule for housekeeping or outside trips.

B. A meeting was conducted between the GB and Hospital/MS leaders to review the findings as noted in “A” of 392 and to convey the following expectations: The need to consistently staff the nursing units according to patient needs and acuity;-The need to ensure 15 minute patient safety checks are done on a consistent basis; -The need to not utilize MHTs beyond the patient care capacity without providing the extra resources needed to accommodate the additional workload and need to require trips to go through the DON versus allowing the Lead MHT to take MHT’s off of the units for trips; -the need to ensure nursing groups are provided consistently and per schedule; and the need to provide

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE: **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 145 | H 1201 | | |

Physician #21 performed an Evaluation of Risk and added Patient #5 had previous suicide attempts by hanging and numerous suicide gestures, such as swallowing rubber gloves. Patient #5 was placed on every 15 minute safety checks.

Review of the safety check reports for Patient #5 revealed a total of 108 checks were documented as missed from 3/17/18 until the patient was discharged on 4/10/18 at 12:48 p.m. Examples of missed checks included:

On 3/24/18 at 10:07 a.m., the patient was checked on. The next check was documented 19 minutes later at 10:26 a.m. The reason for the missed interval was documented as "unit disruption". The patient's next safety check was 21 minutes later at 10:47 a.m. and again documented as missed due to unit disruption. On review of the safety check report for the rest of the day there were 9 more incidents of missed checks due to unit disruption.

On 3/31/18, the patient safety check report indicated 13 missed 15 minute safety checks due to unit disruption.

On 4/7/18, the patient was checked on at 5:36 p.m. and the next check was 31 minutes later at 6:07 p.m. The reason indicated for the missed interval was "just returned from lunch break."

d. Review of Patient #10's medical record showed the patient was admitted on 5/18/18 at 12:30 a.m. and placed on every 15 minute checks. According to the Comprehensive Psychosocial Assessment, Patient #10 was identified as having major depression, anxiety, and hopelessness with a recent suicide attempt.

Review of the safety check report for Patient #10 showed multiple gaps, to include days of missing 15 minute safety checks, identified from

evidence that patient hygiene per regular showers or baths is being provided to patients who need assistance with same. The LS group concurred with the identified root cause and added as a root cause the lack of a dedicated nursing leader available to the one site since the departure of the prior DON and the experience of challenges in filling the position. This group added as an expectation and action step the selection of an Interim dedicated DON for the Hospital

C. Policies were examined to identify the need for new polices or the revision of existing ones. The following were reviewed:
The P&P on Patient Levels of Observation Policy including Close Observation, 15-minute checks, and 1:1 Status;
Patient Hygiene, and Provision of Nursing Care. The policies were retained and were not revised as the source of this deficiency was attributed to lack of compliance with the policies, as written.
A contract was obtained for housekeeping personnel to service the hospital until the housekeeping staffing was, again, at full par and the practice of using MHTs on specific days to function as housekeepers was discontinued;
An Interim Director of Nursing (DON) was obtained to serve in a dedicated role to the Hospital until a permanent DON is identified and oriented to his/her role.
The Staffing guidelines were revised to make them more specific regarding when staffing is to be increased as follows:
1.The baseline staffing on all units at Clear View Behavioral Health is as follows:
Unit 200 – Geriatric -16 beds

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 146<br>5/18/18 until the patient was discharged on 5/23/18 at 7:15 p.m. Examples of missed checks included:<br><br>On 5/19/18 at 6:00 p.m. the patient was checked on. The next check was not documented until 90 minutes later at 7:30 p.m. There was no documentation noted as to why the safety checks had not been completed every 15 minutes as ordered. In addition, there were no 15 minute safety checks documented from 5/19/18 at 10:30 p.m. until 5/22/18 at 4:00 p.m., over two and a half days later.<br><br>Similar findings were found in review of the medical records for Patients #1, #2, #3, #4, #6, #7, #9, #11, #12, and #13, which all included missed 15 minute safety checks.<br><br>e. On 7/17/18 at 4:50 p.m., an interview was conducted with MHT #43. MHT #43 stated she had been called in to work extra and was currently working on the 200 unit. MHT #43 stated "there was a lot of work to do but not enough people to do it" and she would get very overwhelmed. MHT #43 stated patients may have to wait to receive assistance with care due to MHTs being busy.<br><br>On 07/24/18 at 4:34 p.m. an interview with MHT #34 was conducted. MHT #34 stated she worked on all units within the facility and was responsible for conducting patient safety checks. MHT #34 stated patients within the facility were seeking treatment for suicide, depression and anxiety and the purpose of safety checks was to ensure these unstable patients were prevented from self harm.<br><br>MHT #34 stated a unit disruption would be noted on the safety checks if one MHT was with a patient in seclusion. The other MHT would be required to continue with all other unit activities to include safety checks and groups. MHT #34 | H 1201 | Days and nights<br>1-9 patients = 1 nurse, 1 MHT<br>10-16 = 1 nurse , 2 MHT's<br>Unit 300 – Closed – 16 beds<br>Days and nights<br>1-9 patients = 1 nurse, 1 MHT<br>10-16 = 1 nurse, 2 MHT's<br>Unit 400 –Adult– 18 beds<br>Days and nights<br>1-9 patients = 1 nurse, 2 MHT<br>10-18 = 1 nurse, 2 MHT's<br>Unit 500 –Adults – 18 beds<br>Days and nights<br>1-9 patients = 1 nurse, 1 MHT<br>10-18= 1 nurse, 2 MHT's<br>Unit 600 (14 beds) /700 (10 beds) – Adolescent – 24 beds<br>1-9 patients = 1 nurse, 2 MHT's<br>10-24 = 1 nurse 2 MHT's<br>This basic grid is maintained if patients meet the following criteria over the past 1-2 shifts:<br>-Are able to perform own ADL's<br>-No command hallucinations<br>-No impulsive behaviors<br>-15 minute checks<br>-No current history of active SI or self harm while in the hospital<br>-No aggressive behaviors<br>-No medical dressings/care<br>Guidelines for Increasing Staff to the Core staffing:<br>Additional MHT(s) is (are) added to each unit in the following situations:<br>- A patient is on 1:1 level of observation for danger to self or others<br><br>-A Constant Observation level is required for patients displaying disruptive, actively psychotic, or aggressive or impulsive behavior on the unit, or who are at medium suicide risk. Note: One MHT can perform Constant Observation on up to only 3 patients if they are located within | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 147 | H 1201 | | |

stated if a unit disruption occurred and the 15 minute safety checks were missed, this was mainly due to having only one MHT on the floor and no additional staff. MHT #34 stated the facility MHTs were overtasked and understaffed.

f. On 7/25/18 at 2:49 p.m., an interview was conducted with Nursing Supervisor (NS) #16. NS #16 stated safety checks were expected to be completed and she "hoped the techs were holding themselves accountable." NS #16 further stated she assumed staff on the unit would complete the safety checks in a timely manner and if staff was busy they could grab the nurse to do safety checks.

NS #16 then stated she had not performed any audits of the 15 minute safety checks to ensure timely completion was done. NS #16 stated "there was only one of me and many different units."

g. On 7/26/18 at 1:59 p.m., an interview with DON #2 was conducted. DON #2 stated RN and MHT staffing was determined by the policy. On review of the policy, Staffing Plan for Provision of Care, which stated the acuity staffing system shall be based upon objective assessment tools which qualify the number of nursing staffing members needed to fulfill patient needs on each unit, DON #2 stated she had never implemented a staffing tool and was unsure what the staffing tool was. DON #2 stated she did not do reviews or audits to determine if staffing was appropriate for the patient and unit acuity.

DON #2 further stated she did not review or audit 15 minute safety checks to determine the rationale or cause of the missed checks. She stated she felt they were missed due to MHTs being younger, who lacked critical thinking and experience on how to handle situations which arose on the unit.

the same area and if none of the other patient parameters are met within the three Constant Observation patients that they are caring for, as delineated below)
-The patient has required more than two episodes of Seclusion or Restraint or Codes for the shift
-The patient needs transfer to the ED for further care
-More than one patient requires full assistance with ADL's during the shift
-The patient is fully dependent on others for their care needs
This (these) additional MHT (s) may concomitantly serve as the person on the CO or the 1:1 status and a patient with the other patient parameters (excluding CO or 1:1) described as long as only one patient is assigned to this MHT staff member.

** What was intended as this statement is that the same MHT who is serving on a 1:1 or Constant Observation (CO) status may provide the activities of daily living (shower/bath) of the patient who needs assistance and an additional MHT is not needed to perform those duties for the specific patient as long as the MHT continues to fulfill the responsibilities of the 1:1 or CO status. While implied by the definition of a CO status, if the MHT is performing ADLs on a patient who is on CO, they would not be expected to perform CO status of any other patients at the same time as the line of sight requirement could not be met.

To further clarify the intent of this statemen, if a MHT is being added to assist with ADLs on a patient on the unit, and that patient is not on CO or 1:1 status, the MHT may assist with ADLs for more than one patients.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 148<br>3. The facility failed to ensure adequate housekeeping staff was maintained to perform sanitization of the facility, but instead placed the housekeeping duties and the patient care duties on the mental health technicians without providing extra resources to accommodate the extra workload.<br><br>a. An initial tour of the facility was conducted on 7/16/18 at 11:25 a.m. Observations of the 500 unit revealed a MHT cleaning and vacuuming the nurses station. Review of the daily assignment sheet for unit 500, dated 7/16/18 from 7:00 a.m. until 7:30 p.m., showed there were two MHTs assigned. One was assigned to conduct safety checks and the other assigned to hall monitoring. There was no additional staff assigned for housekeeping duties.<br><br>On 7/18/18 at 4:42 a.m., observations of unit 200 were conducted. Observations revealed MHT #52 outside the housekeeping closet door with a mop, bucket and house cleaning cart. During the observations of the unit, MHT #52 stated he had been cleaning the unit which included mopping, cleaning railings and door handles, dusting, sweeping and moving all the furniture in the day room area.<br><br>This was in contrast to the daily shift assignment sheet which indicated MHT #52 was assigned to patient safety checks from 3:00 a.m. until 5:00 a.m. Additionally, the assignment sheet noted MHT #56 was assigned to the one to one (1:1) observation patient and MHT #28 was assigned to perform hall monitoring.<br><br>Further observations revealed MHT #56 was not located on the unit. According to MHT #52, MHT #56 had left the unit to do patient inventory on a different unit. MHT #28 was observed sitting in a patient room with the patient on 1:1 observation. This left one MHT in charge of patient safety checks (due every 15 minutes), | H 1201 | If the MHT is not being added due to the need of 1:1 or CO status, they may care for more than one patient.<br>An additional nurse is added per each unit in any of the following situations:<br>-At least one patient has complex medical care needs requiring frequent nursing assessment, dressing changes, breathing treatments, or more<br>-Two or more patients are on complex or large volumes of medications to be administered during the shift (10 or more-seen on the Gero unit, at times)<br>-Psychiatric patient complexity exists on the unit whereby there are multiple concomitant episodes of Seclusions or Restraints, 1:1's and Constant Observation episodes and patient acting-out behaviors occurring.<br>--CIWAS or other protocols are required on more than one patient per shift.<br>The additional nurse may address multiple patient parameters, as delineated above and is not restricted to only addressing one of these patient situations. The Hospital will use this staffing guideline to staff the hospital and continue to replace any unfilled positions to ensure compliance with same.<br><br>D. Group schedules for all units were reviewed for accuracy and re-printed and re-posted.<br><br>E. Training was conducted for all pertinent Nursing staff on the following: expectations for compliance specific to staffing, compliance with 15 minute checks, Constant Observation, and 1:1 status; not utilizing nursing staff for non-nursing duties without providing extra resources to accommodate the extra | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 149<br>hall monitoring and housekeeping duties.<br><br>On 7/18/18 at 4:45 a.m., an interview was conducted with MHT #52 who stated there was currently no housekeeping staff for the facility so those duties had been assigned to MHTs. This was in addition to the assigned patient care duties required of the MHTs. MHT #52 stated he had been told to clean due to state surveyors being on sight and the facility wanted to avoid being "dinged".<br><br>MHT #52 stated he was unable to perform both the housekeeping duties and the MHT duties at the same time and further stated he had received no training on the housekeeping duties. MHT #52 stated any response to a patient code situation would be delayed due to him having to return all housekeeping supplies to the closet to maintain a safe environment for all other patients prior to responding to the code. MHT #52 stated this was not safe.<br><br>On 7/20/18 at 10:44 a.m., a tour of the 400 unit was done. There was a total of 9 double occupancy rooms on the unit. During the tour, MHT #59 stated he was working on the unit but was also responsible for "cleaning the unit today", including the patients' restrooms (each patient room had a toilet, shower and sink).<br><br>b. A review of the Housekeeping Schedule from 4/1/18 to 7/31/18 was conducted. All housekeeping shifts were scheduled between the hours of 6:00 a.m. to 2:30 p.m. In April, there were no housekeepers scheduled from 4/27/18 through 4/30/18 and only one housekeeper scheduled on 4/1/18-4/8/18, 4/13/18-4/15/18, 4/20/18-4/22/18, and 4/25/18-4/26/18. In May, there were no housekeepers scheduled on Sundays. On all other days in May, except on 5/30/18, there was only one housekeeper scheduled, which was the same staff member (Housekeeper #53). In | H 1201 | workload and not taking MHTs off units for trips or housekeeping; nursing groups occurring, as scheduled; and patient hygiene requirements for patients who need assistance with baths/showers and documentation of such.<br><br>F. A daily Monitoring and Evaluation activity was implemented to ensure evidence of correction of the deficiencies and early identification of any problems, as delineated below.<br><br>3.The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br><br>-Staffing according to patient/needs and acuity;<br>-Compliance with 15-minute checks, Constant Observation, and 1:1 status;<br>-Evidence of staffing to support housekeeping needs separate from MHT staffing /resources;<br>-Compliance with nursing groups per schedule; and<br>- The provision of showers and baths to patients who cannot participate with same or need assistance and documentation of the shower/bath.<br><br>These indicators are being collected on individual data sheets entitled with the names as described above. Information from the patient medical record is used to generate compliance with observations. A log of groups coupled with the patient's medical record is being used to ensure compliance with group therapy sessions per schedule. The staffing grid is compared to the actual staffing as well as | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 150<br>June, there were no housekeepers scheduled on 6/3/18 and 6/17/18. In addition, there was only one housekeeper scheduled on 6/218, 6/5/18, 6/7/18, 6/9/18, 6/16/18, 6/19/18, 6/21/18, 6/24/18, 6/26/18, 6/28/18, and 6/30/18. In July, there were no housekeepers scheduled on Sundays. In addition, there was only one housekeeper scheduled on 7/7/18 and 7/14/18.<br><br>According to a current staff roster, there were only two housekeepers listed as being employec by the facility (Housekeeper #53 and Housekeeper #54). On 7/26/18 at 3:32 p.m., the Chief Operating Officer (COO #15) stated one of the two housekeepers was on maternity leave while the other housekeeper had resigned the prior week, resulting in the facility not having any current housekeepers on staff. COO #15 stated MHTs were performing the housekeeping duties, to include cleaning patients' rooms and performing room turnovers after patients were discharged.<br><br>c. On 7/18/18 at 8:37 a.m., an interview with Patient #1 was conducted. Patient #1 explained she had been a patient at the facility one to two years ago and she had noticed the facility was much cleaner during her previous visit. Patient #1 stated during the current visit, she noticed patient care staff were cleaning the unit, which was not the case during her prior visit.<br><br>On 7/25/18 at 4:27 p.m., an interview was conducted with Lead Mental Health Tech (MHT) #31. MHT #31 stated she was in charge of the hiring and supervision of the mental health technicians, along with creating the monthly and daily schedule for all MHTs. MHT #31 stated she created the schedule based on acuity. MHT #31 described higher acuity as those patients who required one to one observations (1:1) or line of sight patients, all of which required more staff and would be factored into the schedule. | H 1201 | the House Supervisor's report to monitor for compliance with staffing needs. The presence of Housekeepers is monitored by the COO and deficiencies reported out at the Morning Meeting of Hospital Leaders, Monday through Friday (with F, S, S results incorporated into Monday's report). A log of patient showers/baths has been resumed to track compliance with maintaining the patient's hygiene needs. The results from this data are transferred to the Hospital's Scorecard for CMS/State Surveys. Compliance levels below the established standards of 95% and higher result in the responsible leader needing to take action steps and to bring back a description of the action steps at the next day's report of findings.<br><br>These indicators are being use for ongoing assessment for compliance with the established standards and sustained results on a daily basis (S-S).The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed at that time by the Administrator on Call concurrently and reported to the Morning meeting the following Monday. To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to indicators under review to assess for compliance with the corrective actions taken pursuant to these deficiencies are being assessed for evidence of effectiveness in the corrective action.<br><br>The findings are being aggregated by the Director of Compliance/Quality / Risk and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 151<br>On review of the MHT's schedule provided there was no indication MHT staffing had increased to accommodate the increased duties of the housekeeping role.<br><br>4. The facility failed to ensure nursing groups were provided consistently to patients as required to provide health-related education and support the improvement of psychiatric symptoms and skill development for patients.<br><br>a. On 7/18/18 at 8:37 a.m., an interview was conducted with Patient #1, on the geriatric (200) unit, who stated groups had been canceled during the last few days because the staff were busy cleaning and "goofing around". She stated yesterday, on 7/17/18, there were only two groups held when there were supposed to be five groups scheduled.<br><br>Review of Patient #1's medical record revealed Patient #1 attended the nursing group and the psychoeducation group on 7/17/18. There was no documentation in the medical record to show if any of the groups led by the mental health technicians (MHTs) were held on 7/17/18.<br><br>On 7/20/18 at 9:03 a.m., an interview was conducted with Patient A, on the adult (500) unit. Patient A explained he was admitted to the facility for alcohol detoxification, after recently stopping opiate and heroin use for chronic pain related to an accident. Patient A stated his primary complaint was the quality of the therapy. Patient A stated the groups were unhelpful and had typically been offered "on the fly." Patient A stated he needed an experienced therapist who was able to talk to him about his addiction and how he could prevent relapse after he was discharged. Patient A stated the groups had been led by inexperienced staff who did not offer any therapy specific to his situation.<br><br>b. Review of Patient #8's medical record | H 1201 | being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings.<br><br>Because of the high risk nature of these activities not occurring per requirement, this review process and reporting will continue for an indefinite period of time.<br><br>4. Title of the person(s) responsible for implementing the acceptable PoC: Director of Nursing<br><br>5.<br><br>Meeting of GB:<br>7/17/18<br>7/18/18<br>7/19/18<br>8/1/18<br>8/14/18<br>8/16/18<br>9/11/18<br><br>Meeting of GB and LS<br>7/17/18<br>7/18/18<br>7/19/18<br>8/1/18<br>9/7/18<br>9/11/18<br><br>Policy decisions<br>7/19/18<br>8/1/18 and 9/10/18<br><br>Hskpg contract in place:<br>7/23/18<br><br>Trainings:<br>Staffing<br>8/1/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 152<br>revealed she was admitted to the adolescent unit on 6/3/18 with a diagnosis of major depressive disorder and defiant disorder with threats to harm herself and others. Patient #8 remained at the facility until she was discharged on 7/3/18.<br><br>Review of the Final Ancillary Orders revealed an order was placed by Physician #21 on 6/3/18 for Patient #8 to attend group therapy. The Final Ancillary Orders also revealed, on 6/4/18, Therapist #39 created action steps for Patient #8 which included daily groups to explore self-soothing strategies and coping skills for depression and suicidal thoughts. Review of the Initial Psychiatric Evaluation, conducted on 6/3/18 at 4:25 p.m., revealed Physician #40 determined engagement in groups and therapy was a criteria for Patient #8's discharge from inpatient treatment.<br><br>Review of the Nursing Group Notes revealed the daily nursing group was not held on the adolescent unit on the following dates during Patient #8's admission: 6/6/18, 6/12/18, 6/14/18, 6/17/18, 6/22/18, 6/25/18, and 6/28/18. In addition, there was no documentation to determine whether the nursing groups were held or whether Patient #8 participated on 6/16/18, 6/19/18, and 6/27/18. Patient #8 did not have access to the nursing group on 10 days of her 30 day admission.<br><br>c. According to the History and Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to worsening depression and a suicide attempt. Patient #5 was discharged on 4/10/18.<br><br>Review of the Final Ancillary Orders for Patient #5, revealed an order from Physician #21 placed on 3/18/18 at 5:00 a.m. to initiate therapeutic activities per assessment and program schedule. Physician #21 placed a | H 1201 | 15" checks<br>8/1/18<br>Importance of Groups per schedule<br>8/14/18<br>Showers/baths<br>8/14/18<br><br>M&E in place<br>8/1/18<br>Weekly PI meeting with GB representative. As of 9/14/18<br><br>All requirements in place as of: 09/21/2018 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 153 | H 1201 | | |

second order, also on 3/18/18 at 5:00 a.m., for process groups and education groups per the program schedule.

Review of the Medication Administration Record for Patient #5 revealed the Nursing Group was not held on 3/19/18, 3/30/18, or 4/9/18. There was no explanation documented why the group was canceled.

Review of the medical records revealed similar findings of missing nursing groups for Patients #1, #2, #3, #4, #6, #7, and #11.

d. On 7/22/18 at 3:51 p.m., a tour was conducted of the geriatric (200) unit. According to the posted program schedule, the nursing group was scheduled at 5:00 p.m. RN #45 stated she was not planning to lead the group because she did not have time.

e. An interview was conducted with Mental Health Technician (MHT) #44 on 7/24/18 at 9:35 a.m. She stated it was important for MHTs to encourage patients to attend groups because groups were an important part of preparing patients to be ready for discharge. MHT #44 added sticking to a routine schedule was necessary because consistency was important for these patients. MHT #44 then stated groups were sometimes canceled or shortened when staff was busy with discharging patients.

f. On 7/24/18 at 4:34 p.m., an interview was conducted with MHT #34 who stated groups may not be held when there was a unit disruption. MHT #34 gave an example of a time she had 17 patients to lead in a group, and she just didn't have "enough of me" to complete it. MHT #34 stated sometimes the groups were intertwined so two groups occurred as one.

g. On 7/16/18 at 10:36 a.m., an interview was conducted with DON #2. She stated she did not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 154 | H 1201 | | |

track whether groups were held. DON #2 stated she was aware there were occasionally times when the nursing groups were not held.

A follow-up interview with DON #2 was held on 7/26/18 at 1:59 p.m. DON #2 stated the purpose of the nursing groups was to follow the theme of the day, talk about medications and plans after discharge, and provide patient education related to various topics. DON #2 stated the groups were important because they helped patients be successful after discharge.

5. The facility failed to provide regular showers or baths for patients on the geriatric (200) unit.

a. The Bathing of Patients policy read, staff were to assist patients who were unable to be independent with their bathing needs and to assist and encourage independent patients to maintain appropriate personal hygiene practices. Patients who needed assistance had staff assist with hygiene needs as required, including offering a shower/bath every other day or as needed if indicated. Document the completion of a bath in the patient medical record.

b. Review of Patient #4's medical record revealed she was admitted to the geriatric (200) unit on 12/29/17 with a diagnosis of schizophrenia. Patient #4 was discharged to an acute care hospital for medical clearance on 1/31/18 and was readmitted from 2/3/18 until 5/9/18, when Patient #4 was discharged to an assisted living facility.

Review of Nurse Practitioner (NP) #27's medical Progress Notes from 1/19/18, 1/20/18, 1/21/18, and 1/22/18 revealed Patient #4 had bowel incontinence and initially refused to let the RN or MHTs change her. NP #27 documented eventually Patient #4 allowed staff to help her change clothes. No showers were documented

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 155 | H 1201 | | |

in Patient #4's medical record for these days.

Review of the RN note from the night shift of 1/24/18 revealed Patient #4 was incontinent of a large loose bowel movement, which was dried and caked on her buttocks and legs. No shower was documented in Patient #4's medical record on that day.

During her second admission, beginning on 2/3/18, Patient #4 was documented as incontinent of loose stool or diarrhea on 2/6/18, 2/7/18, 2/9/18, 2/14/18, 2/22/18, 3/5/18, and 3/6/18. There was no documentation the patient was showered or offered a shower on these dates. In addition, no showers were documented in Patient #4's medical record from 3/4/18 until 3/24/18.

c. Review of Patient #1's medical record revealed she was admitted to the 200 unit on 7/12/18 and discharged 7/20/18 with a diagnosis of bipolar disorder II and major depressive disorder. Review of the Comprehensive Psychosocial Assessment Tool revealed Patient #1 was too anxious to shower in a communal shower at the residential facility she had been living at prior to this hospitalization.

Further review of Patient #1's medical record did not reveal any evidence Patient #1 was offered a shower or bath during her entire admission. Review of the July, 2018 Daily Shower Log revealed no documentation Patient #1 was offered a bath or shower during her 9 day admission except on 7/15/18 when it was documented on the Shower Log Patient #1 did not shower.

Review of patient medical records and the Daily Shower Logs revealed similar findings for Patients #3, #5, #6, and #9.

d. On 7/24/18 at 9:35 a.m., a tour of the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 156 | H 1201 | | |

geriatric (200) unit was conducted. MHT #44 was interviewed. MHT #44 stated she primarily worked on the 200 unit. MHT #44 stated, in general, staff attempted to bathe patients every other day on the the 200 unit. Some patients required assistance with bathing, including patients with dementia. MHT #44 stated good hygiene was a good way to care for yourself so it was an important aspect of patient care. She stated the unit had a binder where staff was expected to document when patients showered on a Shower Log. MHT #44 was unsure whether showers were documented in patient medical records.

Daily Shower Logs were provided for the months of February, March, April and July, 2018. On 7/26/18 at 7:52 a.m., DON #2 stated the facility was unable to locate the Daily Shower Logs for the months of January, May, and June, 2018.

On 7/25/18 at 12:50 p.m., an interview was conducted with MHT #20 who stated assistance with showers was primarily needed by patients on the 200 unit. MHT #20 stated staff prompted patients to shower, and if there were enough staff available, patients were able to have a bath in the tub, if needed. When a patient needed assistance with showering, MHT #20 stated she would ask the RN to assist the patient.

On 7/24/18 at 4:38 p.m., an interview was conducted with MHT #34 who stated showers were a key point of hygiene at a hospital in order to decrease the spread germs. MHT #34 stated showering was one of the most important hygiene strategies the facility had. MHT #34 stated it was important to document showers in the medical record to show the patients were not neglected.

An interview with Registered Nurse (RN) #49 was conducted on 7/24/18 at 10:01 a.m. RN #49

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1201 | Continued From page 157<br>stated she had been working at the facility since April, 2018. RN #49 stated she had not helped any patients bathe or shower at the facility yet. She stated the MHTs talked to each other and decided who would help with patient showers. RN #49 stated she did not document when patients showered, and she was not familiar with the binder where the MHTs recorded showers. | H 1201 | | |
| H 1208 | IV.12.102(2) Nursing: Nursing Assessments<br><br>Nursing staff shall conduct initial and ongoing assessments and screenings of the patient's physical, cognitive, behavioral, emotional and psychosocial status in sufficient scope and detail to meet the needs of the patient, according to facility policy and professional standards of practice.<br><br>This REGULATION is not met as evidenced by:<br>Based on interviews and document review, the facility failed to assess and reassess patients in accordance with facility policy in 5 of 5 medical records reviewed of patients who experienced a change in condition (Patients #5, #8, #9, #11, and #13). This failure resulted in patients attempting suicide without prior evaluations of suicide risk being conducted to assess if an intervention could have been placed to avoid the suicide attempt. Further, the failures resulted in a patient's injury to go unrecognized despite the patient reporting significant pain.<br><br>Findings include:<br><br>Facility policies: | H 1208 | 1. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited:<br>A. A Governing Board meeting was held and the following identified deficiencies were identified: Failure to assess and reassess patients for suicide risk, for pain, and after a fall; failure to utilize the Suicide Risk Monitoring Tool per requirements and to appropriately increase the levels of observation of patients per the findings from the assessment; failure to consistently assess, address, and reassess pain intensity in patients and response to any pain medications administered per policy requirements; | 09/21/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: CLEAR VIEW BEHAVIORAL HEALTH | | STREET ADDRESS, CITY, STATE, ZIP CODE: 4770 LARIMER PARKWAY JOHNSTOWN 80534 | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1208 | Continued From page 158<br>The Assessment and Reassessment of the Patient policy read, each patient was reassessed every shift. Reassessment was completed by the registered nurse (RN) as needed and with a change of patient condition.<br><br>The Suicide Precautions Policy read, the facility was to provide for the safety and well-being of each individual patient found to be at risk for harm to themselves. The Suicide Risk Monitoring Tool will be the standard tool used by staff to evaluate all patients deemed to be at risk for self harm. The level of observation of the patient is determined by the findings from the suicide monitoring tool. The patient will be rated with a low, medium or high score, but the score is not intended to replace the assessment and judgement of the skilled clinician.<br><br>For patients determined to be at a low risk, the following precautions will be implemented: 15 minute checks, contraband search once on day shift and once on evening shift, complete the suicide risk tool every 24 hours, and daily re-evaluation by physician for appropriateness of level of care and placement<br><br>For patients determined to be at a medium risk, the following precautions will be implemented: 15 minute checks or close observation depending on the degree of lethality, contraband search once on day shift and once on evening shift, reassessment with the suicide risk assessment monitoring tool every 12 hours, progress note documentation every shift related to the status of the patient, and daily re-evaluation by physician for appropriateness of level of care and placement.<br><br>For patients determined to be at a high risk, the following precautions will be implemented: close observation or 1:1 status depending on the degree of lethality, contraband search once on day shift and once on evening shift, | H 1208 | failure to observe for and address a deteriorating change in the patient's condition; failure to complete and submit incident reports, as required by Hospital policy; and failure to monitor for compliance with the above requirements. The root causes identified that led to the deficient items were proposed as follows: (1)Lack of staff knowledge and compliance with the policies related to Suicide Risk Monitoring and Fall Assessment, (2)Lack of staff's knowledge of their ability to ask for additional assessment of a patient's condition from a MS member when patient report seems discrepant with x-ray results and physical condition, (3)Failure to comply with established policies for Suicide assessment, Fall assessment, PRN Medication Administration, Fall Management, Deteriorating patient condition as well as (4)Lack of consideration of Nursing and Medical staff that additional imaging may be needed when x-ray findings are negative but the patient reports pain that cannot be resolved.<br><br>B. A meeting was held between the GB and Hospital Leaders to examine findings, analyze root causes of the findings and delineate expectations and plan of action related to each deficiency cited including: including: Failure to assess and reassess patients for suicide risk, for pain, and after a fall including the failure to utilize the Suicide Risk Monitoring Tool per requirements and to appropriately increase the levels of observation of patients per the findings from the assessment; failure to consistently assess, address, and reassess pain intensity in patients and response to any pain medications administered per policy | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1208 | Continued From page 159<br>reassessment with the suicide risk assessment monitoring tool every 8 hours, progress note documentation every shift related to the status of the patient, daily re-evaluation by physician for appropriateness of level of care and placement, and the RN will discuss findings from the Suicide Risk Tool to verify the most appropriate care.<br><br>According to the Practice Guidelines for Levels of Observations Policy, guidelines for implementing 1:1 observation status would include: seclusion, restraint or emergency use of medication, actively attempting to or imminent harm to self or others, acting on suicidal ideation, hallucinations, demonstrated unpredictable or impulsive behavior placing themselves or others at risk, patient failed line of sight observations, unsafe at a lower level of observation, or status post suicide attempt for 24 hours.<br><br>The Pain Assessment policy read, pain management was based upon a belief every person should have access to the best level of pain relief which may be safely provided to ensure their experience of illness or injury is as atraumatic as possible. The physician, nurse, and other healthcare professionals collaborated to manage pain in the patient. Patients were to be actively involved in pain assessment and management. They were to participate in determining which methods were to be used for pain management. Pain intensity and pain relief were to be assessed and re-assessed at regular intervals using appropriate, reliable methods.<br><br>1. The facility failed to reassess patients and ensure the Suicide Risk Monitoring Tool was completed appropriately for each patient.<br><br>a. According to the History and Physical (H&P), documented on 3/18/18 at 12:59 p.m., Patient #5 was admitted to the facility on 3/17/18 due to | H 1208 | requirements; failure to inspect a patient's injuries as part of the medical exam; failure to observe for and address a deteriorating change in the patient's condition; failure to complete and submit incident reports, as required by Hospital policy. The Leadership group concurred with the root causes that were identified and added that the nursing staff was a relatively inexperienced one so the focus on correction of these deficiencies definitely needed to be on training.<br><br>C. A policy and procedure review was conducted to assess whether or not the policies were outdated and in need of revision or if there were policies present to assist the nurse in assessing the patient in the situations described above. The following policies and procedures (P&Ps) were reviewed: Use of the Suicide Risk Monitoring Tool, Assessment and Reassessment of the Patient, the Fall Assessment, Management of Patient Falls, Pain Assessment and Management, Medication Administration, Management of the Patient with a Deteriorating Condition, and Incident Reports. All the policies were assessed as current and the decision was made that the emphasis on this corrective action plan needed to be on training of expectations and monitoring for compliance and sustained compliance with the requirements.<br><br>D. Inservice education was conducted for Nursing as well as Medical Staff on the following P&P's and associated expectations:<br>a) the Suicide Risk Monitoring tool shall be completed per policy and procedure whereby the frequency of assessment shall be increased based on patient results and increased patient observation | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1208 | Continued From page 160<br>worsening depression and a suicide attempt by attempting to roll her wheelchair into traffic. On 3/18/18 at 6:14 a.m., Assessor #62 conducted an evaluation of risk in which Patient #5 was determined as a moderate suicide risk. Assessor #62 added Patient #5 had previous suicide attempts by hanging and numerous suicide gestures such as swallowing rubber gloves. The initial Suicide Risk Monitoring Tool, completed on 3/18/18 at 6:11 a.m., showed Patient #5 was scored a medium suicide risk, although she was admitted due to a suicide attempt.<br><br>According to the RN Mental Status Assessment, completed by Registered Nurse (RN) #29 on 3/27/18 at 5:49 p.m., Patient #5 was impulsive, had poor insight and judgement and was banging her head on the wall and kicking the door. Patient #5 required multiple attempts at redirection of her behavior. The Suicide Risk Monitoring Tool, completed at 5:55 p.m. by the same RN, scored Patient #5 as a medium risk for self harm, even though she was currently exhibiting self harm behavior by banging her head on the wall and kicking the door.<br><br>According to the policy Practice Guidelines for Levels of Observations Policy, this self-harming behavior could indicate a need for 1:1 (1 staff member with 1 patient at all times) observation status based on the patient actively attempting to harm herself. However, according to the ancillary orders, Patient #5 was only to be monitored every 15 minutes on 3/27/18.<br><br>Review of an incident report, dated 3/27/18 at 8:00 p.m., revealed Patient #5 had a blanket wrapped around her neck in an attempt to harm herself. Patient #5 was restrained and required emergency intramuscular (IM) medication administrations of Zyprexa (antipsychotic medication), Ativan (relieves anxiety) and Benadryl (causes drowsiness). | H 1208 | shall be implemented per the policy's requirements in patients with high risk (Nursing);<br>b) At the time of the patient's admission, the nurse completes an assessment of the patient that encompasses a visualization of any areas the that the patient reports have been injured. Further, the medical provider's history and physical encompasses inspection as part of the physical exam of any areas of injury reported and additional testing is required when the patient's physical appearance and behaviors are discrepant with initial imaging studies (Medical and Nursing);<br>c)The Fall Assessment is to be completed for all patient falls and actions taken per the levels derived (Nursing);<br>d) Staff are to question and seek more information from Medical Staff including additional assessment of a patient's condition from a MS member when a patient's report of their level of pain seems discrepant with x-ray results and physical condition, or if they have reported a fall to a Medical Provider and there is no documentation to support that provider's evaluation of findings (Medical and Nursing);<br>e) Pain is to be assessed on all patient's per the hospital's policy and system for indicating pain (Nursing);<br>f) After PRN Medication is administered, patients are to be assessed for response to same and Medical Providers and the treatment team are to discuss continued pain despite interventions;<br>g) Staff are to adhere to the policy on Management of the Deteriorating Patient Medical Condition" including a report to the Medical Provider in accordance with the procedures (Nursing);<br>h) Nursing and Medical staff should consider that additional imaging (i.e. CT | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1208 | Continued From page 161<br><br>After Patient #5's suicide attempt there was no Suicide Risk Monitoring Tool completed until 3/28/18 at 5:25 p.m., almost 24 hours later, in which Patient #5 was still scored a medium risk for self harm. This was in contrast to the Suicide Precautions policy which stated a medium risk score required a suicide risk reassessment to be performed every 12 hours.<br><br>A Suicide Risk Monitoring Tool was completed on 4/5/18 at 6:28 p.m. Patient #5 was scored as a low risk and should have been reassessed by 4/6/18 at 6:28 p.m. However, there was no suicide risk tool completed until 4/7/18 at 10:17 p.m. During this timeframe the patient had another suicide attempt.<br><br>Record review revealed Patient #5 had a second suicide attempt on 4/7/18 at 6:20 p.m. According to the RN Mental Status Assessment,dated 4/7/18 at 10:08 p.m., Patient #5 gagged and vomited up a plastic bag. RN #3 gave Patient #5 Thorazine (antipsychotic medication that can reduce anxiety) and told her to stay in the milieu (common area) so she could be observed.<br><br>There was no documentation the patient's level of observation was increased to ensure she was monitored and remained safe. Subsequently Patient #5 went to her room where staff found her with a sheet tied tightly around her neck and had difficulty removing it.<br><br>Furthermore, there was no documentation a Suicide Risk Monitoring Tool was completed until 4/7/18 at 10:17 p.m., approximately four hours after the second suicide attempt and more than 48 hours after the previous suicide risk assessment. Review of the tool showed Patient #5 was still scored as a medium risk although the patient attempted suicide four hours prior. | H 1208 | scan, MRI) may be needed when x-ray findings are negative but the patient reports continued pain in a site that cannot otherwise be explained or resolved (Medical and Nursing);<br>i) Even though the incident report was later located that was referenced in this report as missing related to a patient's fall, Nursing Staff were reminded of the need to adhere to the policy and procedure related to completion of an Incident Report for unusual occurrence (Nursing)<br><br>E. A daily Monitoring and Evaluation activity was implemented for each of the above areas to ensure evidence of correction of the deficiencies, early identification of any problems, and sustained compliance as delineated below.<br><br>2. The procedure for implementing the Plan of Correction (PoC), for each deficiency cited:<br>A. A Governing Board meeting was held and the following identified deficiencies were identified: Failure to assess and reassess patients for suicide risk, for pain, and after a fall; failure to utilize the Suicide Risk Monitoring Tool per requirements and to appropriately increase the levels of observation of patients per the findings from the assessment; failure to consistently assess, address, and reassess pain intensity in patients and response to any pain medications administered per policy requirements; failure to observe for and address a deteriorating change in the patient's condition; failure to complete and submit incident reports, as required by Hospital | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 1208 | Continued From page 162<br><br>Further review of the Suicide Risk Monitoring Tools in Patient #5's medical record revealed 20 assessments were not completed within the timeframe outlined in the policy in which to reassess based on her behavior and risk score.<br><br>b. On 7/25/18 at 11:03 a.m., an interview with Physician #14 was conducted. Physician #14 stated Patient #5 threatened suicide often. Physician #14 stated the treatment team did not think Patient #5 was mobile enough to actually attempt suicide, even though she was admitted after a suicide attempt and had frequent episodes of self-harming behavior.<br><br>c. On 7/26/18 at 1:59 p.m., an interview with Director of Nursing (DON) #2 was conducted. DON #2 stated Patient #5's observation status should have increased after she was found gagging on the plastic bag to prevent the subsequent suicide attempt. DON #2 further explained that patients should be scored high on the Suicide Risk Monitoring Tool subsequent to a suicide attempt.<br><br>d. On review of Patient #13's medical record, the patient was transferred to the facility on 7/15/18, after she stated she was going to kill herself. On 7/15/18 at 9:24 a.m., a comprehensive psychosocial assessment was completed. Patient #13 was documented as depressed and anxious and endorsing suicide with a plan to hang herself, cut herself or overdose on medication. At 9:47 a.m., an evaluation risk was completed and Patient #13 was identified as an imminent risk for suicide. The initial Suicide Risk Monitoring Tool, completed on 7/15/18 at 9:53 a.m., revealed Patient #13 was scored a low suicide risk even though she was admitted due to suicidal ideations with a plan.<br><br>The Suicide Risk Monitoring Tool, completed on | H 1208 | policy; and failure to monitor for compliance with the above requirements. The root causes identified that led to the deficient items were proposed as follows: (1)Lack of staff knowledge and compliance with the policies related to Suicide Risk Monitoring and Fall Assessment, (2)Lack of staff's knowledge of their ability to ask for additional assessment of a patient's condition from a MS member when patient report seems discrepant with x-ray results and physical condition, (3)Failure to comply with established policies for Suicide assessment, Fall assessment, PRN Medication Administration, Fall Management, Deteriorating patient condition as well as (4)Lack of consideration of Nursing and Medical staff that additional imaging may be needed when x-ray findings are negative but the patient reports pain that cannot be resolved.<br><br>B. A meeting was held between the GB and Hospital Leaders to examine findings, analyze root causes of the findings and delineate expectations and plan of action related to each deficiency cited including: including: Failure to assess and reassess patients for suicide risk, for pain, and after a fall including the failure to utilize the Suicide Risk Monitoring Tool per requirements and to appropriately increase the levels of observation of patients per the findings from the assessment; failure to consistently assess, address, and reassess pain intensity in patients and response to any pain medications administered per policy requirements; failure to inspect a patient's injuries as part of the medical exam; failure to observe for and address a deteriorating change in the patient's | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 1208 | Continued From page 163<br>7/22/18 at 4:44 p.m. showed the patient was determined to be at a high risk level for self harm and stated she was still suicidal; however, there were no interventions documented in accordance to the policy on how the patient was monitored for safety.<br><br>On 7/22/18 at 10:50 p.m., the RN documented in the progress note Patient #13 reported suicidal thoughts with a plan to overdose on medications. The patient reported she had "some pills saved up that I was going to take." The patient then gave the RN a crushed yellow powder substance rolled up in a paper wrapper. When asked what pills they were, the patient reported they were "mine and other peoples." Patient #13 identified the crushed medications as Vistaril (an anti-anxiety medication), Xanax (used to treat anxiety and panic disorder) and Ativan (used to treat anxiety with sedative properties). The RN documented Patient #13 had been "cheeking [pretending to swallow medications while hiding them in the mouth] random medications." Review of the Incident Report revealed the incident occurred on 7/22/18 at 7:45 p.m., approximately three hours after the patient had been identified as a high risk for self harm.<br><br>The Suicide Risk Monitoring Tool, completed on 7/23/18 at 3:53 a.m. approximately eight hours after the incident, scored Patient #13 a low suicide risk, even though she had a recent plan to swallow pills and had pills in her possession. Increased observation for line of sight (where patients must be in sight of a staff member at all times) was not ordered until the next morning on 7/23/18 at 8:30 a.m.<br><br>On 7/24/18 at 12:20 p.m., an incident report documented Patient #13 was found in her bathroom with a blanket tied around her neck which was attached to the toilet seat. The patient attempted to strangle herself after | H 1208 | condition; failure to complete and submit incident reports, as required by Hospital policy. The Leadership group concurred with the root causes that were identified and added that the nursing staff was a relatively inexperienced one so the focus on correction of these deficiencies definitely needed to be on training.<br><br>C. A policy and procedure review was conducted to assess whether or not the policies were outdated and in need of revision or if there were policies present to assist the nurse in assessing the patient in the situations described above. The following policies and procedures (P&Ps) were reviewed: Use of the Suicide Risk Monitoring Tool, Assessment and Reassessment of the Patient, the Fall Assessment, Management of Patient Falls, Pain Assessment and Management, Medication Administration, Management of the Patient with a Deteriorating Condition, and Incident Reports. All the policies were assessed as current and the decision was made that the emphasis on this corrective action plan needed to be on training of expectations and monitoring for compliance and sustained compliance with the requirements.<br><br>D. Inservice education was conducted for Nursing as well as Medical Staff on the following P&P's and associated expectations:<br>a) the Suicide Risk Monitoring tool shall be completed per policy and procedure whereby the frequency of assessment shall be increased based on patient results and increased patient observation shall be implemented per the policy's requirements in patients with high risk (Nursing);<br>b) At the time of the patient's admission, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: CLEAR VIEW BEHAVIORAL HEALTH | | STREET ADDRESS, CITY, STATE, ZIP CODE: 4770 LARIMER PARKWAY JOHNSTOWN 80534 | |

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|---|---|---|---|---|
| H 1208 | Continued From page 164<br>ripping off her scabs causing her to bleed.<br><br>The Suicide Risk Monitoring Tool, completed on 7/24/18 at 2:05 p.m., less than two hours after the suicide attempt, scored Patient #13 a low suicide risk.<br><br>Further review of the Suicide Risk Monitoring Tools in Patient #13's medical record revealed Patient #13 was scored as a low suicide risk in 14 of 20 assessments, although Patient #13 had continued to endorse suicide with a plan throughout her hospitalization.<br><br>e. On 7/25/18 at 9:27 a.m., an interview with RN #13 was conducted. RN #13 stated the expectation was to complete the Suicide Risk Monitoring Tool on each patient each shift. RN #13 stated he would complete the assessment with the information that he knew to be true and that he believed some questions were prepopulated with scores assessed from the patients' admission. RN #13 stated he never changed the score of the last four questions of the assessment, but was unable to identify which questions he did not assess. Additionally, RN #13 explained some questions on the Suicide Risk Monitoring Tool would ask about the patient's medical history, home life and past trauma which he would not know the answer for. RN #13 stated interventions and monitoring would not change for the patient based on the suicide risk score, which was in contrast to the policy. RN #13 stated he had received training in orientation on how to complete the Suicide Risk Monitoring Tool, but he had come up with his own way scoring patients based on if they had a plan to attempt suicide.<br><br>f. On 7/26/18 at 1:59 p.m., an interview with the Director of Nursing (DON #2) was conducted. DON #2 stated staff were trained how to perform suicide risk assessments during initial training. DON #2 explained nurses were | H 1208 | the nurse completes an assessment of the patient that encompasses a visualization of any areas the that the patient reports have been injured. Further, the medical provider's history and physical encompasses inspection as part of the physical exam of any areas of injury reported and additional testing is required when the patient's physical appearance and behaviors are discrepant with initial imaging studies (Medical and Nursing);<br>c)The Fall Assessment is to be completed for all patient falls and actions taken per the levels derived (Nursing);<br>d) Staff are to question and seek more information from Medical Staff including additional assessment of a patient's condition from a MS member when a patient's report of their level of pain seems discrepant with x-ray results and physical condition, or if they have reported a fall to a Medical Provider and there is no documentation to support that provider's evaluation of findings (Medical and Nursing);<br>e) Pain is to be assessed on all patient's per the hospital's policy and system for indicating pain (Nursing);<br>f) After PRN Medication is administered, patients are to be assessed for response to same and Medical Providers and the treatment team are to discuss continued pain despite interventions;<br>g) Staff are to adhere to the policy on Management of the Deteriorating Patient Medical Condition" including a report to the Medical Provider in accordance with the procedures (Nursing);<br>h) Nursing and Medical staff should consider that additional imaging (i.e. CT scan, MRI) may be needed when x-ray findings are negative but the patient reports continued pain in a site that cannot otherwise be explained or resolved | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 1208 | Continued From page 165<br>expected to answer each question during each suicide risk assessment. DON #2 stated the suicide risk assessment had no prepopulated answers to the questions. DON #2 stated she would occasionally review the medical record after a suicide attempt, however, she did not perform audits to ensure nurses were performing assessments correctly to ensure appropriate interventions and observation status levels were in place. DON #2 confirmed there was no oversight to ensure staff were performing suicide assessments using the Suicide Risk Monitoring Tool at the correct interval according to the policy.<br><br>g. Similar findings of instances where the facility failed to reassess patients and ensure the Suicide Risk Monitoring Tool was completed appropriately for each patient was found in the records of Patients #8 and #11.<br><br>2. The facility failed to consistently assess, address, and reassess pain reported by Patient #9 who had untreated injuries, including pelvic and rib fractures, identified after he was emergently transferred to a higher level of care.<br><br>a. Review of the Comprehensive Psychosocial Assessment Tool, dated 12/31/17 at 10:58 p.m., revealed Patient #9 was brought to the facility by ambulance from the Emergency Department (ED) of an acute care facility. Patient #9 was admitted with a diagnosis of unspecified schizophrenia.<br><br>Review of the Initial Medical Screening Assessment Information, completed on 12/31/17 at 10:48 p.m., revealed Patient #9 presented with a pain level of 9 (on a 0 to 10 scale) and an elevated heart rate (109 beats per minute).<br><br>Review of the Nursing Assessment, completed 12/31/17 at 11:40 p.m. by Registered Nurse | H 1208 | (Medical and Nursing);<br>i) Even though the incident report was later located that was referenced in this report as missing related to a patient's fall, Nursing Staff were reminded of the need to adhere to the policy and procedure related to completion of an Incident Report for unusual occurrence (Nursing)<br><br>E. A daily Monitoring and Evaluation activity was implemented for each of the above areas to ensure evidence of correction of the deficiencies, early identification of any problems, and sustained compliance as delineated below.<br><br>3. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements;<br>A. Performance indicators were developed to assess for compliance with the policies and procedures as follows:<br>- Completion of the patient's Assessment and Reassessment including inspection by the Medical Provider of injured areas;<br>- Completion of the Suicide Risk Monitoring tool and implementation of appropriate interventions including level of observation based on the patient's score and recent presentation of behaviors,<br>-Completion of the Fall Assessment for all falls;<br><br>The DON or trained delegate reviews the Medical Records of patients daily and analyzes them to ensure that all assessments are completed per policy, patients receiving PRN medications are | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEAR VIEW BEHAVIORAL HEALTH | 4770 LARIMER PARKWAY JOHNSTOWN 80534 |

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|---|---|---|---|---|
| H 1208 | Continued From page 166<br>(RN) #7, revealed Patient #9 presented with joint pain, weakness, an unsteady gait, used a wheelchair, and required one person to assist him to walk. RN #7 documented she assessed Patient #9's pain level at a score of 9. The pain was described as sharp and located in the left hip and pelvis, had come on suddenly 2 days prior, and became worse with movement.<br><br>Review of the History and Physical (H&P), completed on 1/1/18 at 12:24 p.m. by Nurse Practitioner (NP) #9, revealed Patient #9 reported no pain and was lying in bed with a pleasant affect. Patient #9 was cleared to participate in the program including activity as tolerated. NP #9's assessment and plan for Patient #9 included addressing his chronic polyarthralgias (pain affecting multiple joints) and acute hip and groin pain with Tylenol 650 mg every 6 hours as needed.<br><br>Review of the Registered Nurse Daily Mental Status Assessment for the 7:00 a.m. to 7:00 p.m. shift on 1/1/18 revealed Registered Nurse (RN) #12 recorded a pain score of 8 for generalized pain. There was no documentation made by RN #12 regarding Patient #9's motor activity (movement). However, the Registered Nurse Daily Assessment Sheet revealed RN #12 documented a nursing note at 1:00 p.m. which stated Patient #9 was complaining of pain in his lungs, heart, groin and legs. He stated he was not able to move his leg because of the pain, and while changing his clothes Patient #9 was verbally aggressive and often cried out in pain.<br><br>On 1/1/18, Patient #9 completed a Patient Self Inventory for Adult Acute where he reported his sleep had been poor last night due to pain, he was having pain-related symptoms he had not had before, and was unable to sign the document because he could not move. This document was reviewed by RN #12 on 1/1/18 at | H 1208 | reassessed per policy, the patient's suicide risk assigned with the Suicide Risk Monitoring tool by the nurse corresponds to patient behaviors and condition, patient falls are assessed per requirement. Pain assessment and monitoring is completed per policy; staff comply with requirements related to a response to a deterioration in the patient's condition; communication to Medical Staff occurs if there is lack of evidence of examination of the patient post fall or other event; Completion of incident reports is accomplished per P&P; and Medical Staff's response to patient complaints of pain from injuries are implemented through additional exam and testing, as appropriate<br><br>The compliance data is recorded on individual data collection sheets with the above titles. The results are transferred to the Hospital's Scorecard for CMS/State Surveys.<br><br>Using these indicators, data from the ongoing assessment for compliance with the established standards is being conducted on a daily basis (S-S). The findings, conclusions, recommendations, and actions are being reported at the Hospital's Morning Leadership meeting, M-F. Compliance issues identified on Saturday and Sunday are being addressed by the Administrator on Call concurrently and reported to the Morning meeting the following Monday.<br><br>To ensure ongoing GB oversight, a weekly Hospital Leadership PI Committee that is attended by a Governing Board member has been implemented whereby all results related to indicators under review to assess for compliance with the corrective | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

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|---|---|---|---|---|
| H 1208 | Continued From page 167<br>1:02 p.m. and reported to the physician and therapist at 1:15 p.m. There was no documentation any reassessment was completed for Patient #9 by either RN #12 or the physician as a result of these statements about the difficulty he was having with pain.<br><br>Review of the MAR revealed Patient #9 was not given any pain medication on 1/1/18 during the day shift.<br><br>Review of the Assessment of the Patient's Medical Status, from the 7:00 p.m. to 7:00 a.m. shift on 1/1/18, revealed RN #7 assessed Patient #9's pain score as a 9 and documented Tylenol and Neurontin were given. Review of the MAR revealed Patient #9 received Neurontin 300 milligrams (mg, used to treat nerve pain), Ativan 1 mg (used to treat anxiety with sedative properties), and acetaminophen 650 mg (treats minor aches and pains) at 8:30 p.m. No reassessment of the patient's response to these medications was documented. This was in contrast to the Pain Assessment policy which stated pain intensity and pain relief were to be assessed and re-assessed at regular intervals using appropriate, reliable methods.<br><br>Review of the Registered Nurse Daily Assessment Sheet revealed a note completed on 1/2/18 at 5:40 a.m. by RN #7 which stated Patient #9 complained of chest pain when he reached across the bed. RN #7 documented Patient #9 grabbed his chest slightly and then let it go. RN #7 documented she took Patient #9's vital signs which were normal. RN #7's note revealed she offered Patient #9 Tylenol and Ativan, but Patient #9 grabbed the medicine cup and threw it across the room and yelled at her, asking her for stronger pain medication and stating: "Why don't you believe me?"<br><br>Review of the medical status assessment form, on 1/2/18 for the 7:00 a.m. to 7:00 p.m. shift, | H 1208 | actions taken pursuant to these deficiencies are being assessed for evidence of effectiveness in the corrective actions taken. The findings are being aggregated by the Director of Compliance/ Quality/Risk and being forwarded to the monthly Quality/PI Council, the monthly Medical Executive Committee and the quarterly Governing Board at each of their respective meetings. Because of the high risk nature of not following these associated policies and procedures, this set of indicators will be monitored indefinitely.<br><br>4.Title of the person(s) responsible for implementing the acceptable PoC:<br>Director of Nursing<br><br>5.<br>GB meeting<br>7/17/18<br>7/18/18<br>7/19/18<br>8/1/18<br>8/14/18<br>8/16/18<br>9/11/18<br><br>GB/LS meeting<br>7/17/18<br>7/18/18<br>7/19/18<br>8/1/18<br>9/7/18<br>9/11/18<br><br>Review of policies<br>7/19/18<br>7/25/18<br><br>Training of staff<br>Assessment | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CLEAR VIEW BEHAVIORAL HEALTH** | **4770 LARIMER PARKWAY JOHNSTOWN 80534** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
|---|---|---|---|---|
| H 1208 | Continued From page 168<br>revealed RN #13 did not document a pain score but stated Patient #9 had chest pain. No additional information about how Patient #9's chest pain was assessed or whether the physician was notified was documented.<br><br>RN #13 also described the patient's gait as unsteady and documented the patient was located on the floor; however, there was no additional documentation which explained why the patient was "on the floor." Review of the Patient Observations document for 1/2/18 revealed an unsigned note which documented Patient #9 told staff he was paralyzed, could not get out of bed, refused to lie on the bed, and preferred to lie on the floor.<br><br>Review of the medical Progress Note, written by NP #27 on 1/2/18 at 9:20 a.m., revealed Patient #9 was in bed yelling and stated he could not get out of bed and his hip was broken. NP #27's Assessment and Plan documented no assessment of Patient #9's mobility or pain. NP #27's plan was to continue Tylenol 650 mg every 6 hours as needed for the chronic polyarthralgias and no narcotics were to be given.<br><br>Review of the Health Pre-Incident Review Report (incident report) written by RN #13 revealed Patient #9 had an unwitnessed fall on 1/2/18 at 1:30 p.m. RN #13 documented Patient #9 was in bed and was later found lying on the floor. RN #13 documented Patient #9 had no apparent injuries; however, there was no documentation of how RN #13 determined Patient #9 was not injured. The incident report revealed the fall was reported to the Nursing Supervisor (NS) #16 and Physician #17.<br><br>There was no documentation of the fall in the medical record including if RN #13 assessed Patient #9 after the fall to ensure he was not injured or if there was a change in the patient's | H 1208 | For Suicidal ideation<br>7/26/18<br>Assessment of Pain, Falls;<br>8/1/18, 8/6/18<br><br>Suicide risk tool<br>8/6/18<br>Incident reports<br>Root cause analyses<br>7/25/18<br><br>M&E implementation and start:<br>8/1/18<br><br>Weekly PI meeting with GB representative present as of:<br>9/14/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **CLEAR VIEW BEHAVIORAL HEALTH** | | STREET ADDRESS, CITY, STATE, ZIP CODE **4770 LARIMER PARKWAY JOHNSTOWN 80534** | |

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|---|---|---|---|---|
| H 1208 | Continued From page 169 | H 1208 | | |

condition.

On 1/2/18 at 5:15 p.m., RN #13 recorded a note on the RN daily assessment sheet describing Patient #9's behavior and how the patient had "wormed" his way out of his room to be out in the milieu (common area). There was no documentation RN #13 reassessed Patient #9's mobility or pain to investigate why he was moving in this manner.

A note documented that evening at 11:00 p.m. by RN #19 revealed Patient #9 continued to lie on the floor and refused to get up. Patient #9 was given an Ativan injection and then told RN #19, "I am paralyzed." There was no documentation in the medical record showing evidence that the patient was assessed by RN #19 as a result of this statement and his unwillingness to move.

Review of the MAR revealed no pain medications were given to Patient #9 on 1/2/18.

Review of the physician's medical progress notes, dated 1/3/18 at 8:30 a.m., showed no evidence the patient was assessed for injuries from his fall and no documentation the NP was even aware of the patient's fall the previous day. NP #27 documented Patient #9 reported pain "all over" and was shaking when she touched him with the stethoscope for examination. NP #27 documented Patient #9 was asking for Percocet, but her plan for managing the patient's chronic polyarthralgias was to continue Tylenol 650 mg every 6 hours as needed and no narcotics were to be given.

Review of the Assessment of the Patient's Medical Status, dated 1/3/18, revealed Patient #9 did not have a numerical pain assessment completed during the day or night shift. There was no record Patient #9 was offered or took any pain medication on 1/3/18.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED |
|---|---|---|---|
| | 064027 | | 07/27/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) | COMPLETION DATE |
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| H 1208 | Continued From page 170<br><br>Review of the medical progress note, dated 1/4/18 at 9:33 a.m., revealed Patient #9 admitted to pain all over his body; however, NP #9 continued the same plan to manage Patient #9's chronic polyarthralgias. In addition, NP #9 directed staff to encourage Patient #9 to get his own drinks, feed himself, transfer to the wheelchair on his own, and propel himself on the unit.<br><br>Review of the Assessment of Patient's Medical Status, dated 1/4/18, revealed RN #13 assessed Patient #9 with a pain score of 9, noting groin and femur pain. There was no documentation on whether this was considered a new concern or how the pain was addressed. There was no documentation this was reported to the physician or NP.<br><br>Review of the medical progress note, dated 1/5/18 at 9:47 a.m., did not reveal an assessment of Patient #9's pain or any changes to the plan of care to manage his pain.<br><br>b. A progress note, written on 1/6/18 at 2:25 a.m. by RN #22, revealed Patient #9 awoke at 1:30 a.m. shouting he was having chest pain and asking for his defibrillator. RN #22 documented she entered Patient #9's room with the mental health technician (MHT) and found the patient mildly responsive (only responding to loud commands), diaphoretic (sweating heavily), shaking, and visibly clutching his chest in pain. A code white (medical emergency) was called, Physician #21 was contacted and an order was obtained to call 911. An ambulance transported Patient #9 to an acute care hospital at approximately 2:00 a.m.<br><br>Review of the Medical Transfer Monitoring Tool, documented by RN #22 on 1/6/18 at 2:45 a.m., revealed Patient #9 had arrived at the receiving facility and was admitted with fractures to his left | H 1208 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | PROVIDER IDENTIFICATION NUMBER: 064027 | MULTIPLE CONSTRUCTION BUILDING: | DATE SURVEY COMPLETED 07/27/2018 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| H 1208 | Continued From page 171<br>ribs, numbers 2 through 5, and a left pelvic fracture. This was a new finding as compared to the imaging results, provided to the facility by the sending acute care hospital, which documented an x-ray of the left hip and pelvis showed no evidence of an acute fracture, dislocation, and showed normal alignment on 12/31/17 at 5:22 p.m.<br><br>c. An interview was conducted on 7/25/18 at 9:27 a.m. with RN #13, who stated he remembered taking care of Patient #9. RN #13 stated he was not aware of why Patient #9 had needed a wheelchair. RN #13 stated he had seen Patient #9 walk, but recalled he was very unsteady. RN #13 stated it was difficult to assess if Patient #9 actually needed to use the wheelchair or was using it as a weapon. RN #13 stated Patient #9 was needy and required a lot of supervision.<br><br>RN #13 recalled taking care of Patient #9 the day he fell. RN #13 stated he typically took the patient's vital signs to see whether they had changed after a fall and documented them in the fall investigative packet. However, on review of the medical record, RN #13 was unable to locate the complete fall packet which included a patient assessment, vital signs and physician notification. RN #13 stated Patient #9's fall was unwitnessed. RN #13 stated all fall documentation, including the reassessment, should have been located in the medical record and he was responsible for putting it in the record.<br><br>d. On 7/26/18 at 9:04 a.m., an interview was conducted with medical NP #26. NP #26 stated he was not familiar with Patient #9, who probably was followed by NP #27, currently on extended leave.<br><br>NP #26 reviewed the H&P and the medical progress notes for Patient #9 and stated Patient | H 1208 | | |

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| H 1208 | Continued From page 172<br>#9 had significant medical issues upon admission including a defibrillator, acute onset of hip pain, and generalized weakness. After reviewing Patient #9's medical history, NP #26 stated he would have been concerned about Patient #9, stating he was about as acute of a patient as he was comfortable for the facility to accept. Specifically, NP #26 stated he would have been worried about Patient #9's oxygen needs, fall risk, chronic pain, unsteady gait, breathing difficulties, cardiovascular status, and acute groin and hip pain.<br><br>NP #26 reviewed NP #27's medical progress note from 1/3/18 and stated it did not appear, based on her documentation, NP #27 was aware of Patient #9's fall or had assessed his mobility. NP #26 stated he would have wanted to be notified of Patient #9's fall to have the opportunity to reassess the Patient and ensure the Patient was not more injured than staff realized.<br><br>NP #26 reviewed the Medical Transfer Monitoring Tool and learned of the fractures to Patient #9's left pelvis and left ribs, numbers 2 through 5, which were discovered after Patient #9 was emergently transferred from the facility. NP #26 stated he was not aware of this finding, but he was concerned the facility should have done more follow-up. NP #26 stated Patient #9 was complaining of pain all over his body in the presence of a fall. He stated the facility should have looked a little harder, assessed the patient further, considered an X-ray, and reviewed the patient's condition after the fall compared to when he first arrived. NP #26 stated Patient #9 became unable to walk, which was a significant change in the patient's condition, and the injury should have been caught sooner. | H 1208 | | |