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0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of the Complaint Investigation Survey completed in your facility on 1/4/17 through 1/17/17, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Hospitals. The census at the beginning of the investigation was 158 patients. The sample size was 21 patients. There were 14 complaints investigated: Complaint #NV00047360 was substantiated. The allegation the facility did not appropriately investigate physical force by a Mental Health Technician was substantiated. See Tag 320. Complaint #NV00047632 was not substantiated. The following allegations could not be substantiated: Allegation #1: A patient was denied medications, physician services and social services. Allegation #2: A patient was not appropriately admitted to the facility. The investigation into the allegations included: A tour of the facility including observations of the physical appearance of patients and interaction between staff and patients. Interviews with current patients. Review of the medical record for the Patient of Concern, including admission and discharge documentation, Legal 2000 Form (State of Nevada's involuntary civil hold process), the patient's Interdisciplinary Treatment Plan, and the patient's Medication Administration Record. Review of the facility's policy titled "Involuntary Admissions". Complaint #NV00044694 could not be substantiated. The following allegations could not be substantiated. Allegation #1 medications were not given as ordered. Allegation #2 a patient fell out of a wheelchair and sustained a black eye. The investigation into the allegations included: Interview with the Director of Quality and Risk Management, and the Chief Nursing Officer. Review of the medical record for the patient of interest. Review of the policies titled "Fall Precautions" and "Treatment Plan". Complaint #NV00047209 could not be substantiated. Allegation #1: A patient was oversedated was not substantiated. The investigation of the allegation included: Interview with the Director of Quality and	0000		

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	Risk Management (Director of Quality). Review of the list of admissions on the date referred to in the complaint. The patient could not be identified. Complaint #NV00046481 could not be substantiated. The following allegation could not be substantiated. Allegation #1: The facility did not admit a patient although the patient was appropriate to the facility. The investigation into the allegation included: An interview with the Director of Clinical Services. An interview with the Director of Quality. Review of the facility call tracking log. Complaint #NV00047016 was substantiated. The allegation a Spanish speaking patient with dementia was not discharged appropriately was substantiated. Please see Tag 143. Complaint #NV00048058 was substantiated. The allegations the facility did not adequately supervise two adolescent patients ages 14 years old and 17 years old resulting in sexual abuse was substantiated. Please see Tags 320 & 602. The allegation the facility did not provide appropriate staffing could not be substantiated. The investigation into the allegation included: A tour of the facility and interaction between staff and patients. Interviews were conducted with staff and patients, the Chief Nursing Officer and the Director of Quality and Risk Management. Review of the facility's policy titled "Nurse Staffing Plan and Nurse Staffing Committee" and the minutes of the Nurse Staffing Committee for the year 2016. Complaint #NV00046158 with the following allegation could not be substantiated: The allegation a teacher pushed a row of desks two to three feet across the room towards a minor patient, and one of the desks hit the patient in the belly button, could not be substantiated. The investigation into the allegation included: Tour throughout the facility on 1/6/17. Observation of the classroom. Review of the video recording available. Observation of a mock restraint process on 1/5/17. Interviews were conducted with the Chief Nursing Officer, two teachers, the Director of Clinical Services, the Director of Quality, three Mental Health Technicians (MHT's), and two Nurse Managers. Interviews were conducted with four minor			

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	patients. Review of 21 clinical records, including the patient of concern. Documents reviewed included the Abuse Policy & Algorithm for Steps to Take in the Event of Suspected Patient Abuse by Staff, Patient Rights & Responsibilities (including Youth Services Patient Rights) and Seclusion / Restraint / Physical Hold. The personnel file for the Teacher was reviewed. Complaint #NV00046425 with the following allegation could not be substantiated: A Mental Health Technician physically assaulted an adolescent patient: The Mental Health Technician grabbed the patient by the hand, forced him into the room, pushed him onto the bed, and started hitting him. The investigation into this allegation included: Tour throughout the facility on 1/6/17. Review of the video recording available. Observation of a mock restraint process on 1/5/17. Observations of interactions between MHT's and adolescent patients on the Units. Interviews were conducted with the Chief Nursing Officer, the Director of Clinical Services, the Director of Quality, two Nurse Managers, two Teachers, the Milieu Manager, and three Mental Health Technicians. Four adolescent patients were interviewed. Record review of 21 patients, including clinical records for the patient of concern. Documents reviewed included the Abuse Policy & Algorithm for Steps to Take in the Event of Suspected Patient Abuse by Staff, Patient Rights & Responsibilities (including Youth Services Patient Rights) and Seclusion / Restraint / Physical Hold. Facility's Incident Reporting documents were reviewed. The complaint allegation was not substantiated. However, other deficiencies were identified related to the facility's internal processes of investigation of alleged patient abuse by staff. See TAG 320. Complaint #NV00047158 with the following allegations could not be substantiated: Allegation #1: A six year old female patient was sexually touched on her private area by a female eight year old patient. Allegation #3: The Patient of Concern told staff every time the other patient tried to touch her. Allegation #3: The Patient of Concern's parents were not told about the incident. The investigation into these allegations included: Tour throughout			

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	the Units. Observations of patients interacting on each Unit, including the Pediatric Unit. Observation of a patient put on 1:1 observation in the Pediatric Day Room. Interviews were conducted with the Chief Nursing Officer, the Director of Quality, two RN Nurse Managers, two Teachers, the Milieu Manager, and three MHT's. Four female adolescent patients were interviewed. Clinical record review of the two Patients of Concern. The facility's Incident Reporting documents were reviewed. Documents reviewed included the Abuse Policy & Algorithm for Steps to Take in the Event of Suspected Patient Abuse by Staff, and Patient Rights & Responsibilities (including Youth Services Patient Rights). The complaint allegation was not substantiated. However, other deficiencies were identified related to the facility's internal processes of investigation of sexual abuse of a child. Complaint #NV00047875 with the following allegation could not be substantiated: The male adolescent patient was physically abused by a staff member: The Mental Health Technician smacked the patient into the wall several times, strangled, and elbowed him. The investigation into this allegation included: Tour throughout the facility on 1/6/17. Review of the video recording available. Observation of a mock restraint process on 1/5/17. Interactions on the Units between staff members and patients. Interviews were conducted with the Chief Nursing Officer, the Director of Quality, the Milieu Manager, two RN Nurse Unit Managers, and three MHT's. Four adolescent patients were interviewed. Clinical record review of 21 patients, including the patient of concern. Documents reviewed included the Facility's Incident Reporting, Abuse Policies and Procedures, including the Algorithm to Investigate Patient Abuse Allegations, Patient Rights and Responsibilities (Including the Rights and Responsibilities of Juvenile Patients), and Seclusion / Restraint / Physical Hold Policies. Complaint #NV00047102 with the following allegations was substantiated: The Patient of Concern's Mother went to visit, and saw another patient wearing the patient's shoes. The Mother then reportedly told one of the staff			

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	(Milieu Manager), who said this kind of thing happens here (but did not take any action). See TAG 322. The following allegations could not be substantiated: Allegation #1: The other kids bullied the patient. Allegation #2: Another patient told the Patient of Concern to hand over his shoes or he would beat the patient up. The investigation into these allegations included: Tour of the Units on 1/6/17. Walk through of the facility. Interactions between staff and patients on each Unit were observed. Observations of interactions between adolescent patients were conducted. Video recordings were reviewed on 1/6/17. Interviews were conducted with the Chief Nursing Officer, the Director of Quality, the Milieu Manager, two RN (Registered Nurse) Unit Managers, and three MHT's. Four inpatient adolescent patients were interviewed. Clinical record review of 21 patients, including the Patient of Concern. Documents reviewed included: Abuse, Patient Rights, including Juvenile Rights and Responsibilities, and Discharge of Patients. Complaint #NV00047895 was substantiated. The allegation of lack of supervision, resulting in an elopement of a minor patient from the Outpatient Program, was substantiated. See TAG 602. Complaint #NV00045403 was substantiated. The allegation of lack of supervision, resulting in sexual activity between two 13-year-old patients was substantiated. See Tag 320. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations,actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
0143 SS= D	NAC 449.332 - Discharge Planning - 1. A hospital shall: (a) Have a process for discharge planning that applies to all inpatients; and (b) Develop and carry out policies and procedures regarding the process for discharge planning. Inspector Comments: Based on interview, record review, and policy review, the facility did not ensure a safe discharge for 1 of 21	0143	1. How will you correct the specific finding (s) stated in the Statement of Deficiencies? a. Pursuant to the findings, Montevista/ Red Rock Hospital will provide education to all direct-care staff about the need to follow physician orders with regard to discharge. If, as in this case, the location	01/30/2017

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	sampled patients (Patient #4). Findings include: Patient #4 Patient #4 was a 97 year old admitted to the facility on 8/5/16 with diagnoses of psychosis, dementia and pain. Patient #4 was admitted onto the Geropsychiatric Unit. The patient's medical record stated the patient was Spanish speaking only. The patient was discharged on 9/7/16 to home. On 8/6/16, an Interdisciplinary Treatment Plan indicated the patient's strengths were "supportive family", and the weaknesses included "aggressiveness" and "confused". The "Patient Stated Goals" were stated by a family member for the patient and included "find her a safe placement for Alzheimer's" and "needs assessments and to be less aggressive". The plan stated the preliminary discharge plan was "Placement in alternative living - Alzheimer's group home". The patient's Psychiatrist documented in the Discharge Summary the patient exhibited "worsening symptoms consistent with dementia with psychosis and behavioral disturbances, the auditory hallucinations, and sundowning effect... Associated with signs and symptoms of affective lability, delusions, paranoid ideations, auditory hallucinations...". On 9/7/16 at 2:44 PM, Patient #4's Clinical Intern documented on the "Discharge/Continuing Care Plan" the patient used a wheelchair to move around, denied suicidal and homicidal ideations and the patient was given discharge instructions and verbalized understanding. The Intern documented "Earlier spoke to (the patient's family member) in Spanish (Social Worker) arranged transportation for patient to be taken home around 6:00 PM today". Patient #4's "Medication Reconciliation - Discharge", dated 9/7/16 at 5:00 PM listed the patient's medications including Risperdal, an antipsychotic medication twice daily for "psychosis", Depakote Sprinkles twice daily for "psychosis", Exelon twice daily for "cognitive dysfunction", and Namenda twice daily for "dementia". The document was provided in English and signed by the patient. Patient #4's "Discharge Safety Plan", dated 9/6/16, stated: -"Was family, legal guardian, friends, or caregivers of the patient invited to		for discharge is changed, the nurse must contact the physician to obtain an order for a different discharge location. Discharge instructions shall be provided in a language and format that is understandable to the patient. b. Additionally, pursuant to this finding, the Hospital has initiated having its forms that are given to patients translated into Spanish so that they are available in both English and Spanish. In the interim period before all forms are translated, Hospital staff utilize our language line and/or a Spanish-speaking staff member when explaining discharge instructions to our patients who speak only Spanish. <u>2. What measure or systematic change(s) will be put in to place to ensure the deficient practice does not recur?</u> a. Discharge plans will be discussed as a part of treatment team meetings so that all members of the treatment team (physician, nursing, social work, etc.) are aware of the specific discharge plans. b. We are in the process of revising Policy 1800.16 – Language and Sign Interpreters, to indicate that written forms should be provided in a language that the patient understands (i.e. English or Spanish) or patient instructions should be given verbally (either in person or via the language line) in a language the patient understands. <u>3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</u> Thirty (30) randomly-selected medical records will be reviewed each month to	

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	participate? ... NO". -"These are important numbers for me to always have available and use when I need to. I will call one or more of these when I start to feel like hurting myself: N/A (not applicable)". The document was provided in English and signed by the patient and co-signed by the Clinical Intern. Patient #4's "Assessment of the Patient's Medical Status", dated 9/7/16, the day of discharge indicated the patient was alert and oriented only to self and spoke Spanish only. On 9/5/16 at 8:20 PM, Patient #4's Psychiatrist wrote an order to discharge the patient to a group home in the morning. On 1/5/17 during a tour of the facility, the Nurse Manager of the Geropsychiatric Unit stated if the physician's order was for the patient to be discharged to a group home the order should have been clarified before the patient was sent home instead. The Manager stated a Spanish speaking only patient should not have been given discharge instructions in English. On 1/5/17 the Director of Quality and Risk Management stated Discharge instructions should not be provided to a Spanish speaking patient in English. The Director stated Patient #4's physician should have been contacted to obtain an order for a discharge to home before the patient was discharged to home. The Director provided the policy titled "Discharge of Patients", dated May 2016. The policy stated "The physician gives an order specifically indicating the type of discharge... Discharge to self, family, responsible adult, etc., as appropriate". Complaint #NV00047016 Severity: 2 Scope: 1		assure that the discharge policy is being followed correctly. The findings will be reported at the Quality/PI Council, the Medical Executive Committee, and Governing Board at each of their respective meetings. The corrective action items in this TAG have been incorporated in to our new employee orientation. <u>4. The title of the person responsible for ensuring the Plan of Correction is implemented.</u> Chief Nursing Officer (CNO) <u>5. The date the corrective action will be completed.</u> a. Staff education was completed on 1/16/2017. b. Hospital review process of thirty (30) randomly-selected discharged charts was initiated 01/30/2017 for discharges in January 2017 and will be ongoing. c. Process of translating forms that are given to patients in to Spanish initiated on 1/23/2017 and it is anticipated that this process will be completed on or before 3/31/17. <u>6. Supporting documents attached:</u> Policy 1800.16 – Language and Sign Interpreters <u>7. How you will identify and correct other areas having potential to be affected by the deficient practice (if applicable).</u> a. The process described in #5a above will be provided to all staff, not just the staff on	

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			the unit where this particular incident occurred and will be included in the orientation process for new staff and be part of the annual staff education/update. b. The chart review process described in #5b above will include charts from all units, not just the unit where this particular incident occurred. c. Once all forms that are given to patients are translated in to Spanish, they will be available throughout the hospital, not just the unit where this particular incident occurred. <u>8. Additional Comments:</u> The corrective action items in this TAG will be monitored for completion by the Quality/Performance Improvement Council.	
0320 SS= H	NAC 449.3628 - Protection of Patient - 1. A governing body shall develop and carry out policies and procedures that prevent and prohibit: (a) Verbal, sexual, physical and mental abuse of patients Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure facility policies were followed to prevent sexual and physical abuse of patients and failed to document and conduct a thorough investigation following: 1) allegations of sexual abuse of a child for 2 of 18 sampled patients (Patient #3, #7); and 2) allegations of physical force used to escort a patient to the room to be put on his bed for disciplinary means by a staff member were addressed (Patient #18, Patient #8); and 3) four adolescent patients who admitted to sexual activity in patient areas (Patients #5, #6, #19 & #20). Findings include: Patient #3 / Patient #7: Patient #3 Patient #3 was a 6 year old female patient admitted to the facility on 9/9/16 with diagnoses including affective mood disorder and conduct disorder. The Problem List	0320	<u>1. How will you correct the specific finding (s) stated in the Statement of Deficiencies?</u> a. Pursuant to this finding, all direct care staff were provided with Just in Time Training (JITT) regarding the expectations related to and importance of continuous patient observation (see supporting documents). b. Leadership staff were provided an in-service on documentation and processes for conducting internal investigations so that they are standardized between leadership team members. <u>2. What measure or systematic change(s) will be put in to place to ensure the deficient practice does not recur?</u> a. Nurse Managers as well as members of Senior Leadership (CEO, CNO, Director of	01/30/2017

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	indicated sexually inappropriate behavior. The Psychiatric Evaluation indicated Patient #3 had homicidal ideation, suicidal ideation, and personal history of self harm and sexual abuse. Patient #7 was an 8 year old female patient admitted 9/12/16 with a diagnosis of disruptive mood dysregulation disorder. The Problem List indicated sexually inappropriate behavior. The facility's Incident Reporting and the Psychiatrist's Discharge Summary documented Patient #3 exposed her underpants and kissed another young female patient on 9/12/16. The Incident Report did not document the name or identity of the other patient. On 1/5/17 at 11:00 AM, the Incident Report was reviewed with the Unit Manager, who verified he conducted the investigation. The Unit Manager indicated, "She (Patient #3) was very alert. There were a couple of alleged incidents. When she pulled down her pants, she initially said there was penetration (digital vaginal penetration by Patient #7). Then she recanted." The Unit Manager indicated he did not specifically investigate the sexual abuse allegations regarding penetration. The Unit Manager further indicated he did not interview the other female child (Patient #7) to find out what had happened. On 1/5/17 at 10:45 AM, the Director of Quality & Risk Management (Director of Quality) indicated the appropriate way to conduct an investigation following allegations of inappropriate sexual touching was to review the incident using all pertinent information (full description of the incident, names of all patients involved, location of incident, all staff on duty) and review the video. Then the physicians and parents would be notified of the outcome of the investigation. There was no documented evidence the facility attempted to complete a thorough investigation with both patients involved and reviewed the video recording. There was no documented evidence the parents and the Psychiatrists for both Patient #3 and the other patient (Patient #7) were made aware of the allegations of inappropriate sexual touching and digital vaginal penetration. The facility's policy, "Child and Elder Domestic and Sexual Abuse", revised		Clinical Services, etc.) will conduct weekly, random audits of video footage to assure that staff is present in the milieu at all times. The CNO will follow-up with staff education for any trends identified and will utilize progressive disciplinary action, as indicated for repeat infractions. b. The Director of Quality, Performance Improvement, Compliance and Risk Management has developed a standardized worksheet for conducting investigations so that the process is thorough, standardized, and well-documented. 3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. a. The Director of Quality, Performance Improvement, Compliance and Risk Management (or a designee) will aggregate, analyze and interpret the data from ongoing video surveillance audits to identify trends and patterns that may be of concern. b. The results of this analysis will be shared with all members of the management team via daily Morning Meetings and also with the Quality Council, Medical Executive Committee and Governing Board. c. The CNO and the Director of Quality, Performance Improvement, Compliance and Risk Management will review all investigations to assure that they are thorough, complete and well-documented. d. The findings, conclusions, recommendations, and actions from the analysis will be compiled and reported to the Quality/PI Council, the Medical	

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	06/2012, indicated to complete the Abuse Reporting Form and distribute as indicated on the Abuse Reporting Form. Documentation is completed in the Medical Record regarding the observation of abuse, victim report, the reporting to supervisor and treatment team, the counseling of the patient, and patient actions taken. Patient #18 / Employee #19 (MHT, date of hire 6/20/16) Patient #18 was a 13 year old male patient admitted to the facility on 6/13/16 with diagnoses including disruptive mood dysregulation disorder, cannabis dependence, and history of extreme oppositional defiant disorder. The Facility's Incident Reporting indicated Patient #18 reported an incident occurred on 7/7/16 in the morning in which he was grabbed by the hand, forced into his room, pushed onto his bed, and then struck multiple times by Employee #19. The written statement by Patient #18 indicated on 7/7/16 in the morning Employee #19 "came & grab me by the hand & force me into my room & he pushed me on my bed & started hitting me". The written statement by Employee #19 regarding the incident indicated, "I escorted (Patient #18) back to his room due to disrespectful comments and verbalizing threats, as we entered room pt (patient) was flailing arms towards me in attempt to strike with elbows. I then sat him down by using HWC (Handle With Care) techniques simultaneously attempting to verbally de-escalate pt..." On 1/6/17 at 12:00 PM, the Chief Nursing Officer (CNO) indicated she was on leave during the week of the incident, during her absence, Employee #19 was terminated for gross misconduct related to the incident. The CNO indicated they did not have enough evidence to say that the physical abuse happened, but there were too many witnesses who said he was verbally inappropriate, and he was still on probation, so he was terminated effective 7/17/16. On 1/6/17 at 2:00 PM, the CNO indicated the facility did not document in the personnel file the concern that Employee #19 used physical force to restrain a child on his bed for disciplinary means. Employee #19 did not return to work from administrative leave and was subsequentenly terminated. The		Executive Committee and the Governing Board at each of their respective meetings. e. The corrective action items in this TAG have been incorporated in to our new employee orientation 4. The title of the person responsible for ensuring the Plan of Correction is implemented. Director of Quality, Performance Improvement, Compliance and Risk 5. The date the corrective action will be completed. a. Direct care staff received JITT on 1/13/2017 through 2/15/2017. b. Intensified video footage audit system process completed and ready for utilization as of 01/30/17. c. Monitoring and evaluation activities with report to the delineated committees was expanded and in place as of 01/30/17. 6. Supporting documents attached: a. Just In Time Training (JITT) b. Levels of Observation Policy 7. How you will identify and correct other areas having potential to be affected by the deficient practice (if applicable). Via the completion of Action Steps 1a&b, 2a&b, and 3a, b&c above. The assessment for compliance with Observation levels will encompass all levels of observation conducted at the hospital and not just specific to Constant Observation.	

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	investigation was not completed. An email correspondence dated 7/15/16 @ 12:17 PM stated, "(Employee #19) came in and picked up his check. He agreed we would take him off payroll. He will be returning his badge & keys to HR." The Witness Statements by other patients and other staff members indicated: -"I heard somebody get hit". -"(Patient #18) was being a smart ass to (Employee #19) so (Employee #19) told him to go to his room for not listening. (Patient #18) did not comply so (Employee #19) dragged him in his room." -"...(Employee #19) threw (Patient #18) on his bed then (Patient #18) swung on him because (Employee #19) threw him." -"...Then saw (Employee #19) grab (Patient #18) hand and say, 'I'm gonna walk him to his room real quick.' Then (another male adolescent patient) was trying to tell the nurse (Employee #19) was putting hands on (Patient #18) but no one listened..." On 1/6/17 in the afternoon, the video recording was reviewed, and showed Employee #19 physically escorting Patient #18 forcefully from the hallway to his room. On 1/5/17 in the afternoon, the CNO and the Nurse Manager demonstrated a mock restraint. The CNO and the Nurse Manager indicated it was not appropriate for a staff member to physically restrain a patient unless the patient was presenting an imminent danger to himself or others. Patient #8 / Employee #7 (MHT) Patient #8 was admitted to the facility on 8/10/16 with diagnoses including mood disorder. The document titled "Abuse Report", dated 10/14/16 and signed by the unit's Nurse Manager (Employee #15) indicated the patient was 15 years old and was laying on the floor and was picked up and placed in her bed. Patient #8 documented the incident (no date) that she was sitting on the floor and told to get into bed and the Mental Health Technician (Employee #7) "got in my face" and "yanked" her to put her in bed. On 1/5/17 at 2:45 PM, Patient #8 was interviewed and was asked about the incident. Initially the patient stated she "was told not to talk about it". She was asked about general issues including the food and her room. Patient #8 stated she was sitting on the floor in her room and Employee #7 grabbed		8. Additional Comments: a. Please note that Montevista Hospital is dedicated to treating all patients with dignity, care and respect. Any staff member who is found to be verbally and/or physically abusive to patients will be entered in to a disciplinary process up to and including termination. b. Please note that, per our discussions with law enforcement (Las Vegas Metropolitan Police), none of the incidents mentioned in this TAG meet the definition of sexual “abuse.” However, per our own policies, they do meet the definition of sexually inappropriate behavior and are dealt with as such. c. The corrective action items in this TAG will be monitored for completion by the Quality/Performance Improvement Council.	

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	her and put her in bed. Patient #11 documented on 10/13/16 at 6:50 PM "... (Patient #8) was sitting by the door again. Then (Employee #7) came back in (Patient #8's) room and told her to get in her bed. Then (Patient #8) said no leave me alone. Then (Employee #7) said if you don't get up imma help you get up". The document stated Employee #7 grabbed Patient #8. On 1/6/17 at 9:30 AM Patient #11 stated she and her roommate were watching Employee #7 and Patient #8 from their room across the hall and saw Employee #7 tell Patient #8 to go to bed and the patient refused, then Employee #7 picked her up. On 1/6/17 at 9:49 AM Patient #12, the roommate of Patient #11 stated Patient #8 was sitting on the floor and Employee #7 told the patient to get off the floor and Patient #8 refused. Employee #7 then grabbed her and was "disrespecting her". On 1/6/17 at 11:00 AM the Chief Nursing Officer stated Employee #7 should have handled the situation differently and needed to be reeducated. The CNO stated there was no need to put Patient #8 in bed. The CNO stated Employee #7 was counseled about the situation, but no documentation was located. Patient #5 / Patient #6 Patient #5, a male adolescent, age 13 years old, was admitted to the facility on 3/1/16 with diagnoses that included mood disorder, schizoaffective disorder, and suicidal ideations. Patient #5's physician documented on 3/7/16 "Patient is currently involved in a sexual misconduct investigation on the unit. He admitted to having intercourse with a female peer on the unit over the weekend on 4 separate occasions and stated they were all consensual". On 3/7/16 at 8:00 AM the facility's Director of Clinical Services documented "(Patient #6) immediately reported that he had been engaging in inappropriate sexual behaviors with another patient on the unit. (Patient #5) reported that it happened (4 times in total). Patient #6 Patient #6, a female adolescent, age 13 years old, was admitted to the facility on 3/2/16 with diagnoses that included pyromania and major depressive disorder. Patient #6's nurse documented on 3/7/16 "Patient stated the male peer had given her			

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	a letter asking her if she wanted to have sex with him. Patient stated they had been having sex for the past five days. Patient stated that she went into her peers' bathroom and had sex for a few minutes each time. Patient stated that no staff saw her and she did not see staff in the hall at shift change and snuck into her room when there were no staff in sight...". Facility documentation indicated the activity was reported to the Las Vegas Metropolitan Police Department and Child Protective Services, as well as the physicians and parents of the adolescent patients. The patients were screened for sexually transmitted disease. The patients were separated further apart. Every 15 minute checks (Q 15 minute checks) were ordered for both adolescents. On 1/5/17 the Nurse Manager of the unit was interviewed at 11:40 AM and stated the children planned the sexual encounters around the planned rounds by staff. On 1/5/17 the Director of Quality and Risk Management stated the facility investigated the incident, reported to the appropriate agencies and substantiated the allegation. The Police Department did not interview the patients "because nothing criminal happened". Patient #19 / Patient #20 Patient #19 Patient #19, a male adolescent, aged 17 years old, was admitted to the facility on 12/11/16 with diagnoses that included bipolar disorder and borderline disorder. Patient #20 Patient #20, a female adolescent, aged 14 years old, was admitted to the facility on 12/12/16 with diagnoses that included mixed personality traits with borderline antisocial behavior and mood disorder. The Unit's Milieu Manager (Employee #23) documented "On December 15, 2016 at 0740 AM" he was told by a patient that Patient #19 went into Patient #20's room the night before. The facility conducted an investigation including viewing the video footage in the Acute Adolescent hall where the patient's were inpatients. The Chief Nursing Officer stated on 1/17/17 the camera only showed the hallway, not the inside of patient's rooms and the footage of 12/14/16 was no longer available for inspectors to view. The Chief Nursing Officer documented on 12/14/16 at 9:42 PM			

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	a staff member was sitting on a chair in the hall. At 9:44 PM a staff member rounded the hallway to check on patients. At 9:46 PM the staff member put the chair back into the Dayroom. At 9:57 PM a staff member again rounded the hallway. From 10:00 PM until 10:14 PM no staff members were on the hallway. At 10:14 PM staff members again rounded the hallway and went back to the nursing station. At 10:17 PM Patient #19 was seen running into Patient #20's room. At 10:29 PM Patient #19 was seen walking back to his room. At 10:31 PM the staff was seen conducting rounds. The Investigation Report indicated Patients #19 & #20 were interviewed and the patients wrote statements. Patient #20 documented Patient #19 "... took me to the bathroom and touched my private area". Patient #19 documented he "made out" with the patient and "hugged her and fingered her last night". The report stated the Las Vegas Metropolitan Police Department, Child Protection Services and the guardians of the children were informed of the incident. The Chief Nursing Officer stated on 1/17/17 the Police Department interviewed the children but did not pursue the incident "because it was digital penetration only". The Chief Nursing Officer stated the Registered Nurse and Lead Mental Health Technician involved were counseled in writing and the Mental Health Technician responsible for the Acute Adolescent hallway was terminated. The facility's policy titled "Levels of Observation - Q 15 minute checks" stated "Staff are to be roving the halls at all times while patients are in their rooms". The facility's Abuse Policy (Child and Elder Domestic and Sexual Abuse, revised 6/2016) indicated: Definition of Child and Domestic Abuse: A child is defined as a person under the age of 18. 11. Staff to Patient Abuse: 11.1: If physical, sexual, emotional or verbal abuse is reported, witnessed, or suspected the staff member alleged to be a violator shall be immediately suspended from work and sent home by the supervisor on duty at the time, returning pending the investigation. The victim shall be assessed by the Charge Nurse regarding their mental, emotional, and physical status and the necessary			

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	interventions shall be done to restore their safety and sense of security. The Director of Clinical Services, Risk Manager and Director of Social Services conduct an investigation. The Abuse Algorithm provided by the Director of QRM indicated the Steps to Take in the Event of Suspected Patient Abuse by Staff was to start the investigation: 1. Review video if possible & place IT (Information Technology) ticket to save video segment. 2. Interview potential witnesses: Staff and patients at alleged date & time. 3. Ask Staff to write or type statement & sign, time and date it. 4. Ensure Incident Report is written. 5. Obtain case or report #'s from police &/or CPS (Child Protective Services). 6. Ensure all is documented in patient's chart & update treatment plan. 7. Review findings with Administration & determine outcome." The facility's Restraint Policy (Seclusion / Restraint / Physical Hold, revised 10/2015) indicated, Seclusion and Restraint (S/R) Interventions are implemented only as a last resort to support patient safety when behaviors pose a risk of imminent harm to the patient or others. All patients have the right to be free from S/R of any form that is imposed as a means of coercion, discipline, convenience or retaliation by staff. The RN (Registered Nurse) and unit staff implement the least restrictive, non-physical interventions. Definitions: Physical Escort: Using a 'light' grasp to escort a patient to a desired location. If the patient cannot easily remove or escape the grasp this would be a physical restraint. Physical Restraint / Hold: Any manual or physical method of holding the patient against the patient's will that restricts freedom of movement or normal access to one's body. Severity: 3 Scope: 2 Complaint #NV00045403 Complaint #NV00047158 Complaint #NV00048058			
0322 SS= D	NAC 449.3628 - Protection of Patients - 2. The governing body shall develop and carry out policies and procedures that prevent and prohibit neglect and misappropriation of the personal property of a patient. Inspector Comments: Based on interview,	0322	<u>1. How will you correct the specific finding (s) stated in the Statement of Deficiencies?</u> a. Pursuant to this incident staff have been educated on the importance of securing	01/30/2017

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	record review and document review, the facility failed to ensure a patient's shoes were not misappropriated by another patient for 1 of 18 sampled patients (Patient #16). Findings include: Patient #16 was a 12 year old male admitted to the facility 8/19/16. Patient #16 was discharged from the facility to home AMA (Against Medical Advice) on 9/15/16 with his Mother. The Discharge Summary documented discharge diagnoses including major depressive disorder and oppositional defiant disorder, and indicated, "This was an AMA discharge. Mother wanted to take him out of the program. She felt too many peers were getting into fights with him." The Belongings Inventory List documented the following: 8/22/16: (1) Shoes 8/28/16: (1) pair shoes The facility's policy and procedure, "Patient Rights - Patient Belongings & Contraband", revised 07/2015, indicated, "E. Patient Belongings: 3. Belongings are to be itemized on the belonging list when brought to the unit. 4. Staff to update the belonging list when visitors bring new items for patient and date each entry. 5. Upon discharge the patient is to review belongings list and sign for articles they are taking home..." On 1/6/17, the Milieu Manager provided the Incident Report dated 9/16/16, which documented the patient had told his Mother he was being bullied, and that his shoes were stolen. However, the patient told staff that he gave the shoes to a peer to make friends, but didn't want to get into trouble with his mom. On 1/6/17 at 2:45 PM, the Director of Quality indicated the facility became aware after the discharge the patient was not discharged with his shoes. There was no documentation in the patient's record regarding the misappropriation of the shoes. There was no documented evidence the facility made a reasonable attempt to locate the missing shoes. The Director of Quality verified at 3:00 PM the shoes were never returned to the patient. The facility did not comply with their Valuables Policy which requires that a patient's belongings are returned to the patient upon discharge. The facility did not take action to compensate or locate the shoes once they became aware they were not provided to the patient upon discharge.		patient belongings and ensuring that patients do not confiscate other patients' belongings. As a result, incident reports involving patient theft/loss have steadily decreased for the 4th Qtr. 2016. b. Nurse Managers and Senior Leadership have verbally reinforced Policy 1800.24 – Patient Belongings and Contraband with all Staff through in-services and at staff meetings. c. If belongings are unable to be located upon discharge, a request for reimbursement of the patient and/or family is made in compliance with Policy 1800.24. This request is reviewed by the CNO and the Director of Quality, Performance Improvement, Compliance and Risk Management prior to issuing a reimbursement. <u>2. What measure or systematic change(s) will be put in to place to ensure the deficient practice does not recur?</u> Beginning Jan. 2017, a specific line item was added to Montevista's Incident Report Dashboard where we are able to track and trend the loss of patient belongings separate from other theft/loss-related incidents. <u>3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</u> a. Using the data obtained from the Dashboard referred to in #2 above, we will be able to monitor the frequency of incidents involving the loss of patient belongings. b. Any time patient belongings are unable	

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	Severity: 2 Scope: 1 Complaint #NV00047102		to be located, a manager or a member of Senior Leadership is involved in order to facilitate prompt reimbursement when warranted. c. The findings from the Dashboard compilation of lost patient belongings will be forwarded to the Quality/PI Council, the MEC, and the Governing Board at each of their respective meetings. d. The corrective action items in this TAG have been incorporated in to our new employee orientation. 4. The title of the person responsible for ensuring the Plan of Correction is implemented. Chief Nursing Officer (CNO) 5. The date the corrective action will be completed 01/30/2017 6. Supporting documents attached: Policy 1800.24 – Patient Belongings and Contraband 7. How you will identify and correct other areas having potential to be affected by the deficient practice (if applicable). Via 1a,b&c, 2a, and 3a&b above. 8. Additional Comments: The corrective action items in this TAG will be monitored for completion by the Quality/Performance Improvement Council.	
0602 SS= G	NAC 449.394 - Psychiatric Services - 3. A hospital shall develop and carry out policies and procedures for the provision of psychiatric treatment and behavioral	0602	1. How will you correct the specific finding (s) stated in the Statement of Deficiencies?	01/30/2017

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	management services that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and services are safely and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient. Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to: 1) Provide protective supervision to ensure a 9 year old child did not elope (Patient #14); 2) Provide protective supervision to ensure a 17 year old patient did not gain access to a nail and did not prevent bullying of the patient (Patient #19); and 3) Ensure adequate emergency response mechanisms were available to be put into place for staff in the event of a patient elopement or other patient emergency for the Outpatient Program. Findings include: Patient #14 Patient #14 was a 9 year old male admitted to the Partial Hospitalization Program (PHP - Outpatient Program) on 12/21/16 with diagnoses including unstable mood affective disorder, attention deficit hyperactivity disorder, oppositional defiance disorder, psychosis, and asthma. The Facility's Incident Reporting, which was reviewed with the Director of Outpatient Services and the Director of Quality & Risk Management on 1/6/17, documented that Patient #14 eloped from the facility's premises (Medical Office Building) on 12/21/16 at some time between 1:30 PM and 1:40 PM. The Incident Report documented that Patient #14 was found at the gas station in Las Vegas, Nevada on Flamingo Road and Jones Boulevard at 2:00 PM on 12/21/16. On 1/6/17, the Director of Outpatient Services indicated Patient #14 walked away from the Mental Health Technician (MHT: Employee #14) while he and a group of adolescent patients were being escorted from the Acute Psychiatric Facility to the Medical Office Building. The Director indicated the MHT could not leave the rest of the patients by themselves, and had to wait until they all reached the Medical Office Building to realize Patient #14 was not in the building, and find out where Patient #14 had gone.		*a. Elopement of a PHP patient* Because our PHP program is an outpatient program and is not a locked inpatient facility, despite best efforts, elopement from the program is a possibility. As a result of the incident involving Patient #14, Montevista Hospital has implemented the following: i. The use of “walkie-talkies” so that staff can communicate with one another should they need assistance; ii. The reinforcement of our elopement policy which, under the sub-heading of “In the Event of Elopement,” indicates that the order of notification of an elopement is police first, then CNO, then patient’s family. iii. Because of the unlocked building, the hospital is reviewing admission criteria for patients to the PHP and is considering history of elopement as a possible exclusionary criteria. iv. The Director of Outpatient Services is currently working with the Director of Activities Therapy to determine ways in which the program schedule can be changed in order to reduce the number of trips between the Medical Office Building and the Main Hospital, thus reducing opportunities for elopement and lowering risk. *b. Self-harm by a 17-year old patient* Pursuant to this event, all courtyards were checked by on Plant Operations Department for any contraband or items that could be used by a patient to harm self or others. The Environmental Unit	

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	On 1/10/17, the MHT (Employee #14) indicated during a telephone interview that he was the only MHT with the responsibility of escorting approximately 11 other adolescent patients from the hospital to the Medical Office Building. Patient #14 told him he needed to go use the bathroom, and the MHT gave consent for him to go ahead of the other patients, and meet everybody inside the Medical Office Building. The MHT verbalized he lost visual sight of Patient #14. The MHT further indicated by the time the group arrived at the Medical Office Building they went to the classroom, and Patient #14 was not anywhere to be seen. The MHT indicated Employee #17, his supervisor, was notified that Patient #14 was missing. A search party was then organized, and staff began searching for the patient at the nearby apartment complex and the library. The MHT indicated he did not contact the police, and, to his knowledge, his supervisor did not contact the police. The patient was later found to be at a nearby gas station with his mother, who drove away with him. On 1/10/17, the Director of Outpatient Services indicated via telephone it was the facility's policy they notify the parent first if a child elopes, and stated, "Typically we want to notify the family and then notify the police. We initiated search mode for the patient. The police were not called. By the time we connected with the Mother she was already with the patient at the gas station." The facility's Elopement Precautions policy (Policy number 1000.30, developed 08/2005): "In event of elopement, announce "Elopement" and location of the elopement on overhead to summon assistance. Designate staff to search for patient on hospital grounds. Do not pursue fleeing patients off of hospital grounds (exception: elderly patients). Try and ascertain direction of travel. If patient has eloped off of hospital grounds, notify police and provide police with description of patient, clothing, and photograph and advise police of any immediate risks, such as suicide or assault potential. Notify the Director of Nursing. Notify guardian or next of kin." The facility's Level of Care Criteria indicated the facility provides one standard of care while		Rounds Checklist has been revised and any areas or items of potential self-harm will be assessed three times per day and removed from the environment. *c. Bullying Allegation* Pursuant to the event… i. An in-service was held with patient care staff with specific reference to the expectation that: Patients who engage in bullying or report having been bullied shall be considered for increased precautions such as line of sight observation or one-to-one monitoring. ii. Programming has been amended whereby patients will receive interventions to increase coping skills regarding how to resist bullies as well as how to manage one's anger without bullying others. <u>2. What measure or systematic change(s) will be put in to place to ensure the deficient practice does not recur?</u> *a. Elopement* i. Direct-care staff for PHP were provided an in-service on the following: (a) They are responsible for the welfare and safety of all patients within their care and that no patient should be allowed to "run ahead to use the bathroom." (b) In the event of an elopement, EMS/the Police will be notified prior to contacting the parent as per our Elopement policy. (c) All patients should be offered a bathroom break prior to transition periods (i.e. movement from the Medical Office Building to the Main Hospital). ii. Direct-care staff for PHP are being asked to sign an Attestation Letter indicating	

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	meeting the patient's individualized needs through a variety of programs based on established admission, continued stay, discharge, and exclusion criteria. Section 3.2 (page 20) indicated for the Child & Adolescent - Partial Hospitalization Program, the patient must meet at least one of the following criteria for severity of illness. Treatment of a psychiatric disorder and co-morbid substance abuse requires a structured psychiatric setting; the patient is at risk to self or others that will escalate without a structured day program; there is evidence of risk and threat towards others and property; or, as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, representing potential serious harm to self. The facility failed to ensure police were contacted after a 9 year old mentally ill child was missing. The facility failed to ensure there was a reasonably adequate system in place for the Mental Health Technicians to provide oversight and emergency response to summon assistance in case of an emergency for up to 12 adolescent patients. Patient #19 Patient #19, a male adolescent, aged 17 years old, was admitted to the facility on 12/11/16 with diagnoses that included bipolar disorder and borderline disorder. Patient #19's "Assessment Form Update", dated 12/12/16 documented the patient "reported that a peer had tried to fight him & another peer had repeatedly encouraged him to fight. (Patient #19) reported not wanting to fight, but instead admitted to grabbing a nail and started self-harming & destroying property". On 1/17/17 the Chief Nursing Officer and the Director of Quality and Risk Management were interviewed together. The CNO and the Director stated facility staff failed to prevent the patient from obtaining the nail and it was probably obtained from the courtyard as the courtyard had been covered in dust after construction. The Chief Nursing Officer stated the facility's process for protecting patients from bullying at the primary level of protection was observation. Methods included observational roving and increasing the level of precaution accordingly, for example, line of sight observation or one to one monitoring.		their understanding of their responsibility for patient safety and welfare. *b. Patient Self-Injury* The Environmental Unit Rounds Checklist was revised to include an assessment for sharps or other objects that could potentially be used for self-harm. *c. Prevention of Bullying* i. Staff were apprised through in-service activity to be on the alert for any bullying. ii. The patient handbook emphasizes that bullying shall not occur or be tolerated. Staff will emphasize this content as part of the orientation of the patient of the program and encourage the patient to report any bullying to the hospital team. iii. Staff aware of patients bullying others will report the incident to the treatment team and physician for consideration of changing the patient to a closer observation or higher status. <u>3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</u> The Director of Outpatient Clinical Services, in consultation with Senior Leadership, will monitor the activity of the PHP direct care staff to ensure that they are compliant with policies and procedures including: a) Notification of police prior to the family in the event of elopement; b) Expanded EOC Safety Rounds, and c) Delineation and discussion of bullying and what to do if one is bullied at time of orientation of patients to the program. The findings from this review will be reported at the Quality/PI Council, Medical Executive Committee and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	650	A. BUILDING _____ B. WING _____	01/17/2017

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	Severity: 3 Scope: 1 Complaint #NV00047895 Complaint #NV00048058		Governing Board at each of their respective meetings. The corrective action items in this TAG have been incorporated in to our new employee orientation. 4. The title of the person responsible for ensuring the Plan of Correction is implemented. Director of Outpatient Clinical Services 5. The date the corrective action will be completed. a. In-services completed for staff on 1/30/2017. b. The Department of Plant Operations checked all of our courtyards between 1/19/2017 and 1/27/2017 for contraband or items that could be used by a patient to harm self or others. c. Anti-bullying emphasis to be discussed as part of orientation of patients to program beginning on 1/30/2017. 6. Supporting Documents Attached a. Elopement Policy b. Training Attestation c. Environmental Unit Rounds Policy d. Environmental Unit Rounds Checklist 7. How you will identify and correct other areas having potential to be affected by the deficient practice (if applicable). Via the implementation of #1(a)(i-iv), #1(b), #1(c)(i-ii), #2(a)(i-ii), #2(b), #2(c)(i-iii) above.	

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			8. Additional Comments: a. Although we have considered whether we could lock the doors at our MOB so that patients could not leave, we determined that we cannot, as this would be considered a denial of rights and incompatible with an outpatient level of care. b. The corrective action items in this TAG will be monitored for completion by the Quality/Performance Improvement Council.	