BEFORE THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
STATE OF COLORADO
Case No. **019-003-HOSPITAL**

NOTICE OF CHARGES AND NOTICE OF DUTY TO ANSWER

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
HEALTH FACILITIES AND EMERGENCY MEDICAL SERVICES DIVISION,
Petitioner,

v.

SBH – North Denver, LLC dba Clear View Behavioral Health ("Facility"),
SBH North Denver, LLC ("Licensee"),
Daniel Zarecky ("Administrator"),
Sharon Pendlebury ("CEO"),
James T. Shaheen ("CEO" and "President"),
Edward J. Dobbs ("Vice President"),
William H. Lawson, Jr. ("Secretary"),
Mike A. Orians ("Treasurer"),
Caroline Kirby Dobbs Floyd 2012 Trust ("Stockholder"),
Caroline Kirby Dobbs 1985 Trust ("Stockholder"),
John Hull Dobbs Jr. 1985 Trust ("Stockholder"),
Jackson Dobbs Allen 2012 Trust ("Stockholder"),
Edward Dobbs Grantor Trust ("Stockholder"), and
Edward J. Dobbs 2009 Trust ("Stockholder"),
Respondents.

THE PEOPLE OF THE STATE OF COLORADO

TO: SBH – North Denver, LLC dba Clear View Behavioral Health, Facility
Mr. Daniel Zarecky, Administrator
4770 Larimer Parkway
Johnstown, Colorado 80534

TO: SBH – North Denver, LLC, Licensee
Beth McClenathan, Director of Nursing
Sharon Pendlebury, CEO
James T. Shaheen, CEO & President
Edward J. Dobbs, Vice President
William H. Lawson, Jr., Secretary
Mike A. Orians, Treasurer
8295 Tournament Drive, Suite 201
Memphis, Tennessee 38655

TO: Caroline Kirby Dobbs Floyd 2012 Trust, Stockholder
Caroline Kirby Dobbs 1985 Trust, Stockholder
John Hull Dobbs Jr. 1985 Trust, Stockholder
Jackson Dobbs Allen 2012 Trust, Stockholder
Edward Dobbs Grantor Trust, Stockholder
Edward J. Dobbs 2009 Trust, Stockholder
6070 Poplar Avenue, Suite 750
Memphis, Tennessee 38119

NOTICE OF DUTY TO ANSWER

YOU ARE HEREBY NOTIFIED that pursuant to Colorado Revised Statutes (C.R.S.) § 24-4-105(2)(b), you are required to file a written answer to the Notice of Charges set forth below. Your **ORIGINAL** answer is to be filed **within thirty (30) days after the mailing of this Notice** as follows:

Michael Lastoczy
Records Manager
Department of Public Health and Environment
Health Facilities and Emergency Medical Services Division
4300 Cherry Creek Drive South
Denver, Colorado 80246

A copy of your answer must ALSO be mailed to the undersigned Assistant Attorney General at the same time it is filed with the Department of Public Health and Environment:

Joan E. Smith*
Assistant Attorney General
Health Care Unit
State Services Section
1300 Broadway, 6th Floor
Denver, Colorado 80203
Ph: (720) 508-6148
*Counsel of Record

IF YOU FAIL TO FILE YOUR WRITTEN ANSWER WITHIN THE TIME REQUIRED, THEN WITHOUT ANY FURTHER NOTICE, AN ORDER ENTERING A DEFAULT DECISION MAY BE ISSUED AGAINST YOU FOR THE RELIEF REQUESTED IN THE NOTICE OF CHARGES OR SUCH OTHER RELIEF OR REMEDIES AS MAY BE PROVIDED BY LAW.

You are hereby further notified that after receipt of a timely answer filed by you, a hearing will be held before an Administrative Law Judge designated by the Office of Administrative Courts, the State Department of Personnel & Administration authorized to act on behalf of the Department. The Administrative Law Judge will determine whether, on the basis of

the charges set forth below, your license to operate a psychiatric hospital should be revoked. Notice of the time and place will be sent to you not less than thirty days before the date of the hearing.

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NOTICE OF CHARGES AND NOTICE OF DUTY TO ANSWER

The Department alleges that the Respondents' license to operate a psychiatric hospital named Clear View Behavioral Health, state health facility license number 011527, should be revoked based on the following charges:

1. SBH North Denver, LLC ("Licensee"), Daniel Zarecky ("Administrator"), Beth McClenathan ("Director of Nursing"), Sharon Pendlebury ("CEO"), James T. Shaheen ("CEO" and "President"), Edward J. Dobbs ("Vice President"), William H. Lawson, Jr. ("Secretary"), Mike A. Orians ("Treasurer"), Caroline Kirby Dobbs Floyd 2012 Trust ("Stockholder"), Caroline Kirby Dobbs 1985 Trust ("Stockholder"), John Hull Dobbs Jr. 1985 Trust ("Stockholder"), Jackson Dobbs Allen 2012 Trust ("Stockholder"), Edward Dobbs Grantor Trust ("Stockholder"), Edward J. Dobbs 2009 Trust ("Stockholder"), (hereinafter, collectively, "Respondents"), applied for and subsequently received an initial health facility license to operate a psychiatric hospital named SB SBH – North Denver, LLC dba Clear View Behavioral Health ("Facility") from the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division ("Department") on November 25, 2015.

2. Licensee/Respondents own and operate the Facility, located at 4770 Larimer Parkway, Johnstown, Colorado 80534, with an effective license renewal term of November 25, 2018 to November 24, 2019. After issuing Licensee/Respondents' most recent renewal license, the Department issued Licensee/ Respondents a conditional license with a term of February 1, 2019, to January 24, 2020.

3. On February 11, 2016, Licensee/Respondents received accreditation of the Facility by the Centers for Medicare & Medicaid Services ("CMS") as a provider of psychiatric hospital services under 42 C.F.R. § 482.

4. Licensee/Respondents were approved by the Joint Commission ("JC"), a private organization that surveys hospitals, for a term effective December 7, 2018 until February December 7, 2021. Pursuant to Colorado House Bill 12-1294, the Department no longer completes unannounced licensure survey inspections when a facility is considered deemed by the JC. The JC conducts surveys in place of CMS. However, the Department maintains the authority and duty to investigate and conduct unannounced investigations based on complaints submitted to the Department under both federal and state regulations.

5. Although the Joint Commission conducts regular surveys at the Facility, the Department is the contracted agent and conducts regular certification surveys and complaint investigations of Licensee/Respondents' Facility on behalf of CMS and the Department. The Department does not have authority over the determinations CMS ultimately makes regarding a licensee's certification to provide services as a CMS participant. The Department makes only recommendations to CMS, as the contracted surveyor. The Department may make recommendations as to whether CMS should recertify or

terminate a licensee from its respective programs. In this Notice of Charges and Duty to Respond, the Department cites to Licensee/Respondents' deficient practice in violation of both federal and state regulations.

6. Licensee/Respondents are required to operate the psychiatric hospital at least at minimum standards for psychiatric hospitals, as established by applicable federal and state statutes and regulations for psychiatric hospitals, including, but not limited to section 25-3-101, *et seq.*, C.R.S.; 6 C.C.R. 1011-1, Chapters 2, 4, and 18; and applicable provisions of 6 C.C.R. 1011-1, Chapter 4.

7. The Department is authorized by section 25-3-103, C.R.S., to issue health facility licenses for the psychiatric hospital health facility type. The Department has jurisdiction over the license, persons, Licensee, Facility, and subject matter herein.

8. Pursuant to section 25-3-102(1)(c), C.R.S., the Department shall issue licenses to those applicants furnishing satisfactory evidence of fitness to conduct and maintain a health facility. The Department shall determine the license applicant's fitness solely based on the specific fitness information or documentation submitted by the applicant upon the Department's request or as otherwise acquired by the Department through its own review or investigation of the applicant. *Id.*

9. The Department is authorized to suspend, revoke, or refuse to renew the license of any hospital that is out of compliance with the requirements of Article 3 of Title 25 pertaining to psychiatric hospitals or with the rules promulgated thereunder.

10. Similarly, the Department regulations at 6 C.C.R. 1011-1, Chapter 2, Section 2.12.4, provide that the Department may revoke, suspend, annul, limit, or modify an existing license at any time during the license term because of a licensee's failure to comply with any of the applicable statutes or regulations. Specifically, 6 C.C.R. 1011-1, Chapter 2, Section 2.12.4 gives the Department authority to revoke or suspend an existing license for good cause including, but not limited to, circumstances in which an owner, officer, director, manager, administrator, and other employee of a licensee: (A) Fails or refuses to comply with the statutory and/or regulatory requirements applicable to that license type; (B) Makes a false statement of material fact about the individuals served by the licensee, its staff, capacity, or other operational components verbally or in any public document or in a matter under investigation by the Department or another governmental entity; (C) Prevents, interferes with, or attempts to impede in any way the work of a representative or agent of the Department in investigating or enforcing the applicable statutes or regulations; (D) Falsely advertises or in any way misrepresents the licensee's ability to care for the individuals served based on the license type or status; (E) Fails to provide reports and documents required by regulation or statutes in a timely and complete fashion; (F) Fails to comply with or complete a plan of correction in the time or manner specified; or (G) Falsifies records or documents.

11. On February 1, 2019, the Department issued Licensee/Respondents' a conditional license after the Department's completion of four complaint investigations on July 27, 2018, under both the state license regulations and the federal requirements set forth in the CMS Conditions of Participation to participate in Medicare programs. The Department declared a finding of "Immediate Jeopardy" under the Infection Control Condition of Participation. The Department determined, in part, that Licensee failed to maintain a sanitary environment throughout all patient care areas and in the kitchen, which was used to prepare patient meals. In addition, Licensee'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 contracting infections. (The Department's CMS 2567 reports for Event IDs OEEC11and KM4F11 detailing deficiencies are hereby incorporated by reference and merged with this Notice.)

12. Two days later, the Department identified a second "Immediate Jeopardy" finding under the Patient Rights Condition of Participation. The Department determined that Licensee failed to provide patient care in a safe setting. Specifically, Licensee failed to investigate patient falls, which potentially resulted in patient injuries, and failed to ensure a safe environment of care by failing to identify and reduce ligature risks. Further, the Department determined that Licensee failed to investigate suicide attempts and ensure interventions were implemented to prevent further suicide attempts. These failures resulted in patient injuries and multiple suicide attempts which Licensee/Respondents failed to investigate. The Department provided Licensee/Respondents with an opportunity to present written data, views, and arguments to the Department as to why the Department should not issue a conditional license to Licensee/Respondents, pursuant to section 24-4-104(3)(a), C.R.S. In addition to the Immediate Jeopardy findings, the Department requested responses to concerning trends in specific areas of care including: failure to provide care involving suicide attempts; failure to provide care involving patient seclusion and restraints; failure to provide care involving patient falls; and failure to provide care involving hygiene and sanitation (attached hereto as Ex. 1: CDPHE Request for Written Data, Views and Arguments).

13. Licensee/Respondents provided a response to the Department on December 28, 2018. Licensee/Respondents requested that the Department forgo issuing a conditional license for reasons including that Licensee/Respondents "not only corrected the deficient practices identified, but has voluntarily implemented significant changes to its personnel and systems to ensure that such incidents will not recur and will in fact allow the [F]acility to achieve sustained compliance." (attached hereto as Ex. 2: Clear View Submission). Licensee/Respondents also proposed hiring a consultant of its choosing to assist with "training onsite personnel in the performance of focused investigations into the root cause of an incident and developing corrective action plans with follow up audits to assess the effectiveness of those plans in addressing and correcting deficient practices that may have led to such incidents." *Id.*

14. On February 1, 2019, after consideration of Licensee/Respondents' written data, views, and argument submissions, the Department determined that the best interests of the State of Colorado, the public, the patients, and the consumers of Licensee/Respondents' Facility would be served by issuing Licensee/Respondents' a conditional license to operate the Facility. The Department required the conditional license term to run concurrent with Licensee's existing health facility license.

15. The Department issued the conditional license and informed Licensee/Respondents that pursuant to 6 C.C.R. 1011-1, Chapter 2, Section 2.9.4, Licensee/Respondents are required to immediately comply with all conditions until and unless said conditions are overturned or stayed on appeal (attached hereto as Ex. 3: Conditional License Terms). Licensee/Respondents elected not to appeal the Department's determination to issue a conditional license and paid the conditional license fee of $676.00 on February 7, 2019.

16. Over the course of Licensee's license history, the Department has conducted an initial state licensure survey, 18 state complaint investigations including revisit complaint investigations, and 17 federal complaint investigations including revisit complaint investigations. The Department determined that the complaints were substantiated in 17 of 19 initial complaint investigations.

17. Since July 27, 2018, Licensee/Respondents have unable to sustain compliance with state licensing and/or federal certification requirements and have been cited by the Department for 85 deficiencies. The Department has declared two separate determinations of Immediate Jeopardy and has made condition-level findings for Federal Conditions of Participation noncompliance seven times in two separate events. Importantly, Licensee/Respondents have been out of compliance for eleven months and have failed to demonstrate evidence that the Facility's compliance is improving.

18. The Department brings this license revocation action based on Licensee/Respondents' failure to rectify the deficient practices that formed the basis for the conditional license and Licensee/Respondents' failure to comply with the requirements of the conditional license, notably Licensee/Respondents' failure to comply with applicable statutes and regulations.

COUNT I

Licensee/Respondents Failed to Follow, Refused to Comply, and/or Materially Breached the Conditions and Limitations Imposed by the Department in the Conditional License

§ 24-4-104, C.R.S.
§ 25-1.5-103, C.R.S.
§ 25-3-101, C.R.S.
6 C.C.R. 1011-1, Chapter 2
6 C.C.R. 1011-1, Chapter 4
6 C.C.R. 1011-1, Chapter 18

19. Paragraphs 1 through 18 above are hereby incorporated, as though fully set forth herein.

20. Licensee/Respondents demonstrated a failure, refusal to comply, and/or breach of the conditions and limitations imposed by the Department in the conditional license demonstrated by Licensee/Respondents' failure to comply with all applicable State and Federal rules, regulations, standards and laws, including without limitation, 6 C.C.R. 1011-1, Chapters 2, 4, and 18 and Sections 25-1.5-103 and 25-3-101, *et seq.,* C.R.S.

21. Based on surveys and complaint investigations conducted at Licensee/Respondents' Facility, the Department required Licensee/Respondents to comply with the following for the term of the conditional license:

    a. Licensee/Respondents are required to retain a Quality Assurance Consultant for the duration of the conditional license. The purpose of the Quality Assurance Consultant is to review and evaluate Licensee/Respondents' processes and practices in the clinical environment, including quality assurances and quality improvement activities, processes and analysis, and provide the Department with an initial written report regarding current processes and practices that may result in negative consequences. The Quality Assurance Consultant is required to provide an on-going monthly report of the comprehensiveness of the quality assurance practices and a gap analysis comparing the present state of the quality assurance program with its future state.

        i. The Department requires the Quality Management Consultant to conduct on-going evaluations of all sentinel events, unplanned events, including rapid response, unplanned patient transfers or deaths, and all incidents resulting in harm or potential harm to a patient. Licensee/Respondents are required to propose a Quality Management Consultant who possesses certain qualifications, and if approved by the Department, that individual is required to submit findings to the Department.

    b. Licensee/Respondents are also required to retain a Nurse Educator Consultant for the duration of the conditional license. The purpose of the Nurse Educator Consultant is to provide technical assistance and training to ensure competent skill levels in initial competencies prior to providing direct patient care for all nursing staff, including registered nurses, licensed practical nurses, certified nurse aides, and mental health technicians.

        i. The Department requires the Nurse Educator Consultant to prepare annual written education plans for ongoing training for all staff, including training for the Director of Nursing, Nurse Manager and Director of Quality to include: care in a safe setting; patient rights; grievances; informed decisions; privacy; ligature risks; use of

restraints/seclusions; and documentation. Licensee/Respondents are required to propose a Nurse Educator Consultant who possesses certain qualifications, and if approved by the Department, that individual is required to submit training and education plans, as well as written monthly reports of the percentage of staff members who have successfully completed the training that the Nurse Educator Consultant delivered and the schedule for the remaining staff members to complete training.

c. Licensee/Respondents' Director of Quality, Director of Nursing, and Nurse Manager are required to complete the Integrated Surveyor Training Website CMS Survey and Certification Group course for Hospital Basic Training Part 1 and 2, Universal Infection Control, and to familiarize themselves with the Psychiatric Hospital State Operations Manual, Appendix AA. The Director of Quality, Director of Nursing, and Nurse Manager are required to submit progress documentation including pre-tests, post-tests, course bookmarking tools, and certificates of completion.

d. In addition to the consultant and education portion of the conditional license, Licensee/Respondents are required to immediately comply with and ensure that at least one (1) qualified registered nurse is on duty at all times in the patient care unit, as required by 6 C.C.R. 1011-1, Chapter 4, Section 12.101(5).

e. The Department required that within 45 days of the effective date of the conditional license, Licensee/Respondents submit an acuity staffing matrix to be used with the advice and consent of the Director of Nursing, Nurse Manager, and the Nurse Educator Consultant. The acuity tool is to clearly delineate minimum staffing for any open patient care unit, as well as additional staffing based on census and patients requiring line-of-site observation, one-on-one staffing, and seclusion and/or restraints. Licensee/Respondents are required to base the acuity model on evidence-based practice.

f. The Department included a material breach clause in the conditional license, which states:

> Continued licensure under the terms of this Conditional License is dependent upon the Facility's and/or Licensee's compliance with all provisions contained herein. Failure to comply with the requirements of Paragraphs 3 and 4 may constitute a material breach of this Conditional License, as determined by the Department. Material breach of this Conditional License by Licensee/Facility authorizes the Department to declare that the Conditional License provisions are unmet and authorizes the Department to proceed with Facility closure and license revocation as set forth in state regulations and law. Material breach of this Conditional

License by Licensee/Facility also authorizes the Department to take other action against Licensee's license and may provide good cause to the Colorado Department of Health Care Policy and Financing to decertify Licensee/Facility and to terminate Licensee/Facility's Medicaid Provider Agreement. Examples of material breach include, but are not limited to, the following: **Failure to comply with the requirements of Paragraphs 3 [Compliance with Applicable Statutes and Regulations] and 4 [Licensee/Facility Operations Conditions and Limitations]**; Failure to adhere to guidance and direction from a consultant; A finding of immediate jeopardy at any time; or **Failure of Facility and/or Licensee to comply with all applicable state rules, regulations and standards, including without limitation, Chapters 2 and 18 of the Department's regulations (6 C.C.R. 1011-1) and the provisions of Article 3 of Title 25, C.R.S.** (Emphasis added).

g. The Department required Licensee/Respondents to retain the pre-approved Quality Assurance Consultant within 20 days of the conditional license effective date, and retain the pre-approved Nurse Educator Consultant within 30 days of the conditional license effective date. The conditional license effective date is February 1, 2019. On February 15, 2019, Licensee/Respondents contacted the Department and stated that they were having trouble finding a Quality Assurance Consultant and a Nurse Educator Consultant that met the Department's requirements. On February 28, 2019, the Department received an executed Nurse Educator Consultant contract. The Nurse Educator Consultant has submitted written reports to the Department beginning March 14, 2019, to present.

h. On May 10, 2019, the Department received an executed Quality Assurance Consultant contract. The Quality Assurance Consultant has submitted reports to the Department beginning June 3, 2019, to present.

22. Section 25-1.5-103(1)(a)(I)(A), C.R.S. invests the Department with the power and duty to annually license and to establish and enforce standards for the operation of psychiatric hospitals.

23. Sections 25-1.5-103(F), 24-4-104, and 25-3-102, C.R.S. govern the issuance, suspension, renewal, revocation, annulment, or modification of licenses. Section 25-1.5-103, C.R.S., states, in relevant part, "Nothing contained in this paragraph (a) prevents the Department from adopting and enforcing, with respect to projects for which federal assistance has been obtained or is requested, higher standards as may be required by applicable federal laws or regulations of federal agencies responsible for the administration of applicable federal laws."

24. Pursuant to section 25-3-102.1(b)(III), C.R.S., if the Department takes an enforcement activity, as defined in section 25-1.5-103(2)(b.5), against a health facility to which it has

granted deemed status, the Department may revoke the health facility's deemed status.

25. Paragraph 3 of the conditional license mandates that "At all times, Licensee/Facility shall comply with all applicable State and Federal rules, regulations, standards, and laws, including and without limitation, Chapters 2 and 18 (6 C.C.R. 1011-1) of the Department's regulations, and the provisions of Article 3, Title 25, Colorado Revised Statutes. Licensee/Facility has an ongoing obligation to comply with all applicable Department rules and regulations concerning any amendment to documents or change in other information required for licensure that may have previously been submitted to the Department."

26. On March 26, 2019, CMS notified Licensee/Respondents that it had determined that Clear View Behavioral Health is not in compliance with the Conditions of Participation for hospitals, and placed it on a 90-day termination tract. CMS based its decision on the February 1, 2019, abbreviated revisit complaint investigation Event ID LK8611 and extended health survey to determine compliance with applicable general hospital requirements, conducted by the Department on behalf of CMS (attached hereto as Ex. 4: CMS Letter). In the letter, CMS informed Licensee/Respondents that the Department of Health and Human Services intends to terminate its provider agreement with Clear View Behavioral Health effective June 24, 2019. The letter informed Licensee/Respondents that the Department would retain survey jurisdiction until Clear View Behavioral Health is in compliance with all Medicare Conditions of Participation. The letter stated that Clear View Behavioral Health failed to meet the following Conditions of Participation: Title 42 C.F.R. Section 482.12 Governing Body; Section 482.13 Patient Rights; and Section 482.23 Nursing Services. CMS informed Licensee/Respondents that it could avoid the 90 day termination action by correcting the condition-level deficiencies prior to the effective date of termination, and that CMS must receive and approve a credible allegation of compliance, in sufficient time to verify, with an unannounced revisit by the Department that the condition-level deficiencies have been corrected. The letter detailed what was required of Licensee/Respondents' plan of correction and provided a deadline of April 5, 2019. The letter stated that the plan of correction would be reviewed for content; however, only an onsite unannounced survey at the Facility shall provide a determination that these areas of non-compliance have been corrected.

27. Generally, the Department investigates complaints regarding a health facility by evaluating the complaint to determine whether and when an onsite investigation is necessary. The Department schedules an unannounced surveyor to visit the facility to investigate complaint allegations under either state or federal regulations, or both. If the surveyor investigates and finds that the allegations are substantiated, the surveyor writes a deficiency list (CMS Form 2567), reporting the Department's findings. The facility has an opportunity to submit a plan of correction describing how it will correct the deficiencies cited. The Department then conducts an unannounced revisit investigation to determine whether the facility has corrected the previous deficiencies cited as it stated in its plan of correction. If the Department finds that it has corrected the deficiencies, then the Department determines that the facility is in substantial compliance and no further

unannounced revisits are necessary under the deficiencies cited. If the Department finds that the facility has not corrected the deficient practice, the Department will recite the deficiency, require the facility to submit another plan of correction, and will schedule another revisit investigation. If the Department is onsite at the facility on a revisit investigation and finds new deficiencies not included within the scope of the revisit investigation, the Department opens a new complaint investigation event for those new deficiencies and the process to monitor compliance under those new deficiencies will be tracked under the new complaint investigation event and not simply added to the original complaint revisit investigation. If the Department is conducting an investigation of any kind and determines that the scope and severity of a deficiency creates a situation of Immediate Jeopardy, the Department does not exit the investigation until the facility has abated the Immediate Jeopardy threat.

28. On May 29, 2019, the Department completed unannounced, third revisit state complaint investigation Event ID OEEC14; federal revisit complaint investigation Event ID LK8612; and first revisit state complaint investigation Event ID BEXX12. The Department discovered new deficiencies not within the scope of the three investigations the Department was onsite investigating, and added the new deficiencies to initial state complaint investigation Event ID Q47411, and initial federal complaint investigation Event ID 8RQW11. (The Department's CMS 2567 reports for Event IDs OEEC14, LK8612, and BEXX12, Q47411, and 8RQW11, detailing deficiencies are hereby incorporated by reference and merged with this Notice.) The Department's five surveys resulted in repeat citations for the following deficient areas of care:

I. Licensee/Respondents Failed to Provide Care in a Safe Setting

A. The Department conducted a third state complaint revisit investigation to determine whether Licensee/Respondents corrected the deficiencies cited in the second revisit state complaint investigation on February 1, 2019.

B. The Department accepted Licensee/Respondents' plan of correction on May 2, 2019, after the February 1, 2019, complaint survey describing how it intended to correct the deficiencies cited.

C. The Department also issued the conditional license on February 1, 2019, to Licensee/Respondents requiring Licensee/Respondents to put measures in place to correct previous deficient practice.

D. Despite the Department citing Licensee/Respondents for failure to provide care in a safe setting on three previous surveys, despite Licensee/Respondents' submitted plan of correction describing how it would bring the Facility back into substantial compliance, and despite the Department issuing a conditional license requiring that Licensee/Respondents implement extensive corrective processes and procedures, the Department determined that Licensee/Respondents had not achieved compliance when it went to conduct the third revisit for this Event ID.

The Department recited Licensee/Respondents for failing to provide care in a safe setting in Event ID OEEC14, citing the following:

E. Pursuant to 6 C.C.R. 1011-1, Chapter 4, Section 6.102(5), the governing board of a hospital shall ensure that the patients receive care in a safe setting.

F. Based on interviews and document review, Licensee/Respondents failed to track contraband for three of three patient care units. The Department observed Licensee/Respondents' policy which specifically stated that Licensee/Respondents would check and monitor patient rooms for contraband items which patients could use for self-harm. Licensee/Respondents' Environmental Unit Rounds Policy stated that "Environmental Unit rounds will be performed to establish and maintain patient safety. The frequency of rounds is dictated by patient acuity and unit concerns, and is performed five times every shift by mental health technicians. The mental health technicians will check and monitor for: Patient rooms are free of any contraband (sharps, aerosol cans, belts, ties, mirrors, razor, glass containers, strings, sporks, plastic bags of any size, caps for juice soda or water bottles). All community areas are free of contraband that can be potentially used for self-harm. Nurse on the unit is made aware by the mental health technicians of any increased patient acuity and/or unit concerns. The above rounds are documented on the Unit Environmental Checklist."

G. The Department also reviewed Licensee/Facility's guidance document for staff members, entitled Leadership Patient Safety Checklist, stating, "This is a patient-focused review. For each patient care shift, complete an assessment of the following parameters. Summarize results and submit findings to the Chief Operating Officer for compilation. Safety: Environment of Care Observations, **any loose pencils** seen in patient areas unsupervised by staff." (Emphasis added).

H. Despite Licensee/Respondents' identification that loose pencils were identified as contraband and a threat to patient safety, the Department determined that Licensee/Respondents failed to track pencils used by patients. The Department conducted a tour of patient care unit 300 and interviewed mental health technician #10 (MHT #10). MHT #10 stated she counted pencils every morning when she started her shift and documented this in the pencil log. She said pencils were to be counted at the beginning of each shift, including day shift and night shift and told the Department that it was important for staff to know the baseline inventory at the beginning of the shift, and account for all pencils to keep patients and staff safe. MHT #10 stated it was important to track contraband, and that pencils were considered contraband and that they could be used by patients to hurt themselves or someone else.

I. The Department reviewed the pencil log for patient care unit 300 and observed from May 1, 2019, through May 28, 2019, (a total of 56 shifts) there were 38 shifts missing a pencil inventory count. The Department reviewed an Incident

Report which stated that House Supervisor #14 searched a walker pouch in a patient room and found three pencils, three sporks, and three apple juice caps, all of which were considered contraband items pursuant to Licensee/Respondents' policy and guidance documents. The Incident Report stated a staff member signed out one of the pencils close to shift change without using the pencil sign out sheet. House Supervisor #14 documented that she had recently provided training to the mental health technicians that had worked the last couple of days.

J. However, the Department observed further documentation dated after the Incident Report and after subsequent training evidencing Licensee/Respondents continued failure to take consistent inventory of pencils. On May 10, 2019, the Department observed documentation showing that a pencil count had not been performed by staff members on May 10, 2019, and not performed again until night shift on May 11, 2019; a total of four shifts with staff members failing to conduct a pencil count. The Department observed documentation that staff members had conducted a pencil count on May 11, 2019, but then had not conducted another pencil count until six shifts later, on May 15, 2019. The Department observed documentation that staff members completed a pencil count on May 18, 2019, but did not conduct a pencil count for another seven shifts on May 22, 2019. The Department observed documentation that staff members completed a pencil count on May 26, 2019, and failed to complete another pencil count for five shifts on May 29, 2019. The Department determined that Licensee/Respondents failed to conduct pencil inventory for at least 38 shifts in May 2019.

K. The Department interviewed MHT #10 about the pencil log during the tour of patient care unit 300. MHT #10 told the Department that she logged the pencil count at the beginning of her shift on May 29, 2019, and there were six pencils; however, she was unable to explain why seven pencils were logged three days earlier on May 26, 2019, because there was no documentation to explain what happened to the missing pencil. MHT #10 stated there had been an issue with logging pencils on patient care unit 300 but she was unsure of who to speak with regarding her concerns. MRT #10 told the Department that it was important to accurately log pencils for inventory because it ensures everyone on the unit was safe and it was important to know which patients had pencils in their possession. The Department interviewed the patient care unit registered nurse (RN) #9 who said when pencils were missing it was dangerous because pencils were a sharp pointy object that patients could use to harm themselves or others and were unsafe. Shortly afterward, the Department conducted an interview with lead MHT #11 on the patient care unit who stated it was important to decrease contraband on the unit for patient safety; she stated tracking pencils was important so staff knew who had the pencils. The Department reviewed the pencil log for patient care unit 300 and observed that no staff member had conducted a pencil count during MHT #11's prior shift. MHT #11 stated she was unsure why they had not documented the count, and stated sometimes it may have been overlooked. MHT #11 stated not tracking pencils was a risk to patient safety and patients could use pencils to

stab someone, or themselves, or patients could eat them.

L. The Department reviewed the pencil log for patient care unit 400. The Department determined that from May 1, 2019, through May 28, 2019, Licensee/Respondents failed to conduct a missing pencil inventory count on 17 of 56 shifts. The Department determined that from the May 1, 2019, night shift to the May 5, 2019, night shift, Licensee/Respondents failed to conduct a single night shift pencil count. Similarly, the Department determined that on night shifts from May 15, 2019, to May 19, 2019, Licensee/Respondents failed to conduct a single pencil count.

M. The Department reviewed the pencil log for patient care unit 600. The Department determined that from May 1, 2019, to May 28, 2019, Licensee/Respondents failed to perform pencil inventory counts in 26 of 56 shifts. The Department conducted an interview with MHT #16 on patient care unit 600 regarding the pencil log. MHT #16 stated she was unsure of what may have happened to the two pencils which were unaccounted for on the pencil log from May 22, 2019, to May 24, 2019. MHT #16 told the Department that the pencils maybe had been lost or broken. She stated that the pencils were to be counted at the beginning of every shift to verify the count, and that the entries should be dated and initialed by staff members.

N. The Department conducted an interview with RN #17 on patient care unit 600, who reviewed the pencil log for May 22, 2019, to May 24, 2019. She said she was unable to tell what happened with the two pencils from reviewing the log. She told the Department that pencils were a big safety issue because they were sharp objects and the pencils could be used by patients to harm themselves or others. RN #17 stated she received contraband training from Licensee/Respondents but was unsure if pencils had been included in the training, and that the mental health technicians were responsible for tracking pencils so they did not get misplaced.

O. The Department interviewed the Director of Compliance, Quality, and Risk (Director #5) who stated she had never reviewed the pencil logs on the three units. She said she was unaware of any policies or guidelines for staff members to use for the pencil sign in and sign out process. Director #5 told the Department that she had provided training for staff members on contraband but did not include pencils in her training. The Director stated the pencils could be used by patients to harm themselves or others, but was unable to provide a policy or procedure that outlined the process for pencil sign in and sign out, or a procedure for pencil inventory that was available for staff members to reference.

P. The Department recited Licensee/Respondents for failure to provide care in a safe setting for third revisit state complaint investigation Event ID OEEC14. The Department cited Licensee/Respondents for failure to provide care in a safe setting in Event ID OEEC13, OEEC12, and OEEC11; Licensee/Facility failed to

achieve compliance for a fourth time for the Event ID OEEC14. The Department had previously cited failure to provide care in a safe setting in federal complaint investigation revisit Event ID LK8612; state complaint investigation revisit Event ID BEXX12; and initial state complaint investigation Event ID Q47411. (The Department's CMS 2567 reports for Event IDs OEEC11 and OEEC12, detailing deficiencies are hereby incorporated by reference and merged with this Notice.)

Q. Importantly, the Department cited Licensee/Respondents for failure to provide care in a safe setting in two previous events on February 1, 2019, for failing to ensure services provided to patients were provided in a safe setting, impacting all patients admitted to the Facility. Specifically, Licensee/Respondents failed to follow processes to ensure patients did not have access to contraband and failed to monitor patients who were ordered to be on Line of Sight monitoring, and failed to increase the level of observation for patients who attempted suicide while in the Facility to further prevent suicide attempts. These failures resulted in multiple suicide attempts by patients who had been admitted to the Facility for risk of attempted suicide.

R. The Department reviewed Licensee/Respondents' Patient Belongings and Contraband Policy which stated that contraband was any weapon, illegal drugs, unidentified substance or powder, alcoholic liquids, or item that could impact patient safety including but not limited to: belts, drawstrings, drug paraphernalia, illegal substances, razor blades, or other sharp objects. Licensee/Respondents' Safety Plan stated that patients may need to be kept safe from themselves and/or from doing harm to others, and informed staff members to be knowledgeable of contraband and assure compliance. Licensee/Respondents' Search for Contraband Policy instructed staff members that upon admission or at any time during hospitalization the patient, his/her clothing, belongings or room may be searched. The policy stated that "[N]o belongings are to be on the unit without having been searched for contraband. Belongings are to be kept in the nurse's station until a search has been completed. Each item is to be searched for contraband. A unit search is a methodical search of all patients' rooms and common areas when staff identified contraband may be present on the unit." Licensee/Respondents' Visitor/Visitation Policy requires that in order to protect the therapeutic milieu for all hospitalized patients, no items such as lighters, matches, scissors, mirrors, tweezers and any other sharp objects should be loaned or given to the patient under any circumstance. The policy stated "Visitors will be wanded back and front with the metal detector and asked to turn their pockets inside out. Visitors will remove all bulky clothing (jackets, ponchos, coveralls, etc.)." Licensee/Respondents' Critical Event and Review and Reporting Policy provided guidelines for communicating, investigating and acting upon critical events and critical analysis shall be completed within 20 days of knowledge of an event that results in or has the potential to cause serious harm or death. Despite Licensee/Respondents' policies and procedures in place, the Department determined that Licensee/Respondents failed to ensure hospital policy was

followed so patients did not have accesses to contraband, and Licensee/Respondents failed to ensure occurrences in which patients were found with contraband were investigated to prevent reoccurrence of events.

S. The Department reviewed Patient #11's medical record which revealed an incident where Patient #11 injected herself with heroin and then injected Patient #17 (admitted with suicide ideation of overdosing) and Patient #18 (admitted with suicide ideation) with heroin as well. Review of Licensee/Respondents' incident report revealed Patient #11, admitted for an intentional overdose of prescription and over the counter drugs, brought contraband on the unit, which consisted of a lighter, metal spoon, multiple syringes, and a substance suspected to be heroin. The Department reviewed Nursing Supervisor #19's documentation that the substance and other contraband were removed, and the contraband was handed over to the police and a thorough shakedown of the unit occurred. The Department reviewed Director of Nursing (DON) #18's documentation that Patient #11's roommate (Patient #17) stated she had been injected with heroin by Patient #11 after Patient #11's husband brought the heroin into the Facility when visiting.

T. The Department reviewed Patient #17's incident report which showed Patient #11 injected her with heroin several times. Patient #17 also reported the use of Xanax and oxycodone. Licensee/Respondents were unable to provide any follow up investigation or details related to the reported use of Xanax and oxycodone, which were classified by Facility policy as contraband.

U. Licensee/Respondents were unable to provide an incident report or investigation details regarding Patient #18's heroin injections while in the care of the Facility. According to Patient #18's discharge summary, Patient #18 tested positive for heroin and his discharge was delayed for one day related to using contraband drugs while in the Facility.

V. In addition, the Department's investigation revealed Licensee/Respondents had a Suicide Precautions Policy, a Suicide Risk Monitoring Tool, and a Suicide Assessment form to evaluate patients at risk of attempted suicide. Despite these tools, the Department reviewed an incident report documenting that Assessment and Referral Assistant #5 (Assessor #5) left Patient #10 unattended while "tending to" other patients. Assessor #5 documented that when she reentered the patient's room, Patient #10 "was laying on the floor and stated that he had tried to strangle himself [with] his belt and stick the metal prong into an electric socket." Assessor #5 noted she took the belt from the patient. The patient was not placed on increased observation and again attempted suicide by stuffing toilet paper into his nose and mouth. Licensee/Respondents failed to create an incident report for the attempt and did not increase observation on the patient. Subsequently, the patient was discovered with his pants wrapped around his neck and banging his head violently on the wall. Patient #10's observation level still was not changed until

Licensee/Respondents received a telephone order from his physician to increase the level of observation after having attempted suicide twice in under 48 hours since arriving at the Facility.

W. In addition, the Department determined that Licensee/Respondents failed to ensure staff was sufficient, trained, and consistently monitored patients who had been ordered to have Line of Sight monitoring. The Department's observations of patient care units revealed multiples incidences where staff were not monitoring patients who had been ordered Line of Sight monitoring. The Department interviewed staff members who stated they were unsure of who they were supposed to be monitoring for Line of Sight, or were mistakenly watching one patient for Line of Sight, when another was actually the ordered Line of Sight patient. Licensee/Respondent staff also had one staff member conducting Line of Sight monitoring for patients, and also doing the 15-minute, unit safety checks on patients; however, the staff member assigned to perform both duties admitted to the Department that the same person could not perform Line of Sight observation and unit safety checks at the same time because she could not keep a patient in her line of sight if she had to turn her back to monitor other patients.

II. Licensee/Respondents Failed to Follow Facility Admission Criteria and Admitted Patients Who Met Facility-Identified Exclusion Criteria

A. Not only did Licensee/Respondents fail to comply with applicable regulations and statutes, and fail to correct deficient practice previously cited for contraband, Licensee/Respondents failed to comply with applicable regulations and statutes and failed to correct previously cited patient admission exclusion deficiencies. The Department conducted a third state complaint revisit investigation Event ID OEEC14 on May 29, 2019, to determine whether Licensee/Respondents corrected the deficiencies cited in second revisit state complaint investigation Event ID OEEC13 on February 1, 2019.

B. Pursuant to 6 C.C.R. 1011-1, Chapter 4, Section 11.102(1)(c), except in emergent situations, patients shall only be accepted for care and services when the facility can meet their identified and reasonably anticipated care, treatment, and service needs.

C. The Department accepted Licensee/Respondents' plan of correction after the February 1, 2019, complaint survey describing how it intended to correct the cited deficient practice.

D. The Department also issued the conditional license on February 1, 2019, to Licensee/Respondents requiring Licensee/Respondents to put measures in place to correct previous deficient practice.

E. Despite the Department citing Licensee/Respondents for failure to follow their own admission criteria process and admission of patients who met Facility identified exclusion criteria for Event ID OEEC14, despite Licensee/Respondents submission of a plan of correction describing how it would bring the Facility back into substantial compliance, and despite the Department issuing a conditional license requiring Licensee/Respondents to implement extensive corrective processes and procedures to address excluded patient admissions citations (Event ID OEEC13), the Department again cited Licensee/Respondents for failing failure to follow the Facility's own admission criteria process and admission of patients who met Facility identified exclusion criteria.

F. The Department cited Licensee/Respondents in Event ID OEEC13, LK8611, and BEXX11 on February 1, 2019, for failure to accept and admit patients based on their ability to meet the patient's needs and pursuant to the Facility's admission criteria. The Department recited Licensee/Respondents in the May 29, 2019, revisit investigation for a different patient who was documented to have uncontrolled diabetes prior to transferring from an outside facility, and who should not have been admitted based on Licensee/Respondents' Facility exclusion criteria.

G. The Department observed Licensee/Respondents' policies for admission criteria, entitled Clinical Guidelines for Inpatient Psychiatric Admissions. Licensee/Respondents categorized patient admissions by green, yellow, red, and black zones. Patients with medical conditions identified in the "yellow zone" require an admission review by a minimum of a house supervisor or designee. Yellow zone conditions included patients who had been transferred to Licensee/Respondents' Facility from another medical facility. Licensee/Respondents categorized patients with medical conditions identified in the "black zone" as "absolute exclusionary criteria; no admission". Medical conditions in the black zone include uncontrolled diabetes, and open or non-healing wounds.

H. The Department reviewed Patient #19's medical record which revealed Licensee/Respondents admitted the patient to the Facility on May 16, 2019, from an outside medical facility. The Department observed the referral packet, which had been reviewed by Admissions and Referral Specialist (Specialist) #21 and House Supervisor #14 prior to the patient's admission. The Department observed documentation which included the patient's medical conditions, including uncontrolled diabetes, medication noncompliance, high blood pressure, and a chronic right foot stump wound.

I. The Department reviewed the Facility admissions and referral staff telephone log which showed House Supervisor #14 called the outside medical facility and determined that the patient had no open wounds, and documented that the patient could be accepted medically. The Department observed a note from Facility

Medical Director Physician #8 accepting the patient for admission. There was no documentation in which Licensee/Respondents addressed the documented uncontrolled diabetes. This was in contrast to the clinical guidelines for inpatient psychiatric admission, which indicated the patient's uncontrolled diabetes fell into the black zone of absolute exclusion criteria.

J. The Department conducted an interview with Facility Director of Compliance, Quality and Risk (Director) #5, who stated that the Facility had provided admission criteria training to include the Clinical Guidelines for Inpatient Psychiatric Admission. Director #5 stated she had not provided training on how staff should proceed if a patient had been admitted who met exclusion criteria because those patients should not be admitted. The training, according to Director #5, had been provided to the admissions and referral staff, nurses, and house supervisors.

K. Director #5 reviewed the clinical guidelines for inpatient psychiatric admissions with the Department and stated the Facility had admission exclusion criteria because patients who fell into the exclusion criteria were patients that the Facility determined could not be cared for safely with the Facility-available nurses and medical equipment. Director #5 stated if a patient was admitted who fell into the exclusion criteria, it put the patient at risk for inappropriate care. Director #5 told the Department that audits had been done on every admission since May 1, 2019, to ensure the admission criteria policy had been followed; she stated she was unaware of any patients who were admitted since then that met exclusion criteria. The Department showed Director #5 Patient #19's medical record and confirmed faxed information from the outside transferring medical facility that had been received prior to accepting the patient for admission and prior to the patient's arrival. Director #5 subsequently reconfirmed with Director #12 that the information had been provided to the Facility for review prior to Patient #19's admission.

L. The Department reviewed Patient #19's transferring hospital documentation with Director #5, which revealed a Behavioral Health Evaluation; Emergency Department Situation, Background, Assessment, and Recommendation ("ED SBAR") tool, and Emergency Department Physician Documentation. The transferring medical facility's Behavioral Health Evaluation revealed the general medical conditions listed for Patient #19, which included uncontrolled diabetes and chronic right foot stump ulcer. The Department's review of the ED SBAR revealed that the patient had a bandaged wound on his left shin and a scabbed ulcer on his right foot. The Department's review of the Physician Documentation revealed that the patient had a past medical history to include right foot amputation from an accident, diabetes. The patient was treated for an elevated blood sugar on May 15, 2019.

M. After reviewing the documentation, Director #5 told the Department that Patient #19 fell into the black zone (absolute exclusionary criteria) due to the documented uncontrolled diabetes. Director #5 stated this had not been identified in the admission chart audit process, identified by leadership, or discussed in any meetings, and that she was unsure how this had occurred, but a root cause analysis would need to be conducted.

N. Director #5 then reviewed the call log from the Facility admissions and referral and informed the Department that there was no documentation that indicated staff had addressed the documented uncontrolled diabetes for Patient #19, and that the patient was accepted for admission by Physician #8.

O. The Department conducted an interview with Facility Chief Nursing Officer (CNO) #20. CNO #20 stated she had been called prior to Patient #19's admission and did not want to accept Patient #19 because she was concerned about his blood sugar. She stated that she had instructed the nurse to call Physician #21 to notify him that she was uncomfortable accepting the patient. CNO #20 stated that she did not have the final word on denying a patient admission, and that decision was left up to the physician. She said that Physician #21 told her that he could manage the patient. CNO #20 told the Department that Patient #19 should have "been caught, it's right here in the black zone and we should not have done it; moving forward I would say no, tell the physician no and be a bit more forceful." CNO #20 told the Department that the Facility had no documentation in which any staff had contacted Physician #21 to notify him that she did not want to accept the patient or to show that the physician reviewed Patient #19's referral packet and stated he could manage the patient.

P. The Department recited Licensee/Respondents for failure to follow their own admission criteria process and admission of patients who met Facility-identified exclusion criteria for the third revisit state complaint investigation Event ID OEEC14 because the Department cited Licensee/Respondents for failure to follow their own admission criteria process and admission of patients who met hospital identified exclusion criteria in Event ID OEEC11 and Event ID OEEC13. Licensee/Respondents failed to achieve compliance for the third time. The Department concurrently cited failure to follow their own admission criteria process and admission of patients who met Facility-identified exclusion criteria in federal complaint investigation revisit Event ID LK8612; state complaint investigation revisit Event ID BEXX12; and initial state complaint investigation Event ID Q47411. The Department had cited this same deficiency less than 6 months earlier on February 1, 2019, in state complaint investigation second revisit Event ID OEEC13, state complaint investigation Event ID BEXX11, and federal complaint investigation revisit LK8612.

Q. Importantly, the Department cited Licensee/Respondents for failure to follow their own admission criteria process and admission of patients who met Facility

identified exclusion criteria in three events on February 1, 2019, for failure to follow their own admission criteria process and admission of patients who met Facility identified exclusion criteria for Patient #7. Specifically, Licensee/Respondents admitted Patient #7 who met Facility identified exclusionary medical criteria and failed to request an admission review for an abnormal laboratory value prior to admission. This failure resulted in the acceptance of a patient with an unstable medical condition and exclusionary co-morbidities, which potentially contributed to Patient #7's death.

R. The Department reviewed Patient #7's medical records which revealed Patient #7 had two admissions at the Facility in a 16-day period, neither of which met the hospital admission criteria. Patient #7 was transferred from the Facility to an acute care hospital for a critical potassium level and remained there until returning to the Facility four days later. Patient #7's medical conditions were not reviewed by Licensee/Respondent leadership prior to the second admission either. Patient #7 was emergently transferred to an acute care hospital after suffering cardiac arrest at the Facility and required cardiopulmonary resuscitation by a Facility psychiatric staff member. Patient #7 died two days later. The Department reviewed the hospital discharge hospital and death note which stated that Patient #7's cause of death was listed as "cardiac arrest due to hyperkalemia" – hyperkalemia, or critical potassium levels, was the same reason Patient #7 had been transferred to an acute care hospital from the Facility originally.

III. Licensee/Respondents Failed to Ensure Patient Discharge Plans Were Re-evaluated to Meet the Needs of Patients When Concerns Were Identified Prior to Patients Being Discharged.

A. In addition to Licensee/Respondents failure to comply with applicable regulations and statutes and to correct deficient practice previously cited for contraband and improper admission practices, Licensee/Respondents failed to comply with applicable regulations and statutes and failed to correct deficient practice related to failing to ensure safe and appropriate patient discharge practices. The Department conducted a third state complaint revisit investigation Event ID OEEC14 on May 29, 2019, to determine whether Licensee/Respondents corrected the deficiencies cited in second revisit state complaint investigation Event ID OEEC13 on February 1, 2019, related to Licensee/Respondents' failure to ensure patients were safe to discharge and discharged with a safe place to go.

B. Pursuant to 6 C.C.R. 1011-1, Chapter 4, Section 11.102(a) and (c)(i)-(iii), the facility shall develop a discharge plan for each inpatient. The discharge plan shall include an evaluation of the post hospital care needs and the availability of the corresponding services; identify the role of the facility staff, patient, patient's family or designated representative in initiating and implementing the discharge planning process; and be discussed with the patient or designated representative prior to leaving the facility.

C. The Department accepted Licensee/Respondents' plan of correction on May 2, 2019, after the February 1, 2019, complaint revisit survey.

D. The Department also issued the conditional license on February 1, 2019, to Licensee/Respondents requiring Licensee/Respondents to put measures in place to correct previous deficient practice.

E. Despite Licensee/Respondents' assurances that they corrected the deficient practice, the Department determined that at the third state complaint revisit investigation Event ID OEEC14 on May 29, 2019, Licensee/Respondents failed to ensure patient discharge plans were re-evaluated to meet the needs of the patient when concerns were identified prior to the patient being discharged, and failed to verify the availability of services prior to discharge in 3 of 14 discharged patients (Patients #10, #19, and #20). Furthermore, Licensee/Respondents failure resulted in patients being discharged to locations which were unable to meet the patients' needs. In the most recent revisit survey, the Department found the following:

Patient #10

i. The Department determined that Licensee/Respondents' failure resulted in Patient #10, who had admitted to sexual perpetration of her younger sibling, being discharged home with the same sibling in the home, with no education to the patient or family on how to address concerns, or to ensure all family members were safe.

ii. The Department reviewed Licensee/Respondents' Discharge and Continuing Care Planning Policy, the Aftercare Compliance with Discharge Plan Policy, Patient Family Education Policy, Discharge Planning Policy, Case Management/Discharge Policy, and Treatment Plan Acute Inpatient Policy, which require family and staff coordination to ensure a safe, appropriate and educated discharge process. The Department determined that Licensee/Respondents' failed to re-evaluate Patient #10's discharge plan after the patient and her family voiced concern multiple times and felt unsafe with the discharge plan.

iii. The Department reviewed Patient #10's medical record which revealed the patient was admitted for suicidal ideation and sexually inappropriate behavior. A Comprehensive Psychosocial Evaluation, completed on admission, documented that the patient currently lived with her step-mother, father and younger siblings. The Department reviewed an Initial Psychiatric Evaluation, completed by the nurse practitioner (Provider #6), documented that Patient #10 had the potential to harm others related to the patient's history of pushing her sibling, causing him to almost fall off of a railing, and she could not be alone with animals due to harming them, with reportedly no remorse. Provider #6 documented Patient #10's current symptoms as acting out sexually, to include watching

pornographic material. The Department reviewed documentation in Patient #10's medical record which showed at least nine conversations documented by multiple staff members which stated Patient #10 and her family felt unsafe and disagreed with the discharge plan put in place by the Licensee/Respondents. The Department reviewed the medical records and was unable to locate any documentation about how staff ensured Patient #10's post-discharge needs had been assessed, addressed, how staff adjusted the treatment plan, and delineated a plan to meet the discharge needs of Patient #10 after information about the sexual perpetration of a sibling was presented. There was also no documentation that the family received any education on how to address Patient #10's sexual perpetration of her younger brother to ensure all family members were safe. This was in contrast to the Facility policies, discharge and continuing care planning which stated that the discharge planning process was coordinated with patient and family input, to identify the patient's needs after discharge, delineate plans to meet those needs, and teach the patient and family how to implement the plan.

iv. The Department reviewed Patient #10's discharge plan review documenting that Registered Nurse #4 stated she was unaware Patient #10 had disclosed she had sexually abused her younger sibling, prior to discharging the patient. Therapist #3, who stated she had been in charge of Patient #10's discharge, stated at the time she took care of Patient #10, she had not been properly trained or received the education she needed to discharge patients. Therapist #3 stated her attitude and main focus was to report the sexual abuse and get it documented; she said that since time had passed, she was able to recognize the safety issues involved; it wasn't a safe discharge, not for Patient #10 or her brother. Therapist #3 told the Department that there had been no follow up by Licensee/Respondents with Patient #10 or her family after Patient #10 admitted to sexual abuse of her younger brother prior to her discharge two days later. She then stated Patient #10 should not have been discharged; she should not have been allowed to be around her younger brother as the patient was at risk of sexually abusing her little brother again. Therapist #3 further stated the nursing staff who had reviewed Patient #10's discharge continuation plan with the patient and her father had not been made aware of the patient's sexual perpetration on her brother. Therapist #3 stated the Facility should have looked at alternative plans for Patient #10 and admitted that they had not.

v. The Department conducted an interview with Medical Director (Physician) #8. Physician #8 stated he had been in his role at the Facility for one year, and there had been no changes in the discharge process since he became the medical director. Physician #8 reviewed Patient #10's medical record and stated he was unaware of the patient's case. On review

of the therapy progress note, the physician stated this should have changed Patient #10's discharge. Physician #8 stated he would have wanted to get Child Protective Services' perspective and additional information to determine if it was safe to send the patient home with other children in the home. Physician #8 confirmed there was no documentation of how the Facility changed Patient #10's discharge plan and that it was up to the patient's parents to ensure the safety of everyone in the household, including Patient #10. On continued review of Patient #10's medical record, Physician #8 stated he was getting more "confused" the more he read and stated "I'm not sure what happened and why it's not documented." Physician #8 stated Patient #10 was at "risk of her perpetrating again and abusing her little brother." Physician #8 then told the Department that Patient #10's parents had appropriate questions which needed to be answered and stated on review of the medical record, the questions were not answered by staff. After further review of Patient #10's medical record, Physician #8 stated he could find nothing which indicated staff had followed Facility policy to ensure a safe and appropriate discharge for Patient #10.

Patient #19

vi. The Department reviewed Patient #19's medical record which showed he was admitted due to suicidal ideation after rolling his wheelchair into traffic in an attempt to end his life. Licensee/Respondents conducted a Comprehensive Psychosocial Evaluation, completed on admission, and noted the patient was homeless and needed placement.

vii. The Department observed the initial nursing assessment which stated that Patient #10 was wheelchair bound, had a history of high blood pressure, and diabetes. The RN documented Patient #19 had a diabetic foot wound with eschar (dry, dark scab or falling away of dead skin) which measured 1 inch wide and 1 inch in length to his right foot stump (amputation) and a 1 3/4 inch long and 1 inch wide wound to the left lower leg, above the ankle which had yellow purulent (pus) drainage with a pink wound bed. The Department reviewed the physician's Review of the History and Physical which showed Patient #19 was legally blind. The physician ordered daily dressing changes for the patient's wounds. The Department observed the provider's initial psychiatric evaluation and a treatment plan, which stated the patient required help with disposition and follow-up appointments, which, according to the physician, would be arranged before discharge. The Department reviewed Physician #8's progress notes, stating that Patient #19 preferred to get placement upon discharge due to having difficulties with his disabilities. However, on review of the medical record, the Department was unable to locate documentation that Licensee/Respondents acknowledged the patient's concerns and attempted any post discharge Facility placement for him. The Department reviewed a

therapy discharge note from Therapist #2 which stated that Patient #19 had no support and was to be discharged to a shelter in Pueblo. The Department reviewed three separate provider notes stating that Patient #19 was "really concerned," "unsure," and "very concerned" about his discharge and how his wounds would be cleaned and dressed if he were to be discharged to a homeless shelter.

viii. The Department reviewed the Discharge/Continuing Care Plan which stated Patient #19 was discharged to a homeless shelter in Pueblo with transportation provided by Licensee/Respondents. The Department reviewed a subsequent Incident Report, written by a Mental Health Technician (MHT), who had driven Patient #19 to the shelter in Pueblo. The summary of the incident stated that Patient #19 was discharged and transported to Pueblo to a homeless shelter. Upon arrival to the shelter, Facility staff was made aware that the shelter had permanently closed. Facility staff then arranged to take Patient #19 to a shelter in Colorado Springs at which time Patient #10 made suicidal ideation comments.

ix. The Department conducted an interview with Case Manager (CM) #1, who stated that she had received one week of training as a case manager prior to discharging patients. CM #1 stated her job was "to make sure discharges [were] safe" and that every patient received a follow up with a therapist, psychologist, or primary care provider, resources they needed, emergency contact information, a safety plan, a therapy discharge note, and a discharge summary. CM #1 told the Department that she reviewed each patient and where they lived, looked for resources for those who required it to include transportation, housing and food. She stated the purpose of the discharge plan was to ensure patients knew where to go if they needed help after discharge and who to follow up with. CM #1 stated a patient had to agree with the discharge plan and Facility staff could not send a patient somewhere they did not want to go. The Department conducted a follow up interview with CM #1 who said she had a process in place to ensure a safe discharge and it included three things, a place to go, some way to get there, and follow-up appointment set. CM #1 stated these things were required to ensure a safe discharge. CM #1 told the Department that she had set up Patient #19's discharge to the homeless shelter but had never been trained to call the shelter prior to the patient being discharged. CM #1 stated, "if I wasn't trained, how am I supposed to know." CM #1 stated a patient discharged to a homeless shelter should receive the same "safe" discharge as a patient being sent home, but was unable to explain why she did not ensure Patient #19's shelter had been called to ensure they had availability and resources to care for the patient prior to sending the patient. CM #1 admitted to sending two patients out to shelters without calling prior to discharging them. She told the Department it would be important to ensure the shelter was able to care for Patient #19

as he was legally blind, in a wheelchair, and required daily wound dressing changes. CM #1 confirmed this had not occurred in Patient #19's case and stated she had not been aware when the patient discharged he had required daily dressing change.

x. The Department interviewed the Clinical Services Director (Director) #12, who said that she provided CM #1 education after the incident with Patient #19. Director #12 stated staff was responsible for making sure shelters receiving patients were set up and had the availability and resources to provide post discharge needs for patients. Director #12 stated this had not occurred for Patient #19.

xi. The Department interviewed Registered Nurse (RN) #7, who discharged Patient #19 and stated if a patient had wound care needs after discharge, she would try and make sure the patient had the supplies, but the Facility had minimal wound care supplies and said patients do not always receive supplies. The Department reviewed Patient #19's medical file with RN #7, who stated the patient should have gone to a nursing home due to his complicated and extensive medical history but she was unsure why this had not been done. RN #7 stated she had not provided Patient #19 with any wound care supplies, nor had she called and confirmed the homeless shelter was able to provide or obtain supplies for Patient #19's post discharge needs.

xii. The Department conducted an interview with Therapist #2, who signed Patient #19's therapy discharge summary. Therapist #2 stated it was case management's job to ensure a "safe discharge" and ensure the patient's discharge location could meet the patient's post discharge needs; to include support, food, shelter, and other basic needs of the patient. Therapist #2 stated it was important to call a shelter to confirm they were able to meet the patient's basic needs and "that they were even open." Therapist #2 reviewed Patient #19's medical record and stated she had trusted CM #1 to set up an appropriate post discharge shelter for Patient #19 and was unaware why CM #1 had not contacted the shelter to ensure they could provide for Patient #19's post discharge needs.

<u>Patient #20</u>

xiii. The Department reviewed Patient #20's medical record which revealed he was admitted on an involuntary admission to the Facility, endorsed suicidal thoughts with a plan to walk into traffic, and was placed on suicide monitoring. The disposition noted Patient #20 would receive help with follow-up and disposition prior to discharge. The Department reviewed the Therapy Services Progress Note, which revealed that after the therapist presented discharge paperwork to fill out, Patient #20 reported he was unable to participate and the thought made him anxious

and suicidal. Patient #20 reported he would not be safe to discharge and would be a threat to himself if he were to leave. The Department reviewed a subsequent Psychiatric Progress note which stated that Patient #20 still reported feeling nervous about discharge. Additionally, the next level of care upon discharge was documented as being a shelter, with outpatient follow-up. The Department reviewed the Discharge Summary, which showed the disposition upon discharge was requiring placement, a therapist, and psychiatric prescriber.

xiv. The Department reviewed an Incident Report which revealed Patient #20 was supposed to be discharged to a facility in Canyon City and upon arrival to the facility after business hours, the facility reported to Licensee/Respondents' staff that they are an outpatient only facility and could not provide a bed to Patient #20. The outpatient facility staff obtained a motel for Patient #20. Supervisor #18 documented Patient #20 was dropped off at a hotel arranged by the outpatient facility and the outpatient facility staff stated they had not been contacted prior to arrival of Patient #20, and no assessment had been arranged for Patient #20.

xv. The Department conducted an interview with the case manager responsible for discharge planning (CM #1). CM #1 confirmed she provided discharge planning for Patient #20. CM #1 stated she assumed Patient #20 would have shelter when he was dropped off at the outpatient location where she referred him, which was 160 miles from the Facility. CM #1 stated when staff arrived to the outpatient facility it was closed, and she spoke with a representative at the outpatient location and they said she could drop off Patient #20 "whenever." CM #1 stated she was unaware the outpatient facility did not provide 24-hour stabilization care, and she had not confirmed hours of operation with the representative she spoke with prior to discharging Patient #20. CM #1 stated there was a lack of communication on her part and she thought Patient #20 could go to the outpatient location and receive respite care (temporary housing) at any time. CM #1 stated she documented her conversation in the Communication Log; however, she could not provide documentation that she spoke with staff at the outpatient facility prior to discharging Patient #20. Review of the document titled, Communication Log, revealed the document was blank. CM #1 stated the risk of transporting patients to a closed facility was that the patients would have no housing on arrival. CM #1 stated she had not met with Patient #20 on the day of discharge to discuss or review his discharge plan. CM #1 stated the therapist and the nurse would discuss the plan with Patient #20. CM #1 was unable to provide evidence she spoke with nursing staff or the therapists to confirm a plan was in place for Patient #20. In fact, CM #1 stated it was not in her practice to speak with patients regarding their discharge plan prior to discharging them from the Facility, and confirmed that she did not involve

Patient #20 in the discharge plan. CM #1 stated it was the therapist's job to discuss the discharge plan with the patient, and by the therapist speaking with the patient on the day of discharge that involved the patient in the discharge process and plan. CM #1 stated she was working to create a discharge process because there was currently no standard discharge process in place at the Facility. CM #1 stated at the end of the first week the state surveyors were onsite, she began calling to confirm appointments, verify facilities were aware that patients were coming, and verify services that would be provided. CM #1 stated that prior to that, she had not followed a standard plan for discharges. CM #1 stated she did not have any written guidelines to show the discharge process. CM #1 stated it was important to have a discharge plan to ensure patients were discharged to a safe environment.

xvi. The Department conducted an interview with Therapist #2, who said she was a therapist, and not a discharge planner. Therapist #2 stated it was the responsibility of the discharge planner to confirm housing with patients prior to discharge and that she did not confirm discharge plans with facilities or patients prior to discharge other than asking patients if they were comfortable with the plan written within the discharge document, titled Discharge Continuing Care Plan. Therapist #2 stated she was unsure what type of a facility Patient #20 was being discharged to when she reviewed the discharge plan with him. Therapist #2 stated it was important to confirm there were beds available for shelter, and the facility's hours of operation, prior to discharge to ensure a safe discharge process.

F. The Department recited Licensee/Respondents for failure to ensure patients were safe to discharge, failure to follow their own admission criteria process for admission of patients who met Facility identified exclusion criteria for third revisit state complaint investigation Event ID OEEC14 because the Department cited Licensee/Respondents for failure to follow their own admission criteria process and admission of patients who met hospital identified exclusion criteria in Event ID OEEC13 and BEXX11.

G. The Department concurrently cited failure to follow their own admission criteria process and admission of patients who met hospital identified exclusion criteria in state complaint investigation revisit Event ID BEXX12; initial state complaint investigation Event ID Q47411, and initial federal complaint investigation 8RQW11. The Department had cited this same deficiency less than six months earlier on February 1, 2019, in state complaint investigation Event ID OEEC13, and state complaint investigation Event ID BEXX11.

H. Importantly, the Department had previously cited Licensee/Respondents for failing to ensure patients were safe to discharge and did not have a suicidal plan or suicidal attempt on the day of discharge, and failed to ensure patients had a safety

plan in place and were discharged with a safe place to go in three of 13 discharged records reviewed in the second state complaint revisit Event ID OEEC13 on February 1, 2019, and initial state complaint investigation Event ID BEXX11.

29. Based on the Department's investigation of Licensee/Respondents, the Department has determined, in accordance with section 25-3-102(1)(c), C.R.S., that Licensee/Respondents are not fit to provide psychiatric hospital services.

30. The Department's regulation at 6 C.C.R. 1011-1, Chapter 2, Section 2.9.3 provides the Department with authority to revoke Licensee/Respondents' license due to its failure to comply with the applicable statutes and regulations.

31. Specifically, the Department has authority pursuant to 6 C.C.R. 1011-1, Chapter 2, Section 2.12.4 to revoke Licensee/Respondents' psychiatric hospital health facility license for good cause, including, but not limited to, Licensee/Respondents' failure or refusal to comply with statutory and regulatory requirements for the psychiatric hospital license type.

WHEREFORE, based on the facts and authority set forth herein, the Department respectfully request the Administrative Law Judge enter an Order revoking health facility license number 011527 issued to SBH – North Denver, LLC dba Clear View Behavioral Health (Licensee), SBH North Denver, LLC (Owner) ("Respondent" or "Licensee") for the facility named Clear View Behavioral Health, 4770 Larimer Parkway, Johnstown, Colorado 80534.

Respectfully submitted this 24th day of June, 2019.

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

D. Randy Kuykendall

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Health Facilities and Emergency Medical Services Division Director

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CERTIFICATE OF SERVICE

This is to certify that I have duly served the within NOTICE OF CHARGES AND DUTY TO ANSWER upon all parties by First-Class U.S. Mail and by U.S. Certified Mail, postage prepaid, in Denver, Colorado this 24th day of June, 2019, addressed as follows:

TO: SBH – North Denver, LLC dba Clear View Behavioral Health, Facility
Mr. Daniel Zarecky, Administrator
4770 Larimer Parkway
Johnstown, Colorado 80534

TO: SBH – North Denver, LLC, Licensee
Beth McClenathan, Director of Nursing
Sharon Pendlebury, CEO
James T. Shaheen, CEO & President
Edward J. Dobbs, Vice President
William H. Lawson, Jr., Secretary
Mike A. Orians, Treasurer
8295 Tournament Drive, Suite 201
Memphis, Tennessee 38655

TO: Caroline Kirby Dobbs Floyd 2012 Trust, Stockholder
Caroline Kirby Dobbs 1985 Trust, Stockholder
John Hull Dobbs Jr. 1985 Trust, Stockholder
Jackson Dobbs Allen 2012 Trust, Stockholder
Edward Dobbs Grantor Trust, Stockholder
Edward J. Dobbs 2009 Trust, Stockholder
6070 Poplar Avenue, Suite 750
Memphis, Tennessee 38119

Shelley Sanderman _____
Name (printed) Signature
Colorado Department of Public Health and Environment